CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2050	**Date: April 3, 2018**
	Change Request 10397

Transmittal 2031, dated February 16, 2018, is being rescinded and replaced by Transmittal 2050, dated, April 3, 2018 to remove CWF from business requirement 10397.2. All other information remains the same.

SUBJECT: Modifications to the Implementation of the Paperwork (PWK) Segment of the Electronic Submission of Medical Documentation (esMD) System

I. SUMMARY OF CHANGES: To enable contractors to receive unsolicited documentation via the esMD system.

EFFECTIVE DATE: July 1, 2018 - The effective date is based on the process date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal:	Date:	Change Request: 10397

Transmittal 2031, dated February 16, 2018, is being rescinded and replaced by Transmittal 2050, dated, April 3, 2018 to remove CWF from business requirement 10397.2. All other information remains the same.

SUBJECT: Modifications to the Implementation of the Paperwork (PWK) Segment of the Electronic Submission of Medical Documentation (esMD) System

EFFECTIVE DATE: July 1, 2018 - The effective date is based on the process date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 2, 2018

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to update business requirements that are necessary to enable contractors to receive unsolicited documentation also known as paperwork (PWK) via the Electronic Submission of Medical Documentation (esMD) system. This instruction is for esMD purposes only. Transmittal 908, dated June 22, 2011, is being amended to include esMD as a form of PWK submissions in Business Requirement 7306.2 and 7306.3. Transmittal 874, dated April 20, 2011 is being amended to include esMD on the cover sheet. It does not supersede instructions in CR 7330 or elsewhere. All other information remains the same. The coversheet updated in CR 10124 is being used to include esMD with this CR.

B. Policy: The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) require the Secretary of HHS to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10397.1	The Medicare Administrative Contractors (MACs) shall modify internal paperwork (PWK), also known as unsolicited documentation procedures to include electronic submission(s) via esMD.	X	X	X	X					
10397.2	The Shared Systems Maintainers (SSMs) shall provide a mechanism to accept the PWK 02 values "EL" and "FT" for those contractors in a CMS - approved esMD system. This mechanism will suppress initial auto letter generation, if applicable, when PWK 02 is "EL" or "FT", and is present at any level of the claim or	X	X	X	X	X		X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	line. The MACs shall set edits to prevent the auto letter generation for claims that get new PWK 02 values. This business requirement amends business requirement 7306.2 in Transmittal 908, dated June 22, 2011 and the business requirement 7041.8 in transmittal 874, dated April 20, 2011. *Note: MCS SPITAB HxxTIPWK allows the MACs to add the PWK02 values and define days to suppress letters.*									
10397.3	Contractors shall communicate to providers (representing agent or trading partner) via companion documents for 5010 X12 837 to include: • The value "EL" (electronic) in PWK 02 to represent an esMD submission for sending the documentation using X12 Standards (6020 X12 275). • The value "FT" (file transfer) in PWK 02 to represent an esMD submission for sending the documentation in PDF format using XDR specifications. *The esMD System shall support XDR transactions for the July 2018 release scope. Value 'EL' is reserved for future use.* This business requirement amends business requirement 7306.03 in Transmittal 908, dated June 22, 2011. *Notes: The values 'EL' and 'FT' are in addition to the existing values for the PWK02 segment.* *CMS shall include the following link related to the X12 837 Companion Guides in the MLN article:* https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html	X	X	X						
10397.4	The MACs shall allow seven calendar "waiting days" (from the date of receipt) for additional information to	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	be submitted when the PWK 02 value is 'EL' or 'FT'. This business requirement amends business requirement 7306.2.1 in Transmittal 908, dated June 22, 2011.									
10397.5	Contractors shall provide the fax/mail/esMD cover sheet to their trading partners via hard copy and/or electronic download. *Notes:* *Contractors shall educate trading partners that the fax/mail/esMD coversheets are not to be modified. Documentation sent via esMD shall included the coversheet.* *CMS has modified the existing cover sheet to reflect esMD as another mode of providing unsolicited (PWK) documentation. None of the data elements of the coversheet have been modified.*	X	X	X	X					
10397.6	Contractors shall use RC Client to reject the PWK data submissions as administrative error(s) when the received cover sheet (via esMD) is incomplete or incorrectly filled out as applicable to current edits. *Notes:* *New generic reason statements shall be introduced to convey the error to the providers. The list of the reason statements is as follows (codes for these statements shall be finalized and sent along with the RC implementation guide):* • *The date(s) of service on the cover sheet received is missing or invalid.* • *The NPI on the cover sheet received is missing or invalid.* • *The state where services were provided is missing or invalid on the cover sheet received.* • *The Medicare ID on the cover sheet received is missing or invalid.* • *The billed amount on the cover sheet received is missing or invalid.* • *The contact phone number on the cover sheet received is missing or invalid.*	X	X	X	X					esMD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• *The beneficiary name on the cover sheet received is missing or invalid.* • *The claim number on the cover sheet received is missing or invalid.* • *The Attachment Control Number (ACN) on the coversheet is missing or invalid.*									
10397.7	The MACs/contractors, if applicable, shall conduct testing during the User Acceptance Testing period.	X	X	X	X					STC, esMD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10397.8	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Melanie Jones, 410-786-5461 or Melanie.Jones@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 3

Insert Company Logo Here

Medicare Part A Fax/Mail/esMD Cover Sheet

Complete all fields then submit this form via the Electronic Submission of Medical Documentation (esMD) system or by fax/mail to the applicable address or number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/Mail/esMD Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN: (Exactly as entered in the PWK loop on the claim):		DCN:
Beneficiary: Last Name	First Name	Medicare ID:
Date(s) of Service: From	To	Total Claim Billed Amount:
Billing Provider's Name:		Contact and Phone Number:
NPI:		
State Where Services Were Provided:		Total Number of Documentation Pages (including cover sheet):

Title at discretion of contractor

State Information (State in which services rendered)	State Information (State in which services rendered)	State Information (State in which services rendered)	State Information (State in which services rendered)
Return Address/Fax Information	Return Address/Fax Information	Return Address/Fax Information	Return Address/Fax Information

Insert Company Logo Here

Medicare Part B Fax/Mail/esMD Cover Sheet

Complete all then submit this form via the Electronic Submission of Medical Documentation (esMD) system or by fax/mail to the applicable address or number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/Mail/esMD Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN: (Exactly as entered in the PWK loop on the claim):		ICN:
Beneficiary: Last Name	First Name	Medicare ID:
Date(s) of Service: From	To	Total Claim Billed Amount:
Billing Provider's Name:		Contact and Phone Number:
NPI:		
State Where Services Were Provided:		Total Number of Documentation Pages (including cover sheet):

Title at discretion of contractor

State Information (State in which services rendered)	**State Information (State in which services rendered)**	**State Information (State in which services rendered)**	**State Information (State in which services rendered)**
Return Address/Fax Information	Return Address/Fax Information	Return Address/Fax Information	Return Address/Fax Information

Insert Company Logo Here

Medicare Part DMAC Fax/Mail/esMD Cover Sheet

Complete all fields then submit this form via the Electronic Submission of Medical Documentation (esMD) system or by fax/mail to the applicable address or number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/Mail/esMD Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN: (Exactly as entered in the PWK loop on the claim):		ICN:
Beneficiary: Last Name	First Name	Medicare ID:
Date(s) of Service: From	To	Total Claim Billed Amount:
Billing Provider's Name:		Contact and Phone Number:
NPI:		
State Where Services Were Provided:		Total Number of Documentation Pages (including cover sheet):

Title at discretion of contractor

State Information (State in which services rendered)	State Information (State in which services rendered)	State Information (State in which services rendered)	State Information (State in which services rendered)
Return Address/Fax Information	Return Address/Fax Information	Return Address/Fax Information	Return Address/Fax Information

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.

Table of Contents

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 http://www.wpc-edi.com/codes/taxonomy. 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 ANNNNNN or AANNNNNN or AANNNNNNNNN or AAANNNNNN or NNNNNNNNNA 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

Loop ID	Reference	Name	Codes	Notes/Comments	Category
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.

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

CMS

Standard Companion Guide Transaction Information

Instructions related to the 837 Health Care Claim: Professionals based on ASC X12 Technical Report Type 3 (TR3), version 005010A1

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.

Table of Contents

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
005010X222A1	Health Care Claim: Professional (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.

005010X222A1 Health Care Claim: Professional

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 seven characters. Claims containing a dollar amount in excess of 99,999.99 will be rejected.	2
				Medicare does not support the submission of foreign currency. Claims containing the 2000A CUR segment will be rejected.	4
				Claims that contain percentage amounts with values in excess of 99.99 will be rejected.	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				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
				Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit will be rejected.	2
				Contractor name 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
				Only loops, segments, and data elements valid for the HIPAA Professional 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

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				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 http://www.wpc-edi.com/codes/taxonomy. 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
				A. You may send up to four modifiers; however, the last two modifiers will not be considered. The Contractors processing system will only use the first two modifiers for adjudication and payment determination of claims. -OR- B. You may send up to four modifiers; however, the last three modifiers will not be considered. The Contractors processing system will only use the first modifier for adjudication and payment determination of claims.	3
	ISA05	Interchange ID Qualifier	27, ZZ	Contractor will reject an interchange (transmission) that does not contain 27 ,	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				or ZZ in ISA05	
	ISA06	Interchange Sender ID		Contractor will reject an interchange (transmission) that does not contain a valid ID in ISA06.	6
	ISA07	Interchange ID Qualifier	27, ZZ	Contractor will reject an interchange (transmission) that does not contain 27 or ZZ in ISA07.	6
	ISA12	Interchange Control Version Number		Contractor will reject an interchange (transmission) that does not contain 00501 in ISA12.	6
	GS – Segment Rule			Contractor will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one type of GS-GE (Functional Group) within an ISA-IEA (Interchange).	4
	GS – Segment Rule			Contractor will only process one type of transaction 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 carrier definition.	6
	GS04	Functional Group Creation Date		Contractor will reject an interchange (transmission) that is submitted with a future date.	6
	ST – Segment Rule			Contractor will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				(Transaction Set) will cause the transaction to be rejected.	
	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 carrier name (NM1).	5
2000B	HL04	Hierarchical Child Code	0	The value accepted is “0”. Submission of “1” will cause your file to reject.	6
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=MB). The Patient Hierarchical Level (2000C loop) is not used.	6
2000B	PAT08	Patient Weight		The maximum number of characters to be submitted in the patient weight field is four characters to the left of the decimal and two	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				characters to the right. Claims with patient weight in excess of 9,999.99 pounds will be rejected.	
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	DTP02	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 Rule	PATIENT INFORMATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2010CA	Loop Rule	PATIENT NAME LOOP		Must not be present. Submission of this loop	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				will cause your claim to reject.	
2300	CLM05-3	Claim Frequency Type Code	1	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" will be rejected.	6
2300	CLM20	Delay Reason Code		Data submitted in CLM20 will not be used for processing.	3
2300	DTP03	Onset of Current Illness or Injury Date		Must not be a future date.	6
2300	DTP03	Initial Treatment Date		Must not be a future date.	6
2300	DTP03	Acute Manifestation Date		Must not be a future date.	6
2300	DTP03	Accident Date		Must not be a future date.	6
2300	DTP03	Last Menstrual Period Date		Must not be a future date.	6
2300	DTP03	Last X-Ray Date		Must not be a future date.	6
2300	DTP03	Prescription Date		Must not be a future date.	6
2300	DTP03	Last Worked Date		Must not be a future date.	6
2300	DTP03	Related Hospitalization Admission Date		Must not be a future date.	6
2300	DTP – Segment Rule	ADMISSION DATE		Admission date (DTP 435) is required when the place of service code is "21", "51" or "61". Claims for POS “21”, “51”, or “61”without the admission date will be rejected.	1
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	1

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				claim adjudication. .	
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	CONTRACT INFORMATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2300	REF – Segment Rule	MANDATORY MEDICARE (SECTION 4081) CROSSOVER INDICATOR		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
2300	CR102	Patient Weight		The maximum number of characters to be submitted in the patient weight field is four characters to the left of the decimal and two characters to the right. Patient weight in excess of 9,999.99 pounds will be rejected.	2
2300	CR106	Transport Distance		The maximum number of characters to be submitted in the transport distance is four characters. Transport distance in excess of 9,999 miles will be rejected.	2
2300	HI – Segment Rule	Health Care Diagnosis Code		All diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes (pointed to or not) will be rejected.	1
2310A	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
2310C	REF – Segment Rule	SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				will cause your claim to reject	
2310D	REF – Segment Rule	SUPERVISING PROVIDER SECONDARY IDENTIFIER		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 REFERRING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330D	Loop Rule	OTHER PAYER RENDERING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330E	Loop Rule	OTHER PAYER SERVICE FACILITY LOCATION LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330F	Loop Rule	OTHER PAYER SUPERVISING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330G	Loop Rule	OTHER PAYER BILLING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2400	SV101-1	Product or Service ID Qualifier	HC	Must be “HC”. Claims for services with any other value will be rejected.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	SV102	Line Item Charge Amount		SV102 must equal the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts.	9
2400	SV103	Unit or Basis for Measurement Code	MJ, UN	SV103 must be "MJ" when SV101-3, SV101-4, SV101-5, or SV101-6 is an anesthesia modifier (AA, AD, QK, QS, QX, QY or QZ). Otherwise, must be "UN".	6
2400	SV104	Service Unit Count	MJ	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104)	6
2400	SV104	Service Unit Count		The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104)	2
2400	SV104	Service Unit Count		The max value for units (qualifier UN) cannot exceed 4 bytes numeric and one decimal place. Claims for medical services that exceed this value will be rejected. (SV104)	2
2400	SV104	Service Unit Count		SV104 (Service unit counts) (units or minutes) cannot exceed 9999.9.	2
2400	PWK – Segment Rule	DURABLE MEDICAL EQUIPMENT CERTIFICATE OF MEDICAL NECESSITY INDICATOR		Must not be present. Submission of this segment for Part B will cause your claim to reject.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	CR106	Patient Weight		The maximum number of characters to be submitted in the patient weight field is four characters to the left of the decimal and two characters to the right. Patient weight in excess of 9,999.99 pounds will be rejected.	2
2400	CR3 – Segment Rule	Transport Distance		The maximum number of characters to be submitted in the transport distance is four characters. Transport distance in excess of 9,999 miles will be rejected.	2
2400	CRC – Segment Rule	DURABLE MEDICAL EQUIPMENT CERTIFICATION		Must not be present. Submission of this segment for Part B will cause your claim to reject.	4
2400	DTP03	CONDITION INDICATOR/ DURABLE MEDICAL EQUIPMENT		Must not be a future date.	4
2400	DTP03	DATE - SERVICE DATE		Must not be a future date.	6
2400	DTP – Segment Rule	DATE - PRESCRIPTION DATE		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6
2400	DTP03	DATE - CERTIFICATION REVISION/RECERTIFICATION DATE		Must not be a future date.	4
2400	DTP – Segment Rule	Certification Revision Recertification Date		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6
2400	DTP03	DATE – BEGIN THERAPY DATE		Must not be a future date.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	DTP – Segment Rule	Begin Therapy Date		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6
2400	DTP03	DATE - LAST CERTIFICATION DATE		Must not be a future date.	4
2400	DTP03	Last Certification Date		Must not be a future date.	6
2400	DTP03	Last Seen Date		Must not be a future date.	6
2400	DTP03	Test Performed Date		Must not be a future date.	6
2400	DTP03	X-ray date		Must not be a future date.	6
2400	QTY02	Initial Treatment Date		Must be between 1 and 99. Submission of a value less than 1 or greater than 99 will cause your claim to reject.	6
2400	QTY02	Ambulance Patient Count		Must be between 1 and 99. Submission of a value less than 1 or greater than 99 will cause your claim to reject.	2
2400	MEA03	Obstetric Additional Units		Must be one to two positions and can contain one decimal place. Submission of a value greater than 99.9 will cause your claim to reject.	2
2400	CN1 – Segment Rule	Test Result		Must not be present. Submission of this segment for Part B will cause your claim to reject.	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	PS1 – Segment Rule	CONTRACT INFORMATION		Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line level (Loop 2400). Claims which contain a purchased service provider (QB) but that do not contain the PS1 segment data will be rejected.	4
2400	LIN02	PURCHASED SERVICE PROVIDER IDENTIFIER		LIN02 must be qualifier value "N4". Submission of any other value will cause your claim to reject.	1
2410	CTP04	National Drug Unit Count		The max value for international units (qualifier F2), in the CTP segment, cannot exceed seven bytes numeric with three decimal places. Claims for drugs that exceed this value will be rejected.	4
2410	REF – Segment Rule	PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER		If modifier J1 is used to bill the claim, this segment must be submitted.	2
2410	REF – Segment Rule	PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	1
2420A	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

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2420B	REF – Segment Rule	PURCHASED SERVICE PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420C	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
2420D	REF – Segment Rule	SUPERVISING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420E	REF – Segment Rule	ORDERING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420F	LQ – Segment Rule	REFERRING PROVIDER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment for Part B will cause your claim to reject.	4
2440	LQ – Segment Rule	FORM IDENTIFICATION CODE		If 2400 PWK01 = CT and PWK02= AD, the LQ segment must be submitted.	4
2440	LQ01	FORM IDENTIFICATION CODE	UT	Must be “UT”. Submission of any other value will cause your claim to reject.	1
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		When LQ02 = "484.03", occurrences of FRM with FRM01 = ("1A" or "1B") and FRM01 = "1C" and FRM01 = "05" are required.	4
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		When LQ02 = "484.03" and FRM01 = "1A" and FRM03 >= 55.5 and <= 59.4, one occurrence of FRM with FRM01 = "07", "08" or "09" is required.	1
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		When LQ02 = "484.03" and FRM01 = "1B" and FRM03 >= 88.5 and <=89.4, one occurrence of FRM with FRM01 = "07", "08" or "09" is required.	1
2440	FRM01	SUPPORTING DOCUMENTATION		When LQ02='484.03' and FRM01='05' is present and the value in FRM03 is > '4', an occurrence of FRM01 with the value of '6A' or '6B' is required.	1
2440	FRM01	Question Number/Letter		When LQ02='484.03' and FRM01='6A' or '6B', an occurrence of FRM01 with the value of '6C' is required.	1
2440	FRM01	Question Number/Letter		When LQ02='484.03' and FRM01='6C', an occurrence of FRM01 with the value of '6A' or '6B' is required.	1
2440	FRM02	Question Number/Letter		When LQ02 = '484.03" and FRM with FRM01 = "04", "07", "08" or "09" is present, then FRM02 must	1

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				be present.	
2440	FRM03	Question Response		When LQ02 = "04.04" and FRM01 = "07B", "09B", "10B" or "10C", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "06.03" and FRM01 = "02" or "03", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "09.03" and FRM01 = "01", "01A", "01B", "01C", "02", "02A", "02B", "02C", "03" or "04", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "10.03" and FRM01 = "03", "03A", "03B", "04", "04A", "04B", "05", "06", "08A", "08C", "08D", "08F", "08G" or "09", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "484.03" and FRM01 = "02", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = '484.03" and FRM with FRM01 = "1A", "1B", "02", "03" or "05" is present, then FRM03 must be present.	1
2440	FRM04	Question Response		Must not be a future date.	1
2440	FRM04	Question Response		When LQ02 = '484.03" and FRM with FRM01 = "1C" is present, then	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				FRM04 must be present.	
2440	FRM05	Question Response		When LQ02 = "10.03" and FRM01 = "08B", "08E" or "08H", FRM05 must be present.	1
2440	FRM05	Question Response		Must between 0 and 100 and can contain one decimal place. Submission of a value greater than 100.0 will cause your claim to reject.	1
				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 of use during the 5010 transition year.

Resource	Web Address
ASC X12 TR3 Implementation Guides	http://store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/content/view/711/401/

Resource	Web Address
Central Version 005010 and D.0 Webpage on CMS website	http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html
Educational Resources (including MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from national provider calls)	http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/40_Educational_Resources.html
Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences)	http://www.cms.gov/MFFS5010D0/
Frequently Asked Questions	http://questions.cms.gov
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/