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# CMS

## **Standard Companion Guide Transaction Information**

**Instructions related to the 837 Health  
Care Claim: Institutional Transaction  
based on ASC X12 Technical Report  
Type 3 (TR3), version 005010A2**

**Companion Guide Version Number: 3.0  
January 30, 2018**

## Preface

Companion Guides (CGs) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is in conformance with ASC X12's Fair Use and Copyright statements.

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# Transaction Instruction (TI)

## 1. TI Introduction

### 1.1 Background

#### 1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

#### 1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

#### 1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

## 1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

## 2. Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guide for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X223A2	Health Care Claim: Institutional (837)

## 3. Instruction Table

This table contains rows for where supplemental instruction information is located. The order of table content follows the order of the implementation transaction set as presented in the corresponding implementation guide.

**Category 1.** Situational Rules that explicitly depend upon and reference knowledge of the transaction receiver's policies or processes.

**Category 2.** Technical characteristics or attributes of data elements that have been assigned by the payer or other receiving entity, including size, and character sets applicable, that a sender must be aware of for preparing a transmission.

**Category 3.** Situational segments and elements that are allowed by the implementation guide but do not impact the receiver's processing. (applies to inbound transactions)

**Category 4.** Optional business functions supported by an implementation guide that an entity doesn't support.

**Category 5.** To indicate if there needs to be an agreement between PAYER and the transaction sender to send a specific type of transaction (claim/encounter or specific kind of benefit data) where a specific mandate doesn't already exist.

**Category 6.** To indicate a specific value needed for processing, such that processing may fail without that value, where there are options in the TR3.

**Category 7.** TR3 specification constraints that apply differently between batch and real-time implementations, and are not explicitly set in the guide.

**Category 8.** To identify data values sent by a sender to the receiver.

**Category 9.** To identify processing schedules or constraints that are important to trading partner expectations.

**Category 10.** To identify situational data values or elements that are never sent.

**005010X223A2 Health Care Claim: Institutional**

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				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.	9
				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.	9
				The maximum number of characters to be submitted in any dollar amount field is ten characters. Claims containing a dollar amount in excess of 99,999,999.99 will be rejected.	2
				Medicare does not support the submission of foreign currency. Claims containing the 2000A CUR segment will be rejected.	4
				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.	2
				Contractor will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.	9
				Medicare requires the National Provider Identifier (NPI) be submitted as the identifier for all claims. Claims submitted with legacy identifiers will be rejected. (Non-VA contractors).	6
				National Provider Identifiers will be validated against the NPI algorithm. Claims which fail validation will be rejected.	2
				Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at <a href="http://www.wpc-edi.com/codes/taxonomy">http://www.wpc-edi.com/codes/taxonomy</a> . Claims submitted with invalid taxonomy codes will be rejected.	4
				All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).	2
	ISA05	Interchange ID Qualifier	28, ZZ	Contractor will reject an interchange (transmission) that does not contain 28 or ZZ in ISA05	6
	ISA06	Interchange Sender ID		Contractor will reject an interchange (transmission) that does not contain a valid ID in ISA06.	6
	ISA07	Interchange ID Qualifier	28, ZZ	Contractor will reject an interchange (transmission) that does not contain 28 or ZZ in ISA07.	6
	ISA12	Interchange Control Version Number		Contractor will reject an interchange (transmission) that does not contain 00501 in ISA12.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				Contractor will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).	4
				Contractor will only process one transaction type per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).	4
	GS03	Application Receiver's Code		Contractor will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the contractor definition.	6
	GS04	Functional Group Creation Date		Contractor will reject an interchange (transmission) that is submitted with a future date.	6
				Contractor 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.	4
	ST02	Transaction Control Set		Contractor will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	6
	BHT02	Transaction Set Purpose Code	00	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	6
	BHT06	Claim/Encounter Identifier	CH	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).	6
1000A	NM109	Submitter ID		Contractor will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	5
1000B	NM103	Receiver Name		Contractor will reject an interchange (transmission) that is not submitted with a valid Part A MAC name (NM1).	5
1000B	NM109	Receiver Primary Identifier		Contractor will reject an interchange (transmission) that is not submitted with a valid Part A MAC code (NM1). Each individual Contractor determines this code.	5
2000B	HL04	Hierarchical Child Code	0	The value accepted is "0". Submission of "1" will cause your file to reject.	6



Loop ID	Reference	Name	Codes	Notes/Comments	Category
2000B	SBR01	Payer Responsibility Sequence Number Code	P, S	The values accepted are “P” and “S”. Submission of other values will cause your claim to reject.	6
2000B	SBR02, SBR09	Subscriber Information		For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). The Patient Hierarchical Level (2000C loop) is not used.	6
2010AA	REF – Segment Rule	BILLING PROVIDER UPIN/LICENSE INFORMATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2010AC	Loop Rule	PAY TO PLAN LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2010BA	NM102	Subscriber Entity Type Qualifier	1	The value accepted is 1. Submission of value 2 will cause your claim to reject.	6
2010BA	NM108	Subscriber Identification Code Qualifier	MI	The value accepted is “MI”. Submission of value “II” will cause your claim to reject.	6
2010BA	NM109	Subscriber Identification Code		Must be in the format of AAANNNNNNNNN or ANNNNNNN or AANNNNNNN or AANNNNNNNNNN or AAANNNNNN or NNNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN (“A” - alpha character, “N” - numeric digit). Submission of other formats will cause your claim to reject.	6
2010BA	DMG02	Subscriber Birth Date		Must not be a future date.	6
2010BA	REF – Segment Rule	SUBSCRIBER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2010BB	NM108	Payer Identification Code Qualifier	PI	The value accepted is “PI”. Submission of value “XV” will cause your claim to reject.	6
2010BB	REF – Segment Rule	PAYER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2010BB	REF – Segment Rule	BILLING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2000C	HL – Segment Rule	PATIENT HIERARCHICAL LEVEL		Must not be present. Submission of this segment will cause your claim to reject.	4
2000C	PAT – Segment	PATIENT INFORMATION		Must not be present. Submission of this segment will cause your claim to reject.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
	Rule				
2010CA	Loop Rule	PATIENT NAME LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2300	CLM02	Total Submitted Charges		Total Submitted Charges (CLM02) must equal the sum of all 2320 & 2430 CAS amounts and the 2320 AMT02 (AMT01=D).	9
2300	CLM20	Delay Reason Code		Data submitted in CLM20 will not be used for processing.	3
2300	DTP03	Admission Date		Must not be a future date.	6
2300	DTP03	Related Hospitalization Discharge Date		Must not be a future date.	6
2300	PWK – Segment Rule	CLAIM SUPPLEMENTAL INFORMATION		Only the first iteration of the PWK, at either the claim level and/or line level, will be considered in the claim adjudication.	4
2300	PWK – Segment Rule	CLAIM SUPPLEMENTAL INFORMATION		All PWK additional documentation relevant to the claim being submitted must be sent at the same time, or immediately after.. PWK data sent after the 7-10 day waiting period will not be considered in the claim adjudication.	1
2300	PWK02	Attachment Transmission Code	BM, FX, FT, EL	The only values which may be used in adjudication are “BM”, “FX”, “FT”, “EL”.	6
2300	CN1 – Segment Rule	CONTRACT INFORMATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2300	REF – Segment Rule	PAYER CLAIM CONTROL NUMBER		Must not be present. Submission of this segment will cause your claim to reject.	4
2310A	REF – Segment Rule	ATTENDING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2310B	REF – Segment Rule	OPERATING PHYSICIAN SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2310C	REF – Segment Rule	OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2310D	REF – Segment Rule	RENDERING PROVIDER SECONDARY IDENTIFIER		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject	4
2310E	REF – Segment Rule	SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject	4
2320	SBR01	Payer Responsibility Sequence Number Code		The SBR must contain a different value in each iteration of the SBR01. Each value may only be used one time per claim. Repeating a previously used value (in the same claim) will cause the claim to be rejected.	6
2320	SBR09	Claim Filing Indicator Code		The value cannot be “MA” or “MB”. Sending the value of “MA” or “MB” will cause the claim to be rejected.	6
2330B	DTP03	Adjudication or Payment Date		Must not be a future date.	6
2330C	Loop Rule	OTHER PAYER ATTENDING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330D	Loop Rule	OTHER PAYER OPERATING PHYSICIAN LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330E	Loop Rule	OTHER PAYER OTHER OPERATING PHYSICIAN LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330F	Loop Rule	OTHER PAYER SERVICE FACILITY LOCATION LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330G	Loop Rule	OTHER PAYER RENDERING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330H	Loop Rule	OTHER PAYER REFERRING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330I	Loop Rule	OTHER PAYER BILLING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2400	SV202-1	Product or Service ID Qualifier	HC, HP	Must be “HC” or “HP”. Claims for services with any other value will be rejected.	6
2400	SV205	Quantity		Must be greater than zero.	6
2400	SV205	Quantity		Must be less than or equal to 999,999.9.	6

<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Codes</b>	<b>Notes/Comments</b>	<b>Category</b>
2400	SV205	Quantity		Must be 0 or 1 decimal position.	6
2400	DTP03	DATE - SERVICE DATE		Must not be a future date.	6
2410	CTP04	Quantity		CTP04 must be greater than 0 and less than or equal to 9,999,999.999.	2
2410	CTP04	Quantity		CTP04 is limited to up to 3 decimal positions.	2
2420A	REF – Segment Rule	OPERATING PHYSICIAN SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420B	REF – Segment Rule	OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420C	REF – Segment Rule	RENDERING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420D	REF – Segment Rule	REFERRING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2430	SVD05	Quantity		Must be greater than zero.	6
2430	SVD05	Quantity		Must be less than or equal to 999,999.9.	6
2430	SVD05	Quantity		Must be 0 or 1 decimal position.	6
				We suggest retrieval of the ANSI 999 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission OR We suggest retrieval of the ANSI 999 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.	

## 4. TI Additional Information

### 4.1 Other Resources

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources during the transition year.

<b>Resource</b>	<b>Web Address</b>
ASC X12 TR3 Implementation Guides	<a href="http://store.x12.org">http://store.x12.org</a>
Washington Publishing Company Health Care Code Sets	<a href="http://www.wpc-edi.com/content/view/711/401/">http://www.wpc-edi.com/content/view/711/401/</a>
Central Version 005010 and D.0 Webpage on CMS website	<a href="https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html">https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html</a>
Educational Resources (including MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from national provider calls)	<a href="https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/40_Educational_Resources.html">https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/40_Educational_Resources.html</a>
Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences)	<a href="http://www.cms.gov/MFFS5010D0/">http://www.cms.gov/MFFS5010D0/</a>
Frequently Asked Questions	<a href="https://questions.cms.gov/">https://questions.cms.gov/</a>
To request changes to HIPAA adopted standards	<a href="http://www.hipaa-dsmo.org/">http://www.hipaa-dsmo.org/</a>