Centers for Medicare & Medicaid Services (CMS)

Standard Companion Guide

Health Care Claim Status Request and Response (276/277)

Based on ASC X12N TR3, Version 005010X212

Companion Guide Version Number: 8.2,
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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 276/277 Technical Report Type 3 (TR3) Version 005010 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)
- Chapter 31 – X12 Formats Other than Claims or Remittance (https://www.cms.gov/manuals/downloads/clm104c31.pdf)

1.1 Scope

EDI addresses how Trading Partners exchange professional and institutional claims, claim acknowledgments, claim remittance advice, claim status inquiry and responses, and eligibility inquiry and responses electronically with Medicare. This CG also applies to ASC X12N 276/277 transactions that are being exchanged with Medicare by third parties, such as clearinghouses, billing services or network service vendors.

This CG provides technical and connectivity specification for the 276/277 Health Care Claim Status Request/Response transaction Version 005010.

1.2 Overview

This CG includes information needed to commence and maintain communication exchange with Medicare. In addition, this CG has been written to assist you in designing and implementing the ASC X12N 276/277 transaction standards to meet Medicare's processing standards. This information is organized in the sections listed below:

- *Getting Started:* This section includes information related to hours of operation, 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 276/277.
- *Acknowledgments and Reports:* This section contains information on all transaction acknowledgments sent by Medicare and report inventory.
- *Trading Partner Agreement:* This section contains information related to implementation checklists, transmission examples, Trading Partner Agreements and other resources.
- *Transaction Specific Information:* This section describes the specific CMS requirements over and above the information in the ASC X12N 276/277 TR3.

1.3 References

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

Table 1. EDI Transactions and Code Set References

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

1.4 Additional Information

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

Table 2. Additional EDI Resources

Resource	Web Address
Medicare FFS EDI Operations	https://www.cms.gov/ElectronicBillingEDITrans/
CAQH Core Phase II Policy Rules	https://www.caqh.org/sites/default/files/core/phase-ii/policy-rules/250-v5010.pdf
Central Version 005010 and D.0 web page on the CMS website	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html
Medicare FFS EDI Operations	https://www.cms.gov/ElectronicBillingEDITrans/
Responses to Technical Comments	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/AdoptedStandardsandOperatingRules.html

2 Getting Started

2.1 Working Together

National Government Services (NGS) is dedicated to providing communication channels to ensure communication remains constant and efficient. NGS has several options to assist the community with their electronic data exchange needs. By using any of these methods NGS 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 NGS 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 NGS EDI help desk and email access, see Section 5 for additional contact information.

NGS also has several external communication components in place to reach out to the Trading Partner community. NGS posts all critical updates, system issues and EDI-specific billing material to their website (https://www.ngsmedicare.com/); after creating an account and/or login, then select Resources > EDI Solutions option. All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. NGS also distributes EDI pertinent information in the form of an EDI newsletter or comparable

publication, which is posted to the website every month. In addition to the website, a distribution list has been established in order to broadcast urgent messages. Please register for NGS distribution list by selecting "Subscribe to Email Updates," to register with the appropriate line of business.

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

2.2 Trading Partner Registration

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

Medicare FFS and NGS 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 NGS 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 NGS.

To register with NGS EDI, providers must complete the following registration forms:

- The EDI Enrollment Agreement which indicates providers' acceptance to comply with CMS instructions for use of electronic transactions.
- The EDI Registration Form to request a submitter identifier (ID).

If the provider will be using a clearinghouse or other third-party billing service, the provider must also submit an EDI Registration Form. A clearinghouse or other third-party billing service may register for a submitter ID by completing the EDI Registration Form. Third party submitters will not be issued a submitter ID unless a provider has submitted an EDI Registration form authorizing the third party to perform EDI transactions on their behalf.

The EDI registration forms are submitted online via the NGS website (https://www.NGSMedicare.com), select Resources, > EDI Enrollment.

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 NGS furnish information on EDI to new Trading Partners that request Medicare claim privileges. Additionally, Medicare requires NGS 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 NGS prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. NGS is required to verify that NPI is on the Provider Enrollment Chain and Ownership System (PECOS). If the NPI is not verified on the PECOS, the EDI Enrollment Agreement is denied, and the provider is encouraged to contact the appropriate MAC provider enrollment department (for Medicare Part A and Part B provider) or the National Supplier Clearinghouse (for Durable Medical Equipment suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

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

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

Third parties are required to register with NGS 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 on the NGS website (https://www.NGSMedicare.com), under Resources, > EDI Enrollment.

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

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

2.3 Trading Partner Certification and Testing Process

New NGS submitters are required to test with NGS. The exception is new submitters who are using an approved vendor software package or the PC-ACE free billing software.

Claims Testing

- Testing is available to all submitters 24/7.
- Test 837 claim files should be limited to 25-100 claims. (ISA15 Test/Prod Indicator submitted with a 'T').
- The TRN report and acknowledgement transactions TA1 and 999 will be available within minutes.
- The 277 Claims Acknowledgment (277CA) will follow within 2 hours of the TA1 and 999 transactions. The acknowledgement transactions will require translation to a 'human readable' or text format. See Section 8 for more detail on Reports and Acknowledgments.
- Test claims will not be sent to the claims systems.
- Production Criteria for 837 Claims:
    - Level I syntax compliance – 100%.
    - 999 Acknowledgement status is 'Accepted'.
    - Level Medicare situational and business edit compliance – 95%.
    - 277 Claims Acknowledgement indicates 95% claim acceptance.
    - Trading Partners will be notified with approval for production for 837 claims submission.

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 NGS, 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 on the NGS website (https://www.NGSMedicare.com), select Resources, > EDI Enrollment.
    - 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. When appropriate, NGS will test and approve software vendor products for 5010 compliance with NGS. NGS will not require each of the clients (submitters) to test with NGS.

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

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

3.2 Certification Requirements

Medicare FFS does not certify Trading Partners. However, NGS does certify vendors, clearinghouses, and billing services by conducting testing with them and maintaining an approved vendor list that can be accessed on the NGS website (https://www.NGSMedicare.com), select Resources, > EDI Enrollment.

4 Connectivity / Communications

4.1 Process Flows

Process flows for batch submissions of the HIPAA Transactions Sets can be found in the front matter of the applicable TR3.

NGS supports two EDI Gateways. Requirements for telecommunications for each Gateway are as follows:

sFTP Gateway

All submitters (providers and third-parties) must contract with an NGS Network Service Vendor (NSV) for connectivity to the Secure File Transfer Protocol (sFTP) Gateway. The list of approved NGS NSVs is available on the NGS website (https://www.NGSMedicare.com), Resources, EDI Solutions, Network Service Vendors.

Internet Gateway

In addition to the sFTP Gateway solution, Trading Partners have the option to send/receive batch 276 Claim Status Inquiry transactions, 277 Response Transactions and receive 835 transactions via an NGS Internet EDI Gateway. This Internet solution has been developed to be compliant with CAQH/CORE Phase I, II and Phase III Batch and Telecommunications Operating Rules, excluding real time. The TA1 and 999 Transactions will also be available for download in response to 276 transactions.

Trading Partners choosing to use the Internet Gateway for 276/277 file transfer and/or 835 ERA access will continue to have the capability to access the sFTP Gateway for batch file transfer activities for these transactions as well as for submission of their 837 claim file submissions. No additional EDI Enrollment forms are necessary for access to the NGS Internet Gateway.

Requirements for Trading Partners who wish to facilitate file transfer of the 276/277 Claim Status Inquiry and Claim Status Response over the Internet Gateway:

- Must support HTTP/S V1.1 transport over the Internet Gateway.
- Must support HTTP v1.1+ Message Envelope Standards and Message Exchanges:
    - {Hypertext Transfer Protocol & Multipurpose Internet Mail Extensions (HTTP+MIME) or
    - Simple Object Access Protocol & Web Service Definition Language (SOAP+WSDL) Message}.

Samples of HTTP+MIME and SOAP+WSDL Messaging Standards can be found in the CAQH CORE Connectivity Operating Rules vC4.0.0
(https://www.caqh.org/sites/default/files/core/CAQH%20CORE%20Connectivity%20Rule%20vC4.0.0_0.pdf)

- Within the HTTP+MIME and SOAP+WSDL envelopes the Sender and Receiver IDs must be populated as follows:
    - Sender ID = NGS Assigned Trading Partner ID
    - Receiver ID = NGSEDI
- In the Outbound transactions, NGS will populate the Sender ID with NGSEDI and the NGS Assigned Trading Partner ID as the Receiver ID.
- Obtain X.509 certificate for authentication purposes from the NGS preferred X.509 Certificate Vendors list. See Section 4.2 for sending certificate information to NGS.
- Information about the HTTP:MIME Protocol (https://www.edi.ngsmedicare.com/CoreBatchGateway/TransactionSocketServlet) can be found on the NGS website.

- Information about the SOAP/WSDL Protocol (https://www.edi.ngsmedicare.com/CoreBatchGateway/soap/coreservice?wsdl) can be found on the NGS website.

4.2 Transmission

NGS sFTP Gateway is accessed through an NGS-approved NSV. NGS requires use of the sFTP protocol for file transfer.

A list of the approved NGS NSVs, can be found on the NGS website (https://www.NGSMedicare.com), under the Resources, select the EDI Solutions, Network Service Vendors.

Access to the NGS Internet Gateway requires the trading partner to share their X.509 digital certificate information with NGS for authentication purposes.

- Trading Partners will submit the X.509 file provided by the Certificate Authority to the NGS sFTP Gateway.
- Trading Partners will use the Submitter ID and password assigned for access to the sFTP Gateway to transfer the X.509 digital certificate file.
- NGS will validate the Certificate information and respond with the results of the validation via the TRN report.
    - Certificates must be obtained from the NGS approved Certificate Authority, DigiCert;
    - Certificates cannot be valid for longer than three (3) years;
    - Only one Certificate is allowed per Trading Partner (Submitter) ID;
    - A Trading Partner with multiple Submitter IDs, must provide a Certificate for each Submitter ID.
    - Certificates cannot be transferred from one Trading Partner to another.
    - The status of the transmission of the Certificate file will be communicated via the TRN report. If the file transfer is successful, a TRN Report will be generated indicating that no errors were identified. When the file transfer is unsuccessful, the following messages that may be returned are:
        - TRNACK when a Certificate has incomplete or missing certificate information Error number = 101 Severity = 1 Incomplete or missing certificate information – Serial Number
        - Error number = 101 Severity = 1 Incomplete or missing certificate information – Issuer DN
        - Error number = 101 Severity = 1 Incomplete or missing certificate information – Subject DN
        - Error number = 101 Severity = 1 Incomplete or missing certificate information – Start Date

- Error number = 101 Severity = 1 Incomplete or missing certificate information – End Date
- TRNACK when a Certificate has already been loaded to current Org Error number = 201 Severity = 1 Duplicate - Certificate already on file for this Trading Partner
- TRNACK when a Certificate has already been assigned to a different Org Error number = 301 Severity = 1 Certificate linked to another Trading Partner
- TRNACK when a Certificate is expired Error number = 401 Severity = 1
- Certificate Authority not approved - PKIX path validation failed: java.security.cert.CertPathValidatorException: timestamp check failed
- TRNACK when a Certificate Authority is not approved Error number = 401 Severity = 1 Certificate Authority not approved – {message}
- TRNACK when a Certificate is valid for more than 3 years Error number = 501 Severity = 1 Validity period > 3 years
- TRNACK when a Certificate is invalid for an exception. This error may occur instead of the “101” errors. Error number = 602 Severity = 1 Certificate exception {message}
- TRNACK when a Certificate is invalid, not properly formatted Error number = 602 Severity = 1 Fail to parse input stream

Note: TRN Reports will be generated for 276 Claims Status Inquiry files sent via the NGS Internet Gateway; however, they will not be available for retrieval via the internet Gateway. TRN Reports generated for 276 files submitted via either NGS Gateway will be available for retrieval via the NGS sFTP Gateway only.

4.2.1 Re-transmission Procedures

Submitters should not retransmit any file that has successfully passed EDI editing without specific instruction from NGS.

Submitters may retransmit any file that has failed EDI editing, once the file has been corrected.

4.3 Communication Protocol Specifications

NGS supports Secured FTP (sFTP) protocol for all EDI file transfer activity through the NGS sFTP Gateway. Connectivity to this gateway is obtained through an NGS-approved NSV.

The NGS Internet Gateway requires the following protocols:

- HTTP/S V1.1
- HTTP/MIME; or
- SOAP/WSDL

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

Upon registering with NGS for EDI or DDE services, NGS will provide a submitter or User ID and a default password. The default password will expire upon initial use to allow the user to define a unique password. See Section 2.2 for EDI registration procedures.

NGS has specific requirements for establishing passwords for both file transfer submitter IDs and Resource Access Control Facility (RACF) User IDs for access to the DDE application. These requirements are as follows:

- The password length must be eight (8) characters.
- Contain a combination of alpha and numeric characters.
- Passwords must have at least one (1) of these special characters -- @, # or $ --.
- Passwords must include at least one (1) uppercase and one (1) lowercase letter (case sensitive).
- May not contain a four letter or greater ‘dictionary’ word, i.e., any word four letters or greater that can be found in a dictionary.
- A minimum of four characters must be changed in each password reset.
- May not be changed more than once in any 24-hour rolling period.
- You should choose passwords that are easy for you to remember but hard for others to guess. One of the easiest ways to choose a password is to use the first letters of a phrase you can easily remember. For example, "I like to go to the dollar theater" could translate to "IL2GTT$t." Other examples of acceptable passwords include SPR1Ng$4 and C@nad@01.
- You should never write down your passwords or share them with anyone.
- DDE RACF user IDs are revoked after three (3) consecutive unsuccessful password attempts.
- Use of previous 12 passwords is prohibited.
- Reset passwords cannot be the same as any of the previous 12 passwords.
- EDI Submitter ID passwords will expire after 60 days.
- EDI Submitter IDs will suspend after 30 days of inactivity.
- Inactive DDE RACF user IDs will auto revoke after 30 days. After 60 days of inactivity the DDE RACF user ID will be permanently deleted.
- The DDE RACF passwords can only be reset one time a day. End-users must wait a minimum of one (1) day before they can change their own password again.

- DDE RACF passwords expire after 30 days. Users are required to enter a new valid password upon receiving this prompt from the system.

5 Contact Information

5.1 EDI Customer Service

EDI Help Desk:

J6: 877-273-4334

JK: 888-379-9132

EDI Help Desk hours:

7:00 a.m.-4:00 p.m. CT / 8:00 a.m.-5:00 p.m. ET

Inquiries can be sent using the EDI Help Desk Email Inquiry Form found on the NGS Website (https://www.NGSMedicare.com), select Resources, Contact Us, follow the link to the EDI Help Desk Information.

5.2 EDI Technical Assistance

EDI Help Desk:

J6: 877-273-4334

JK: 888-379-9132

EDI Help Desk hours:

7:00 a.m.-4:00 p.m. CT / 8:00 a.m.-5:00 p.m. ET

Inquiries can be sent using the EDI Help Desk Email Inquiry Form found on the NGS Website (https://www.NGSMedicare.com), select Resources, Contact Us, follow the link to the EDI Help Desk Information.

5.3 Trading Partner Service Number

For questions on claims in the claim s systems or questions on remittance payments, contact the Provider Customer Care or the IVR number.

JK:

- IVR: 877-567-7205
- Toll-Free Number: 888-855-4356
- TTY: 866-786-7155

J6:

- Illinois, Wisconsin, and Federally Qualified Health Centers: IVR: 877-567-7206
- Toll-Free Number: 877-702-990
- TTY: 888-897-7523

Hours Available:

- Monday – Friday, 7:00 a.m.-4:00 p.m. CT / 8:00 a.m.-5:00 p.m. ET
- Thursdays closed for training: 1:00-3:00 p.m. CT / 2:00-4:00 p.m. ET

5.4 Applicable Websites / Email

Refer to Sections 1.4 for applicable websites and Section 5 for email contact.

6 Control Segments / Envelopes

Enveloping information must be as follows for the 276:

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

Table 3. ISA Interchange Control Header (276)

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA01	Authorization Information Qualifier	00, 03	ISA01 must be “00” or “03”.
C.4	ISA02	Authorization Information	-	Medicare expects 10 spaces.
C.4	ISA03	Security Information Qualifier	00, 01	Medicare expects the value to be “00” or “01”.
C.4	ISA04	Security Information	-	Medicare expects 10 spaces.
C.4	ISA05	Interchange ID Qualifier	27, 28, ZZ	ISA05 = “27”, “28”, or “ZZ”.

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA06	Interchange Sender ID	-	This value is required to be in the 2100A Loop, NM1 Segment, NM109 data element.
C.5	ISA07	Interchange ID Qualifier	27, 28, ZZ	ISA07 = “27”, “28”, or “ZZ”.

Page #	Element	Name	Codes/Content	Notes/Comments
C.5	ISA08	Interchange Receiver ID	-	**Institutional:** • California (HHH) 06014 • Connecticut 13101 • Illinois 06101 • Maine 14011 • Massachusetts 14211 • Minnesota 06201 • New Hampshire 14013 • New York 13201 • Rhode Island 14411 • Vermont 14013 • Wisconsin (incl. FQHC and HHH) 06001 **Home Health & Hospice (HHH)**: • Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont only 14011 **Professional:** • Connecticut 13102 • Illinois 06102 • Maine 14112 • Massachusetts 14212 • Minnesota 06202 • New Hampshire 14312 • New York (Upstate) 13282 • New York (Downstate) 13202 • New York (Queens) 13292 • Rhode Island 14412 • Vermont 14512 • Wisconsin 06302
C.5	ISA11	Repetition Separator	-	Defined by the submitter and must be present.

Page #	Element	Name	Codes/Content	Notes/Comments
C.6	ISA14	Acknowledgement Requested	1	Medicare requires submitter to send code value 1 - Interchange Acknowledgment Requested (TA1). Medicare will only return a TA1 segment when there is an error in the ISA/IEA Interchange Envelope.

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

Table 4. GS Functional Group Header (276)

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	-	Submitter number assigned by NGS.

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS03	Application Receiver Code	-	**Institutional:** • California (HHH) 06014 • Connecticut 13101 • Illinois 06101 • Maine 14011 • Massachusetts 14211 • Minnesota 06201 • New Hampshire 14013 • New York 13201 • Rhode Island 14411 • Vermont 14013 • Wisconsin (incl. FQHC and HHH) 06001 **Home Health & Hospice (HHH)**: • Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont only 14011 **Professional:** • Connecticut 13102 • Illinois 06102 • Maine 14112 • Massachusetts 14212 • Minnesota 06202 • New Hampshire 14312 • New York (Upstate) 13282 • New York (Downstate) 13202 • New York (Queens) 13292 • Rhode Island 14412 • Vermont 14512 • Wisconsin 06302
C.7	GS04	Functional Group Creation Date	-	Must not be a future date.
C.7	GS08	Version Identifier Code	005010X212	GS08 must also match the ST03.

Enveloping information will be sent as follows for the 277:

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

Table 5. ISA Interchange Control Header (277)

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA01	Authorization Information Qualifier	00, 01	Medicare will send “00”.
C.4	ISA02	Authorization Information	-	Medicare will send 10 spaces.
C.4	ISA03	Security Information Qualifier	00	Medicare will send “00”.
C.4	ISA04	Security Information	-	Medicare will send 10 spaces.
C.4	ISA05	Interchange ID Qualifier	ZZ	Medicare will send “ZZ”.
C.4	ISA06	Interchange Sender ID	-	Medicare will send back the value from 276 ISA08.
C.5	ISA07	Interchange ID Qualifier	ZZ	Medicare will send “ZZ”.
C.5	ISA08	Interchange Receiver ID	-	NGS-assigned Submitter ID. Medicare will send back the value from 276 ISA06.
C.5	ISA11	Repetition Separator	-	NGS repetition separator character.
C.6	ISA14	Acknowledgement Requested	0	Medicare requires submitter to send code value 1 - Interchange Acknowledgment Requested (TA1). Medicare will only return a TA1 segment when there is an error in the ISA/IEA Interchange Envelope.

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

Table 6. GS Functional Group (277)

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	-	NGS contract code (the Submitter is Receiving). Medicare will send back the value from 276 GS03.

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS03	Application Receiver Code	-	NGS-assigned Submitter ID. Medicare will send back the value from 276 GS02.
C.8	GS08	Version Identifier Code	005010X212	GS08 must match ST03.

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

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

6.1 ISA-IEA

Delimiters – Inbound Transactions

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

Delimiters – Outbound Transactions

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

Table 7. Outbound Transaction Delimiters

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

Inbound Data Element Detail and Explanation

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

6.2 GS-GE

Functional group (GS-GE) codes are transaction-specific. Therefore, information concerning the GS/GE Functional Group Envelope can be found in Tables 4 and 6.

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

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

7.2 General Transaction Notes

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

- For 276 files processed through the batch process that are received before 9PM EST, the 277 responses are returned the next business day by 7AM EST.
- 276's sent for dental claims that were processed in the cloud will receive the 'Not Found' on the 277 responses.
- Part A will be returning claim level status information, but not line level status information.
- Information Receiver Status Information (Loop ID 2200B, STC – Segment Rule) has a limitation of up to five iterations allowed for all occurrences in these transactions.
- Dependent level is never used for Medicare.
- Reference TR3 Appendix B.1.1.3.1.2 for notes regarding amount fields in this transaction set.
- Real Time Claims Status – 276 files formatted with one inquiry per (ST-SE) will be routed through the Real Time Claim Status process.
    - In most cases, the 277 claim status response file will be received within minutes instead of hours.
    - The Real Time Claims Status process runs during the existing claim system availability on regular business days. The process will not be available on weekends and holidays. Files eligible for the

real time process received during off hours will be held and processed when the systems become available.

- Real Time Claims Status process is excluded from the following (will be processed through the Claims Status Batch process):
  - Inquiries with a 2200D DTP03 date span greater than 1 year.
  - 276 files formatted with multiple inquiries per ST-SE.

7.3 Medicare Specific Business Rules

NGS has no Medicare specific business rules.

8 Acknowledgments and Reports

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.

The following two acknowledgments will replace proprietary reports previously provided by NGS.

8.1 TA1 Interchange Acknowledgment

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

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

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

8.2 999 Implementation Acknowledgment

Medicare FFS has adopted the ASC X12 999. For submissions that are out of compliance with the ASC X12N Version 005010 standard, the appropriate response for such errors will be returned with a 999. Refer to Section 8.3 for specific 999-related business rules.

Technical specifications for the ASC X12N 999 are published for the ASC X12N 276/277 Health Care Claim Status Request and Response transactions on the NGS Website (https://www.NGSMedicare.com); after creating an account and/or login then select Resources > EDI Solutions > Technical Guides and Information > X12 Website.

8.3 Report Inventory

Transaction Acknowledgement (TRN) Report

The TRN is a text report file indicating initial validation of the inbound transaction file, including whether or not a transaction file was identified as being an American National Standards Institute (ANSI) file.

- The naming format is trn.(input filename).txt.##### where - ##### is a sequence number generated by EDI Systems.
    - For example: trn.TRANS.837.041313.txt.52731
- For TRNs generated in response to transactions sent via the sFTP and the Internet Gateway with spaces in the file name “ABC 123 DEF”, the naming convention, will replace spaces with underscores and is as follows: TRN.ABC 123 DEF.##### (##### = 5-digit sequence number).
    - For example: TRN.ABC_123_DEF.12345
- The TRN will contain the Time Stamp, File Name, Trading Partner ID, and Original File size of the received claim file.
- The TRN will identify Internet Gateway transmission errors related to both the submission of the X.509 digital certificate data or file transfer activities.
- The file naming convention for the TRN generated for 276 files submitted via the Internet Gateway is as follows: “TRN.COREBATCH.[payloadid].%s” where [payloadid] is the payload ID from the originally submitted file and %s is the EDI assigned sequence number.

Note: The TRN Reports generated for 276 files submitted via the Internet Gateway can only be accessed via the sFTP Gateway.

Transaction Acknowledgement (TA1)

- The TA1 segment indicates whether there are problems encountered with the X12 interchange control structure.
- The TA1 will not be returned if the originally submitted data was not recognized as an X12 formatted file.

- For TA1s generated in response to transactions sent via the sFTP and the Internet Gateway, the file naming convention is as follows: TA1.File Name.#### (4 digit sequence number).
    - For example:TA1.FileName.1234
- For TA1's generated in response to transactions sent via the sFTP and the Internet Gateway with spaces in the file name "ABC 123 DEF", the naming convention, will replace spaces with underscores and is as follows: TRN.ABC 123 DEF.#### (#### = 4-digit sequence number).
    - For example: TA1.ABC_123_DEF.1234
- The TA1 will return standard ANSI X12 reasons for the rejection of a submitted file based on control structures.
- The TA1 will use the delimiters from the submitted file as the delimiters in the TA1.
    - For example, using > as the Component Element Separator in the inbound claims file will cause the TA1 to return the > as the Component Element Separator

Implementation Acknowledgement for Health Care Insurance (999)

- The 999 is an ANSI file indicating results of data integrity analysis of the transaction file.
- The naming format is 999.(input file name).txt_000001.##### where ##### is the sequence number. For example: 999.TRANS.837.041313.txt_000001.52745.

  Note: 'input file name' if more than 32 characters will start to truncate the 999 name generated.
- The file naming convention for the 999 generated for a 276 file submitted via the Internet Gateway is as follows: "999.COREBATCH.[payloadid].%s" where the payload ID is the payload ID from the envelope of the 276 file submission.
- The 999 will return standard delimiters regardless of those used in the claims file.
- If the 999 is rejected at the Functional Group Response Trailer (AK9), the 999 will instead return the delimiters used in the original submitted file.
- The 999 will be "wrapped," with all segments on one long line of data.

8.4 999 Implementation Acknowledgment Error Responses

The table below contains details for the Acknowledgment Error Responses.

Table 8. 999 Acknowledgment Error Responses

Element/Description	Details	Error Code
GS02	Must be present	AK905: 14 "Unknown Security Originator".
GS03	Must be present	AK905: 13 "Unknown Security Recipient".

Element/Description	Details	Error Code
2100D – NM108	Must be “MI”	IK403 = 7: “Invalid Code Value”.
2200D – REF – Institutional Bill Type Identification	Only 1 iteration of 2200D REF with REF01 = ‘BLT’ is allowed for Part A	IK304 = 5: “Segment Exceeds Maximum Use”.
2200D – REF – Claim Service Date	For institutional claims, 2200D DTP with DTP01 = “472” must be present	IK304 = I6: “Implementation Dependent Segment Missing”.

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 NGS. This agreement can be found on the NGS Website (https://www.NGSMedicare.com).

Additionally, NGS requires the following: Submission of an EDI Registration Form when contracting with a third party (clearinghouse, billing service) to perform EDI transactions on behalf of a provider. NGS also requires obtaining connectivity to the NGS EDI Gateway through one of the NGS approved NSVs. A list of the NSVs can be found on the NGS Website (https://www.NGSMedicare.com), select Resources > EDI Solutions > Network Service Vendors.

10 Transaction-Specific Information

This section defines specific CMS requirements over and above the standard information in the ASC X12N 276/277 TR3.

10.1 Health Care Claim Status Request Transaction (276)

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

10.1.1 Header (276)

The following table contains specific details for the 276 Header.

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

Table 9. ST Transaction Set Header (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
36	N/A	ST	Transaction Set Header	-	-	Files formatted with one inquiry per ST-SE will be processed through the Real Time Claim Status Process.

Table 10. BHT Beginning of Hierarchical Transaction (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
37	N/A	BHT02	Transaction Set Purpose Code	13	2	Must equal “13”.

10.1.2 Loop 2000A Information Source Level Structure (276)

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

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

Table 11. Loop 2100A NM1 Payer Name (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
42	2100A	NM108	Identification Code Qualifier	PI	2	Medicare expects "PI".
42	2100A	NM109	Payer Identifier	-	80	Sender ID must match the value submitted in ISA06 and GS02.

10.1.3 Loop 2000B Information Receiver Level Structures (276)

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

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

Table 12. Loop 2100B NM1 Information Receiver Name (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
46	2100B	NM109	Information Receiver Identification Number	-	80	Receiver ID must match the value submitted in ISA08 and GS03.

10.1.4 Loop 2000C Service Provider Detail Structures (276)

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

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

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

Table 13. Loop 2100C NM1 Provider Name (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
50	2100C	NM101	Entity Identifier Code	1P	3	Medicare Limitation: Only one iteration allowed.
51	2100C	NM108	Identification Code Qualifier	XX, SV	2	2100C NM108 must be “XX” except for VA. VA must use “XX” or “SV.”
51	2100C	NM109	Provider Identifier	-	80	None

10.1.5 Loop 2000D Subscriber Level Structures (276)

The following tables define the specific details associated with Information Receiver Structures.

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

Note:

- A hyphen in the table below means N/A.
- A new table exists for each segment.

Table 14. Loop 2000D DMG Subscriber Demographic Information (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
55	2000D	DMG02	Subscriber Birth Date	-	35	Must not be a future date.

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

Table 15. Loop 2100D NM1 Subscriber Name (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
56	2100D	NM102	Entity Type Qualifier	1	1	Medicare requires value = “1”.
57	2100D	NM104	Subscriber First Name	-	35	Medicare requires Subscriber First Name.
57	2100D	NM108	Identification Code Qualifier	MI	2	Must be "MI".
57	2100D	NM109	Subscriber Identifier	-	80	Refer to Section 7.1 for Medicare-specific information. For the Medicare Beneficiary Identifier MBI: Must be 11 positions in the format of C A AN N A AN N A A N N where "C" represents a constrained numeric 1 thru 9; "A" represents alphabetic character A - Z but excluding S, L, O, I, B, Z; "N" represents numeric 0 thru 9; "AN" represents either "A" or "N".

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

Table 16. Loop 2200D REF Payer Claim Control Number (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
59	2200D	REF02	Payer Claim Control Number	-	50	For DME, must be 14 digits. For Part B, must be 13 digits. For Part A, must be 14 - 23 characters.

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

Table 17. Loop 2200D REF Institutional Bill Type Identification (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
60	2200D	REF01	Bill Type Qualifier	BLT	3	Part A only. Not allowed for CEDI and Part B.
60	2200D	REF02	Bill Type Identifier	-	50	None

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

Table 18. Loop 2200D REF Application or Location System Identifier (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
61	2200D	REF01	Reference Identification Qualifier	LU	3	For VA, “LU” must be present.
61	2200D	REF02	Application or Location System Identifier	-	50	For VA, the value must be the value directly obtained from the contractor when beginning to exchange information.

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

Table 19. Loop 2200D AMT Total Claim Charge Amount (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
66	2200D	AMT02	Total Claim Charge Amount	-	10	2200D AMT02 must be less than or equal to 99,999,999.99. Refer to TR3 Section B.1.1.3.1.2.

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

Table 20. Loop 2200D DTP Claim Service Date (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
67	2200D	DTP01	Date Time Qualifier	-	3	For Part A, must be present. For Part B and DME, 2200D DTP with DTP01 = “472” must be present when 2210D DTP with DTP01 = “472” is not present.
68	2200D	DTP03	Claim Service Period	-	35	If 2200D DTP02 = "RD8" then the 2nd date listed in 2200D DTP03 must be greater than or equal to the 1st date listed in 2200D DTP03.

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

Table 21. Loop 2210D SVC Service Line Information (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
69	2210D	SVC01-1	Product or Service ID Qualifier	HC, HP, NU, N4	2	Part A – “HC”, “HP”, or “NU” must be used. Part B – “HC” must be used. CEDI – “HC” or “N4” must be used.
71	2210D	SVC01-2	Procedure Code	-	48	None
72	2210D	SVC02	Line Item Charge Amount	-	10	2210D SVC02 must be greater than or equal to 0. Refer to TR3 Section B.1.1.3.1.2.

10.1.6 Loop 2200E Dependent Level Structures (276)

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

Table 22. Loop 2200E Dependent Level Detail (276)

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

10.2 Health Care Claim Response Transaction (277)

This section defines CMS-specific requirements in conjunction with the standard information in the ASC X12N 276/277 Version 005010X212.

The MAC that produced the claim status response will be the Information Source for all outbound Medicare transactions.

10.2.1 Header (277)

The following table contains specific details for the 277 Header.

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

Table 23. ST Transaction Set Header (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
106	N/A	ST02	Transaction Set Control Number	-	9	None

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

Table 24. BHT Beginning of Hierarchical Transaction (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
107	N/A	BHT03	Originator Application Transaction Identifier	-	50	BHT03 will be the cycle date in CCYYDDD Julian date format concatenated with value from ST02.

10.2.2 Loop 2000A Information Source Level Structures (277)

The following tables define the specific details associated with Information Source Structures.

Note:

- A hyphen in the table below means N/A.
- A new table exists for each segment.

Table 25. Loop 2100A NM1 Payer Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
112	2100A	NM108	Identification Code Qualifier	PI	2	Medicare generates the value of "PI".
112	2100A	NM109	Payer Identifier	-	80	Transmitted value from the associated 276.

For Loop 2100A PER – The telephone number will always be transmitted in the first communication number set, an email address will be sent in the second communication number set, if the information is applicable and available. The third communication number set will not be transmitted.

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

Table 26. Loop 2100A PER Payer Contact Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
114	2100A	PER02	Payer Contact Name	-	60	Payer Contact Name.
114	2100A	PER03	Payer Contact Information	TE	2	For DME only the value “TE” will be used.
114	2100A	PER05	Payer Contact Information	EM	2	For DME, the PER05 is not used.
115	2100A	PER07	Communication Number Qualifier	FX	2	For DME, the PER07 is not used.

10.2.3 Loop 2000B Information Receiver Level Structures (277)

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

Note:

- A hyphen in the table below means N/A.
- A new table exists for each segment.

Table 27. Loop 2100B NM1 Information Receiver Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
118	2100B	NM101	Entity Identifier Code	-	3	Transmitted value from the associated 276.
118	2100B	NM102	Entity Type Qualifier	-	1	Transmitted value from the associated 276.
119	2100B	NM103	Information Receiver Last or Organization Name	-	60	Transmitted value from the associated 276.
119	2100B	NM104	Information Receiver First Name	-	35	Transmitted value from the associated 276.
119	2100B	NM105	Information Receiver Middle Name	-	25	Transmitted value from the associated 276.
119	2100B	NM108	Identification Code Qualifier	-	2	Transmitted value from the associated 276.
119	2100B	NM109	Information Receiver Identification Number	-	80	Transmitted value from the associated 276. Same as GS02.

Table 28. Loop 2200B TRN Information Receiver Trace Identifier (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
120	2200B	TRN01	Referenced Transaction Trace Number	2	2	None

For Loop 2200B STC – Up to five iterations of the STC will be allowed for all occurrences in these transactions. When 2000B HL04 = "0", one iteration of 2200B STC is required. When not triggered, 2200B STC is not allowed.

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

Table 29. Loop 2200B STC Information Receiver Status Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
121	2200B	STC01-1	Health Care Claim Status Category Code	-	41	None
122	2200B	STC02	Status Information Effective Date	-	8	The current (system) date in CCYYMMDD format.
122	2200B	STC10-1	Health Care Claim Status Category Code	-	30	None
123	2200B	STC11-1	Health Care Claim Status Category Code	-	30	None

10.2.4 Loop 2000C Service Provider Level Structures (277)

The following tables define specific details associated with 277 Service Provider Structures.

Only 1 iteration of the 2100C loop allowed by Medicare.

Note:

- A hyphen in the table below means N/A.
- A new table exists for each segment.

Table 30. Loop 2100C NM1 Provider Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
127	2100C	NM101	Entity Identifier Code	-	3	Transmitted value from the associated 276.
127	2100C	NM102	Entity Type Qualifier	-	1	Transmitted value from the associated 276.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
127	2100C	NM103	Provider Last or Organization Name	-	60	Transmitted value from the associated 276.
127	2100C	NM104	Provider First Name	-	35	Transmitted value from the associated 276.
127	2100C	NM105	Provider Middle Name	-	25	Transmitted value from the associated 276.
127	2100C	NM107	Provider Name Suffix	-	10	Transmitted value from the associated 276.
128	2100C	NM108	Identification Code Qualifier	-	2	Transmitted value from the associated 276.
128	2100C	NM109	Provider Identifier	-	80	Transmitted value from the associated 276.

Up to five iterations of the STC will be allowed for all occurrences in these transactions. When 2000B HL04 = "0", one iteration of 2200B STC is required.

When not triggered, 2200B STC is not allowed.

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

Table 31. Loop 2200C STC Provider Status Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
131	2200C	STC02	Status Information Effective Date	-	8	Current (system) date in CCYYMMDD format.

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

Table 32. Loop 2200C STC10 Health Care Claim Status (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
131	2200C	STC10-1	Health Care Claim Status Category Code	-	30	None

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

Table 33. Loop 2200C STC11 Health Care Claim Status (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
132	2200C	STC11-1	Health Care Claim Status Category Code	-	30	2200C STC11-1 may be present if 2200C STC10-1 is present.

10.2.5 Subscriber Level Structures (277)

The following tables define specific details associated with 277 Service Provider Structures.

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

Note:

- A hyphen in the table below means N/A.
- A new table exists for each segment.

Table 34. Loop 2100D NM1 Subscriber Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
135	2100D	NM102	Entity Type Qualifier	1	1	None
136	2100D	NM103	Subscriber Last Name	-	60	Transmitted value from the associated 276.
136	2100D	NM104	Subscriber First Name	-	35	Transmitted value from the associated 276.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
136	2100D	NM105	Subscriber Middle Name or Initial	-	25	Transmitted value from the associated 276.
136	2100D	NM107	Subscriber Name Suffix	-	10	Transmitted value from the associated 276.
136	2100D	NM108	Subscriber Name	-	2	Transmitted from the associated 276.
136	2100D	NM109	Subscriber Identifier	-	80	For 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; "AN" represents either "A" or "N".

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

Table 35. Loop 2200D TRN Claim Status Tracking Number (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
137	2200D	TRN02	Referenced Transaction Trace Number	-	50	Transmitted value from the associated 276.

Part A returns claim level status information, but not line level status information.

Up to five iterations of the STC will be allowed for all occurrences in these transactions.

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

Table 36. Loop 2200D STC Claim Level Status Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
138	2200D	STC01-1	Health Care Claim Status Category Code	-	30	**Claim Found:** Any valid Health Care Claim Status Code Category, except "R". **Claim Not Found:** Category Code of "A4" will be generated.
138	2200D	STC01-2	Status Code	-	30	**Claim Found:** Any valid Claim Status Code Valid Claim Status Code. **Claim Not Found:** Status code "35" will be generated for Part B or CEDI “247” for Part A.
144	2200D	STC01-4	Code List Qualifier Code	-	3	Not present
145	2200D	STC02	Status Information Effective Date	-	8	**Claim Found:** Date the claim moved to the current location status from the internal system, in CCYYMMDD format. **Claim Not Found:** Current (system) date, in CCYYMMDD format.
145	2200D	STC04	Total Claim Charge Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.
145	2200D	STC05	Claim Payment Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.
145	2200D	STC06	Adjudication Finalized Date	-	8	None

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
146	2200D	STC08	Remittance Date	-	8	None
146	2200D	STC09	Remittance Trace Number	-	16	None
146	2200D	STC10-1	Health Care Claim Status Category Code	-	30	Any valid Health Care Claim Status Code Category, except "R".
147	2200D	STC10-4	Code List Qualifier Code	-	3	Not present
148	2200D	STC11-4	Code List Qualifier Code	-	3	Not present
148	2200D	STC12	Free-form Message Text	-	264	Not present

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

Table 37. Loop 2200D REF Payer Claim Control Number (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
149	2200D	REF02	Payer Claim Control Number	-	50	For DME, this will be 14 digits. For Part B this will be 13 digits. For Part A this will be 14-23 characters.

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

Table 38. Loop 2200D REF Patient Control Number (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
151	2200D	REF02	Patient Control Number	-	20	Transmitted value from the associated 276. If not transmitted from the 276 and claim found, will be the patient account number from the internal system.

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

Table 39. Loop 2200D REF Pharmacy Prescription Number (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
152	2200D	REF02	Pharmacy Prescription Number	-	50	Transmitted value from the associated 276. If not transmitted from the 276, will be the pharmacy prescription number from the internal system.

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

Table 40. Loop 2200D REF Voucher Identifier (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
153	2200D	REF	Voucher Identifier	-	18	Not used by Medicare.

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

Table 41. Loop 2200D REF Claim Identification Number for Clearinghouses (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
154	2200D	REF02	Clearinghouse Trace Number	-	50	Transmitted value from the associated 276.

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

Table 42. Loop 2200D DTP Claim Service Date (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
156	2200D	DTP03	Claim Service Period	-	35	Transmitted value from the associated 276.

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

Table 43. Loop 2220D SVC Service Line Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
157	2220D	SVC01-1	Product or Service ID Qualifier	-	2	**Claim Found:** transmitted value from the associated 276.
159	2220D	SVC01-2	Procedure Code	-	48	**Claim Found:** Procedure code used to adjudicate the claim (from the internal system). **Claim Not Found:** value transmitted from the associated 276.
159	2220D	SVC01-3	Procedure Modifier	-	2	**Claim Found:** If applicable, first procedure modifier used to adjudicate the claim (from the internal system). **Claim Not Found:** Value transmitted from the associated 276.
159	2220D	SVC01-4	Procedure Modifier	-	2	**Claim Found:** If applicable, second procedure modifier used to adjudicate the claim (from the internal system). **Claim Not Found:** Transmitted value from the associated 276.
159	2220D	SVC01-5	Procedure Modifier	-	2	**Claim Found:** If applicable, third procedure modifier used to adjudicate the claim (from the internal system). **Claim Not Found:** Transmitted value from associated 276.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
160	2220D	SVC01-6	Procedure Modifier	-	2	**Claim Found:** If applicable, fourth procedure modifier used to adjudicate the claim (from the internal system). **Claim Not Found:** Transmitted value from the associated 276.
160	2220D	SVC02	Line Item Charge Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.
160	2220D	SVC03	Line Item Payment Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.
160	2220D	SVC04	Revenue Code	-	48	**Claim Found:** If 2220D SVC01-2 is present then SVC04 may be present. **Claim Not Found:** Transmitted value from the associated 276.
160	2220D	SVC07	Units of Service Count	-	15	**Claim Found:** Units from the internal system. **Claim Not Found:** Transmitted value from the associated 276.

Line found: Up to five iterations of the STC are allowed for all occurrences in these transactions.

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

Table 44. Loop 2220D STC Service Line Status Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
161	2220D	STC01-1	Health Care Claim Status Category Code	A4	30	**Line Not Found:** “A4”.
161	2220D	STC01-2	Health Care Claim Status Code	35, 247	30	**Line found:** Any valid Claim Status Code. **Line not found:** “35”.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
167	2220D	STC01-4	Code List Qualifier Code	-	3	Not used by Medicare.
168	2220D	STC02	Status Information Effective Date	-	8	**Line found:** Date the claim moved to the current location status from the internal system, in CCYYMMDD format. **Line Not Found:** Current (system) date in CCYYMMDD format.
169	2220D	STC10-4	Code List Qualifier Code	-	3	Not used by Medicare.
170	2220D	STC11-4	Code List Qualifier Code	-	3	Not used by Medicare.

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

Table 45. Loop 2220D REF Service Line Item Identification (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
171	2220D	REF02	Line Item Control Number	-	50	Contains at least one non-space character and transmitted value from associated 276.

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

Table 46. Loop 2220D DTP Service Line Date (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
172	2220D	DTP02	Date Time Period Format Qualifier	-	3	Transmitted value from associated 276.
172	2220D	DTP03	Date Time Period	-	35	Transmitted value from associated 276.

10.2.6 Loop 2200E Dependent Level Structures (277)

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

Table 47. Loop 2200E Dependent Level Detail (277)

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

11 Appendices

11.1 Implementation Checklist

Network Service Vendor Connectivity established for sFTP Gateway.

- Practice Management Software supports current HIPAA versions of transaction sets.
- Practice Management Software supports translation of Acknowledgement Transactions.
- EDI Enrollment and Registration Forms on file with NGS.
- Submitter ID established or Provider Authorization Form submitted for third-party submitter.

11.2 Transmission Examples

Examples of the 276 control segments and envelopes is below.

Figure 1. 276 Control Segment and Envelope - Professional

```
ISA*00*   *00*    *ZZ*SENDERID  *27*13282
          *100915*1828*^*00501*182827994*1*P*:~
GS*HR*SENDERID*13282*20090915*1828*1*X*005010X212~
ST*276*6A92000Ax*005010X212~
SE*15*6A92000Ax~
GE*1*1~
IEA*1*182827994~
```

Figure 2. 276 Control Segment and Envelope - Institutional

```
ISA*00*    *00*    *ZZ*SENDERID  *28*13101
           *100915*1828*^*00501*182827994*1*P*:~
GS*HR*SENDERID*13101*20090915*1828*1*X*005010X212~
ST*276*6A92000Ax*005010X212~
SE*15*6A92000Ax~
GE*1*1~
IEA*1*182827994~
```

Examples of the 277 control segments and envelopes is below.

Figure 3. 277 Control Segment and Envelope - Professional

```
ISA*00*    *00*    *ZZ*13202  *28*SENDERID
           *100720*2135*^*00501*000000001*0*T*:~
GS*HN*13202*SENDERID*20100720*21351929*32*X*005010X212~
ST*277*000000001*005010X212~
SE*18*000000001~
GE*1*32~
IEA*1*000000001~
```

Figure 4. 277 Control Segment and Envelope - Institutional

```
ISA*00*    *00*    *ZZ*13101  *28*SENDERID
           *100720*2135*^*00501*000000001*0*T*:~
GS*HN*13101*SENDERID*20100720*21351929*32*X*005010X212~
ST*277*000000001*005010X212~
SE*18*000000001~
GE*1*32~
IEA*1*00000000~
```

11.3 Frequently Asked Questions

Frequently asked questions can be accessed at Medicare FFS EDI Operations (https://www.cms.gov/ElectronicBillingEDITrans/) and on the NGS website (https://www.ngsmedicare.com/) select Education > Help and FAQ's.

11.4 Acronym Listing

Table 48. Acronyms List

Acronym	Definition
276	276 Claim Status Request transaction
277	277 Claim Status Response transaction

Acronym	Definition
277CA	277 Claim Acknowledgment
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
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
MIME	Multipurpose Internet Mail Extensions
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
NSC	National Supplier Clearinghouse
NSV	Network Service Vendor

Acronym	Definition
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 Acknowledgement 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 49. Companion Guide Version History

Version	Date	Section(s) Changed	Change Summary
1.0	November 5, 2010	All	Initial Draft.
2.0	January 3, 2011	All	1st Publication Version.
3.0	April 2011	6.0	2nd Publication Version.
4.0	September 2015	All	3rd Publication Version.
5.0	August 2017	All	4th Publication Version.
6.0	July 2018	4.2	5th Publication Version.
7.0	March 2019	All	6th Publication Version.
7.1	July 2019	8.3	Note added to the naming format of the 999. Small wording correction.
7.2	May 2020	1.3, 1.4 & 11.4	Updated URL language for WPC and X12.

Version	Date	Section(s) Changed	Change Summary
7.3	March 2022	Tables 4, 5, 8, & 9	Updated language for ISA06, ISA08, GS02 and 2100A & 2100B NM109.
7.4	May 2022	2.3, 6, 7.2, 10.1.1, 11.1.1	Formatting changes. Added information on Real Time Claim Status. Updated 2200D DTP03 to note that any date span greater than 1 year will exclude real time. Added expected time frame for batch process. Updates for Consistency for ISA06 ISA08 GS02 and GS03.
8.0	July 2022	All	508 Compliance updates.
8.1	February 2023	10.2.5	SVC01-6 updated modifier reference from third to fourth.
8.2	May 2024	Section 7.2	Added information about Dental Claim responses.