CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12108	**Date: June 29, 2023**
	Change Request 13233

SUBJECT: Creation of the Medicare Fee-For-Service (FFS) Companion Guide for 837D (Dental Format)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the Medicare Administrative Contractors (MACs) to use the attached template to revise the Medicare FFS Companion Guide for 837D with individual MAC specific information.

EFFECTIVE DATE: 01/01/2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: 09/01/2023

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: 12108	Date: June 29, 2023	Change Request: 13233

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I. GENERAL INFORMATION

A. Background: The CMS is issuing a Companion Guide Template for the Health Care Claim Dental (837D), based on the X12N Implementation Guides also known as the Technical Report Type 3 (TR3). The Secretary of the Department of Health and Human Services (HHS) named the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) as the authoring entity of the Phase I, II, and III Operating Rules. The Operating Rules are intended to provide additional direction and clarification to the Electronic Data Interchange (EDI) standard adopted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, amended by Section 1104 of the Affordable Care Act (ACA). The CAQH CORE 152 and 250 Operating Rules require health plan Companion Guides covering certain transactions to follow a specific format/flow as defined in the CAQH CORE Master Companion Guide Version 5010.

The purpose of this Change Request (CR) is for the Medicare Administrative Contractors (MACs) to use the attached template to create a MAC specific Companion Guide for the 837D to adhere to a standardized format as defined in the CAQH CORE Master Companion Guide for Version 5010.

Note: Publishing of the companion guide to the MAC website and any associated provider communication instructions will be provided at a later date.

B. Policy: The CMS will implement the HIPAA standard as adopted by the Secretary's Final Rules that were published in the Federal Register on January 16, 2009, by the DHHS: 45 CFR Part 162.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13233.1	Contractors shall develop a MAC-specific Companion Guide for the X12N Transactions 837D using the CMS approved template.		X							
13233.2	Contractors shall follow the same process established for review and approval of other existing Companion		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Guides.									
13233.3	Contractors shall email the draft 837D Companion Guide to CMS to EDI_CR@CMS.HHS.GOV by September 1, 2023.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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): Charlene Parks, 410-786-8684 or Charlene.Parks@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: 1

Centers for Medicare & Medicaid Services (CMS)

Standard Companion Guide

Health Care Claim: Dental (837D)

Based on ASC X12N TR3, Version 005010X224A2

Companion Guide Version Number: #.#,
[Month, Year]

User Instructions
Blue text contains instructions to the template user and must be deleted before publishing the final document.

[Bracketed text] identifies variable information and must be replaced with entity-specific text before publishing the final document.

Unbracketed black text is part of the template and must not be modified by the authors and must be included in the published companion guide.

If a section is optional it will be marked as such in the template. If an optional section is not included by the authoring entity, the section heading should be retained to keep the numbering of the sections in the published guide in sync with the numbering of the sections in the template.

Remove this page from the published document following completion of the instructions.

Disclosure Statement

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

Preface

This Companion Guide (CG) to the ASC X12N Technical Report Type 3 (TR3) Version 005010 and associated errata adopted under Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Medicare. Transmissions based on this CG, used in tandem with the TR3, are compliant with both ASC X12N syntax and those guides. This CG is intended to convey information that is within the framework of the TR3 adopted for use under HIPAA. This CG is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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

In addition, this CG contains the information needed by Trading Partners to send and receive electronic data with the publishing entity, who is acting on behalf of CMS, including detailed instructions for submission of specific electronic transactions. The instructional content is limited by ASC X12N's copyrights and Fair Use statement.

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1 Introduction

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

An EDI Trading Partner is defined as any Medicare customer (e.g., provider/supplier, billing service, clearinghouse, or software vendor) that transmits to, or receives electronic data from Medicare. Medicare's EDI transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this guide.

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

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

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

- Chapter 24 – General EDI and EDI Support, Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf)

1.1 Scope

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

This CG provides technical and connectivity specification for the 837 Health Care Claim: Dental transaction Version 005010A2.

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 837D transaction standard to meet Medicare's processing standards. This information is organized in the sections listed below:

- *Getting Started:* This section includes information related to hours of operation, and data services. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.

- *Testing and Certification Requirements:* This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.
- *Connectivity/Communications:* This section includes information on Medicare's transmission procedures as well as communication and security protocols.
- *Contact Information:* This section includes EDI customer service, EDI technical assistance, Trading Partner services and applicable websites.
- *Control Segments/Envelopes:* This section contains information needed to create the Interchange Control Header/Trailer (ISA/IEA), Functional Group Header/Trailer (GS/GE), and Transaction Set Header/Trailer (ST/SE) control segments for transactions to be submitted to or received from Medicare.
- *Specific Business Rules and Limitations:* This section contains Medicare business rules and limitations specific to the ASC X12N 837D.
- *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 837D 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

[MAC/CEDI to provide information as appropriate.]

The websites in the following table provide additional resources for HIPAA Version 005010A1 implementation:

Table 2. Additional EDI Resources

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

2 Getting Started

2.1 Working Together

[MAC name/CEDI] is dedicated to providing communication channels to ensure communication remains constant and efficient. [MAC name/CEDI] has several options to assist the community with their electronic data exchange needs. By using any of these methods [MAC name/CEDI] 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 [MAC name/CEDI] 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 [MAC name/CEDI's] EDI help desk and email access, see Section 5 for additional contact information.

[MAC name/CEDI] also has several external communication components in place to reach out to the Trading Partner community. [MAC name/CEDI] posts all critical updates, system issues and EDI-specific billing material to their website, [MAC/CEDI to provide website address]. All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. [MAC name/CEDI] also distributes EDI pertinent information in the form of an EDI newsletter or comparable publication, which is posted to the website every [MAC/CEDI to provide frequency of update] months. In addition to the website, a distribution list has been established in order to broadcast urgent messages. Please register for [MAC name/CEDI's] distribution list by [MAC/CEDI to insert steps here].

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 [MAC name/CEDI] 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 [MAC name/CEDI] 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 [MAC name/CEDI].

[MAC/CEDI to provide specific registration/enrollment process.]

Under HIPAA, EDI applies to all covered entities transmitting the following HIPAA-established administrative transactions: 837I, 837P and 837D, 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 [MAC name/CEDI] furnish information on EDI to new Trading Partners that request Medicare claim privileges. Additionally, Medicare requires [MAC name/CEDI] 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 [MAC name/CEDI] prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. [MAC name/CEDI] 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 [MAC name/CEDI] which third party agents they will be using on their EDI Enrollment form.

Third parties are required to register with [MAC name/CEDI] by completing the third-party agreement form. This will ensure that their connectivity is completed properly, however they may need to enroll in mailing lists separately in order to receive all publications and email notifications.
Additional third-party billing information can be found at [MACs to provide link to their third-party billing information].

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 [MAC name/CEDI]. For a complete reference to security requirements, see Section 4.4.

2.3 Trading Partner Certification and Testing Process

[MAC/CEDI to provide instructions to Trading Partners on testing expectations, and applicable schedules (frequency and dates/times).

MAC/CEDI to provide the process for testing:
• How to "sign up",
☐ What to expect throughout the process (in terms of communication from the MAC),
☐ Description of delivery and interpretation of results, and
☐ Any follow-up actions required]

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.

[MACs/CEDI to provide testing instructions, as appropriate.]

- 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 [MAC name/CEDI], 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 at [MAC/CEDI specify URL here].
    - 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. Trading Partners do not need to test if they are using an approved software vendor. Trading Partners may see if their vendor has passed testing or to locate an approved vendor on the [MACs/CEDI to provide their testing protocols for submitters using the same software.].

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, [MAC name/CEDI] does certify vendors, clearinghouses, and billing services by conducting testing with them and maintaining an approved vendor list that can be accessed at: [MAC/CEDI to provide website for approved vendor list].

4 Connectivity / Communications

4.1 Process Flows

The following diagrams show how production and test transactions flow into and out of [MAC name/CEDI].

Figure 1. [MAC name/CEDI] Process Flows

[MAC/CEDI to provide a High-Level Transaction Flow document a brief supporting document as to what the diagram depicts.]

4.2 Transmission

[MAC/CEDI to provide their procedures.]
[MAC/CEDI to provide where the connectivity specifications are located – URLs, etc.]

4.2.1 Re-transmission Procedures

[MAC/CEDI to provide any procedures relating to re-transmission of files which might include any statement that submitters can retransmit files at their discretion.]

4.3 Communication Protocol Specifications

[MAC/CEDI to provide *detailed* specifications and procedures as they relate to each type of Communication Protocol that they support.]

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. [MAC name/CEDI] is responsible for notifying all affected Trading Partners as well as reporting the system revocation to CMS.

[MAC/CEDI to provide the following:

- Identify the procedures of assignment of logon IDs and passwords by EDI personnel, and should include any statements regarding that EDI Transactions submitted by unauthorized Trading Partners will not be accepted;
- Describe how Trading Partners should protect password privacy by limiting knowledge of the password to key personnel, and all procedures that should be followed on password requirements, and intervals to change password, and when password should be changed when there are any personnel changes;
- Specifications for Trading Partners to electronically transmit files; and
- Password duration/expiration, resetting, requirements (Federal Information Security Management Act [Federal Information Security Management Act (FISMA)], Audit Security)]

4.4.1 Guidelines for Creating a "Good" Password

Most security breaches are a direct result of users selecting "bad" passwords. The selection of a "good" password is critical to ensuring the security and integrity of your health care information. A good password is one that is difficult for others to guess and yet is easily remembered by the user.

Passwords will expire every sixty days.

The following basic guidelines should help when creating a password:

DO

- Must be exactly eight (8) characters in length
- Must contain both alphabetic and numeric characters in the password
- Must contain at least 1 uppercase and 1 lowercase letter
- Must contain a special character; for example: ! $ %
- Passwords are case sensitive
- Must contain a minimum of four (4) characters different than the previous password
- Must be different than the last nine (9) passwords

DON'T

- Do not use English defined words
- Do not use your user ID or any permutation of it as the password
- Do not use your company name, department name, or any permutation of it as a password
- Do not use your name or initials in any form
- Do not use family members or pets as part of the password
- Do not use swear words or obscene words; they're among the first words tried when guessing passwords
- Do not write down your password
- Do not reuse your password
- Do not store your password in scripts, files, or applications unless compensating controls are in place
- Do not use any form of date such as month, day, year, etc.

5 Contact Information

5.1 EDI Customer Service

[MAC/CEDI to provide, but not limited to, the following contact information – if any of the below are not supported indicate with "not available."

- Mailing Address
- Telephone Number both toll free 800 number and regular number Fax number
- Email Address
- Time and Day of Operations – including a link to MAC/CEDI website for closures and holidays]

5.2 EDI Technical Assistance

[MAC/CEDI to provide, but not limited to, the following contact information – if any of the below are not supported indicate with "not available."

- Mailing Address
- Telephone Number both toll free 800 number and regular number Fax number
- Email Address
- Time and Day of Operations – including a link to MAC/CEDI website for closures and holidays]

5.3 Trading Partner Service Number

[MAC/CEDI to provide detailed information concerning Trading Partner Services, including contact numbers, if applicable.]

5.4 Applicable Websites / Email

[MAC/CEDI to provide any additional websites or email addresses relevant to this section – if no additional, state "See Sections [fill in appropriate sections] for applicable website/email information."]

6 Control Segments / Envelopes

[MAC/CEDI to review for applicable organization-specific control segments/envelopes – in addition to, not in place of, what is provided here.]

Enveloping information must be as follows:

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 3. ISA Interchange Control Header

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA01	Authorization Information Qualifier	00	Medicare expects the value to be 00.

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA02	Authorization Information	[10 spaces]	ISA02 shall contain 10 blank spaces.
C.4	ISA03	Security Information Qualifier	00	Medicare expects the value to be 00 and ISA04 shall contain 2 blank spaces.
C.4	ISA04	Security Information	[10 spaces]	Medicare does not use Security Information and will ignore content sent in ISA04.
C.4	ISA05	Interchange ID Qualifier	27, ZZ	Must be “27” or “ZZ”
C.4	ISA06	Interchange Sender ID	[Submitter ID]	[MAC name/CEDI] assigned Submitter ID. This is also required in the GS02.
C.5	ISA07	Interchange ID Qualifier	27, ZZ	Must be “27” or “ZZ”
C.5	ISA08	Interchange Receiver ID	[Receiver ID]	[MAC name/CEDI] contract number [MAC name/CEDI to insert value here].
C.5	ISA11	Repetition Separator	[Submitter Defined]	Defined by the submitter
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: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 4. GS Functional Group Header

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	[Submitter ID]	Submitter number assigned by [MAC name/CEDI]
C.7	GS03	Application Receiver’s Code	[Receiver Code]	[MAC name/CEDI] contract number [MAC name/CEDI to insert value here].
C.7	GS04	Functional Group Creation Date	[date]	Must not be a future date
C.8	GS08	Version Identifier Code	005010X224	Medicare expects value “005010X224A2”

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

6.1 ISA-IEA

Delimiters – Inbound Transactions

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

Delimiters – Outbound Transactions

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

[MAC/CEDI to populate with their delimiters as appropriate.]

Inbound Data Element Detail and Explanation

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

6.2 GS-GE

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

6.3 ST-SE

Medicare FFS follows the HIPAA-adopted TR3 requirements.

7 Specific Business Rules

This section describes the specific CMS requirements over and above the standard information in the TR3.

7.1 General Notes

Errors identified for business level edits performed prior to the Subscriber loop (2000B) will result in immediate file failure at that point. When this occurs, no further editing will be performed beyond the point of failure.

The billing provider must be associated with an approved electronic submitter. Claims submitted for billing providers that are not associated to an approved electronic submitter will be rejected. The following table describes segments/ elements not accepted by Medicare.

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 5. Segment / Elements Not Accepted by Medicare

Page #	Loop ID	Reference	Name	Codes/Content	Notes/Comments
79	2000A	CUR	Foreign Currency Information	[Not Supported]	Medicare does not support the submission of foreign currency.
91	2010AA	REF	Billing Provider UPIN/License Information	[Not Used]	Must not be present.
101	2010AC	Loop Rule	Pay to Plan Loop	[Not Used]	Must not be present.
122	2010BA	REF	Subscriber Secondary Identification (REF01 = “SY”)	[Not Used]	Must not be present.
129	2010BB	REF	Payer Secondary Identification	[Not Used]	Must not be present.
131	2010BB	REF	Billing Provider Secondary Identification	[Not Used]	Must not be present.
133	2000C	HL	Patient Hierarchical Level	[Not Used]	Must not be present. For Medicare, the subscriber is always the same as the patient.

Page #	Loop ID	Reference	Name	Codes/Content	Notes/Comments
135	2000C	PAT	Patient Information	[Not Used]	Must not be present. For Medicare, the subscriber is always the same as the patient.
137	2010CA	Loop Rule	Patient Name Loop	[Not Used]	Must not be present.
168	2300	REF	Payer Claim Control Number	[Not Used]	Must not be present.
259	2330C	Loop Rule	Other Payer Referring Provider	[Not Used]	Must not be present.
263	2330D	Loop Rule	Other Payer Rendering Provider	[Not Used]	Must not be present.
267	2330E	Loop Rule	Other Payer Supervising Provider	[Not Used]	Must not be present.
271	2330F	Loop Rule	Other Payer Billing Provider	[Not Used]	Must not be present.
274	2330G	Loop Rule	Other Payer Service Facility Location	[Not Used]	Must not be present.
296	2400	CN1	Contract Information	[Not Used]	Must not be present.
311	2400	HCP	Line Pricing/Repricing Information	[Not Used]	Must not be present.

7.2 General Transaction Notes

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

- The maximum number of characters to be submitted in any dollar amount field is seven characters. Claims containing a dollar amount in excess of 99,999.99 will be rejected.
- Claims that contain percentage amounts with values in excess of 99.99 will be rejected.
- With the exception of the CAS segment, all amounts must be submitted as positive amounts. Negative amounts submitted in any non-CAS amount element will cause the claim to be rejected.

- Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit will be rejected.
- Only loops, segments, and data elements valid for the TR3 will be translated. Submitting invalid data will cause files to be rejected.
- Medicare requires the NPI be submitted as the identifier for all claims. Claims submitted with legacy identifiers will be rejected.
- National Provider Identifiers will be validated against the NPI algorithm. Claims which fail validation will be rejected.
- The MAC will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
- Submissions with more than one GS-GE (Functional Group) per ISA-IEA (interchange) will be rejected.

8 Acknowledgments and Reports

[MAC/CEDI to provide information and examples on any acknowledgements and/or reports generated for Trading Partners.]

Medicare has adopted three acknowledgement transactions with the Version 005010 implementation: the 277CA, the TA1, and the 999.

Medicare FFS has adopted a process to only reject claim submissions that are out of compliance with the ASC X12N Version 005010 standard; the appropriate response for such errors will be returned on a 999. Batch submissions with errors will not be rejected in totality, unless warranted.

8.1 Report Inventory

[MAC/CEDI to provide a listing/inventory of applicable proprietary acknowledgments, including hard-copy reports.]

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 [MAC name/CEDI]. This agreement can be found at [MAC/CEDI to provide URL for their Trading Partner Agreement forms].

Additionally, [MAC name/CEDI] requires the following: [MAC/CEDI to provide any additional Trading Partner requirements – if a MAC's Trading Partner Agreement process is identical to their EDI enrollment and registration process, then indicate that here.]

10 Transaction-Specific Information

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

10.1 Header

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

10.1.1 Header and Information Source

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

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.
- A new table exists for each segment.

Table 6. ST Transaction Set Header

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
65	N/A	ST02	Transaction Set Control Number	[Control Number]	9	[MAC name/CEDI] will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.

Table 7. BHT Beginning of Hierarchical Transaction

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
66	N/A	BHT02	Transaction Set Purpose Code	00	2	Must equal "00" (ORIGINAL).
67	N/A	BHT06	Claim/Encounter Identifier	CH	2	Must equal "CH" (CHARGEABLE).

10.1.2 Loop 1000A Submitter Name

The following table defines the specific details associated with Loop 1000A Submitter Name:

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 8. Loop 1000A NM1 Submitter Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
70	1000A	NM105	Submitter Middle Name or Initial	[Name or Initial]	25	The first position must be alphabetic (A-Z).
70	1000A	NM109	Submitter ID	[Submitter ID]	80	[MAC name/CEDI] will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission. Submitter ID must match the value submitted in ISA06 and GS02.

10.1.3 Loop 1000B Receiver Name

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

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 9. Loop 1000B NM1 Receiver Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
75	1000B	NM109	Receiver Primary Identifier	[Primary Identifier]	80	[MAC name/CEDI] will reject an interchange (transmission) that is not submitted with a valid [MAC/CEDI] contractor code. Each individual MAC determines this identifier. Submitter ID must match the value submitted in ISA08 and GS03.

10.2Billing Provider

The following sub-sections contain specific details associated with Billing Provider.

10.2.1 Loop 2000A Billing Provider Detail

The following table defines the specific details associated with Loop 2000A Billing Provider.

Table 10. Loop 2000A Billing Provider Detail

Loop ID	Notes/Comments
2000A	The Billing Provider Detail Section of this CG contains no unique CMS Medicare requirements that differ from the TR3. Refer to the TR3 specifications for the following Loops: 2000A, 2010AA, 2010AB.
2010AA	NM109: billing provider must be “associated” to the submitter (from a Trading Partner management perspective) in 1000A NM109. [MAC name/CEDI] will provide appropriate direction to VA providers.

10.2.2 Loop 2010AA Billing Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 11. Loop 2010AA NM1 Billing Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
84	2010AA	NM105	Billing Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.3Subscriber Detail

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

10.3.1 Loop 2000B Subscriber Hierarchical Level

The following tables define the specific details associated with Loop 2000B Subscriber Hierarchical Level.

Note: A new table exists for each segment.

Table 12. Loop 2000B HL Subscriber Hierarchical Level

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
110	2000B	HL04	Hierarchical Child Code	0	1	The value accepted is “0”

Table 13. Loop 2000B SBR Subscriber Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
111	2000B	SBR01	Payer Responsibility Sequence Number Code	P, S	1	The values accepted are “P” or “S”
112	2000B	SBR02	Individual Relationship Code	18	2	For Medicare, the subscriber is always the same as the patient.
113	2000B	SBR09	Claim Filing Indicator Code	MB	2	For Medicare, the subscriber is always the same as the patient.

10.3.2 Loop 2010BA Subscriber Name

The following tables define the specific details associated with Loop 2010BA Subscriber Name.

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

- A new table exists for each segment.

Table 15. Loop 2010BA NM1 Subscriber Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
115	2010BA	NM102	Subscriber Entity Type Qualifier	1	1	The value accepted is 1.
115	2010BA	NM105	Subscriber Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).
115	2010BA	NM108	Subscriber Identification Code Qualifier	MI	2	The value accepted is “MI”
116	2010BA	NM109	Subscriber Primary Identifier	[Primary Identifier]	80	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: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 16. Loop 2010BA DMG Subscriber Demographic Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
120	2010BA	DMG02	Subscriber Birth Date	[Date]	35	Must not be a future date.

10.3.3 Loop 2010BB Payer Name

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

Table 17. Loop 2010BB NM1 Payer Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
125	2010BB	NM108	Payer Identification Code Qualifier	PI	2	The value accepted is “PI”

10.4Patient Detail

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

10.4.1 Loop 2300 Claim Information

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

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.
- A new table exists for each segment.

Table 18. Loop 2300 CLM Claim Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
146	2300	CLM01	Patient Control Number	[Number]	38	Only 20 characters will be stored and returned by Medicare.
147	2300	CLM02	Total Claim Charge Amount	[Amount]	18	Must be >=0 and <= 99,999.99. When Medicare is primary payer, CLM02 must equal the sum of all SV102 service line charge amounts. When Medicare is Secondary. Total Submitted Charges (CLM02) must equal the sum of all 2320 & 2430 CAS amounts and the 2320 AMT02 (AMT01=D).
147	2300	CLM05-3	Claim Frequency Code	1	1	Must be equal to “1” (ORIGINAL).
151	2300	CLM20	Delay Reason Code	[Code]	2	Data submitted in CLM20 will not be used for processing.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 19. Loop 2300 DTP Date Elements

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
152	2300	DTP03	Accident Date	[Date]	35	Must not be a future date.
153	2300	DTP03	Appliance Placement Date	[Date]	35	Must not be a future date.
154	2300	DTP03	Service Date	[Date]	35	Must not be a future date.
155	2300	DTP03	Repricer Received Date	[Date]	35	Must not be a future date.

In the table below, for Loop 2300 Claim Supplement Information, only the first iteration of the PWK, at either the claim level and/or line level, will be considered in the claim adjudication.

Table 21. Loop 2300 PWK Claim Supplement Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
160	2300	PWK02	Attachment Transmission Code	BM, FX, EL, FT	2	Must be “BM”, “FX”, “EL”, or “FT”

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 23. Loop 2300 HI Health Care Diagnosis Code

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
181	2300	HI01-2	Health Care Diagnosis Code	[Diagnosis Code]	30	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.

10.4.2 Loop 2310A Referring Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 24. Loop 2310A NM1 Referring Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
191	2310A	NM105	Referring Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.4.3 Loop 2310B Rendering Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 25. Loop 2310B NM1 Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
197	2310B	NM105	Rendering Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.4.4 Loop 2310E Supervising Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 26. Loop 2310D NM1 Supervising Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
217	2310E	NM105	Supervising Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.4.5 Loop 2320 Other Subscriber Information

The following tables define the specific details associated with Loop 2320 Other Subscriber Information.

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.
- A new table exists for each segment.

Table 27. Loop 2320 SBR Other Subscriber Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
222	2320	SBR01	Payer Responsibility Sequence Number Code	[Code]	1	2320 SBR01 = ”P” must be present when 2000B SBR01 = ”S”
224	2320	SBR09	Claim Filing Indicator Code	[Code]	2	The value cannot be “MA” or “MB”

In the table below, for Loop 2320 Claim Level Adjustments, CAS segment must not be present when 2000B SBR01 = “P”.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 28. Loop 2320 CAS Claim Level Adjustments

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
227	2320	CAS01	Claim Level Adjustments	[Code]	2	CAS segment must not be present when 2000B SBR01 = “P”

Table 29. Loop 2320 AMT COB Payer Paid Amount

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
231	2320	AMT01	Coordination of Benefits (COB) Payer Paid Amount	D	3	Medicare requires one occurrence of 2320 loop with an AMT segment AMT01 = ”D” must be present when 2000B SBR01 = ”S”.

10.4.6 Loop 2330A Other Subscriber Name

The following tables define the specific details associated with Loop 2330A Other Subscriber Name.

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.
- A new table exists for each segment.

Table 30. Loop 2330A NM1 Other Subscriber Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
240	2330A	NM105	Other Insured Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 31. Loop 2330A REF Other Subscriber Secondary Identification

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
245	2330A	REF02	Other Insured Additional Identifier	[Identifier]	9	Must be 9 digits with no punctuation. First 3 digits cannot be higher than “272”. Digits 1-3, 4-5, and 6-9 cannot be zeros (0).

10.4.7 Loop 2330B Other Payer Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 32. Loop 2330B DTP Claim Check or Remittance Date

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
251	2330B	DTP03	Date Time Period	[Date]	35	Must not be a future date.

10.4.8 Loop 2400 Service Line Number

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

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.
- A new table exists for each segment.

Table 33. Loop 2400 SV3 Dental Service

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
282	2400	SV301-1	Product or Service ID Qualifier	AD	2	Must be “AD”.
284	2400	SV302	Line Item Charge Amount	[Amount]	18	SV302 must be greater than 0. SV302’s decimal positions are limited to 0, 1, or 2.
286	2400	SV306	Procedure Count	[Quantity]	15	Must be > 0 with maximum of 4 whole numbers and 1 decimal position (cannot exceed 9999.9).

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 38. Loop 2400 DTP Service Date

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
290	2400	DTP03	Date – Service Date	[Date]	35	Must not be a future date.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
291	2400	DTP03	Date – Prior Placement	[Date]	35	Must not be a future date.
292	2400	DTP03	Date – Appliance Placement	[Date]	35	Must not be a future date.
293	2400	DTP03	Date – Replacement	[Date]	35	Must not be a future date.
294	2400	DTP03	Date – Treatment Start Date	[Date]	35	Must not be a future date.
295	2400	DTP03	Date – Treatment Completion	[Date]	35	Must not be a future date

10.4.9 Loop 2420A Rendering Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 45. Loop 2420A NM1 Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
317	2420A	NM105	Rendering Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.4.10 Loop 2420C Supervising Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 46. Loop 2420C NM1 Supervising Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
329	2420C	NM105	Supervising Provider Middle Name	[Name or Initial]	25	First position of Supervising Provider Middle Name must be alphabetic (A-Z).

10.4.11 Loop 2430 Line Adjudication Information

The following tables define the specific details associated with Loop 2430 Line Adjudication Information.

Note:

- Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.
- A new table exists for each segment.

Table 49. Loop 2430 SVD Line Adjudication Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
342	2430	SVD03-1	Product or Service ID Qualifier	AD	2	Must be “AD”. Claims with “ER” will be rejected.
344	2430	SVD05	Paid Service Unit Count	[Quantity]	15	Must not exceed 4 whole numbers and one decimal position. Must be a value greater than or equal to 0 and less than or equal to 9999.9
344	2430	SVD06	Bundled Line Number	[Number]	6	Must be an integer (no decimals).

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 50. Loop 2430 DTP Line Check or Remittance Date

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
351	2430	DTP03	Adjudication or Payment Date	[Date]	35	Must not be a future date.

10.4.12 Transaction Set Trailer

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 53. SE Transaction Set Trailer

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

11 Appendices

11.1Implementation Checklist

[MAC/CEDI to provide all necessary steps for going live with EDI exchange.]

11.2Transmission Examples

[MAC/CEDI to provide examples of the control segments and envelopes.]

11.3Frequently Asked Questions

Frequently asked questions can be accessed at Medicare FFS EDI Operations (https://www.cms.gov/ElectronicBillingEDITrans/) and [MAC/CEDI to provide website for FAQs – if different from Medicare FFS site].

11.4Acronym Listing

Table 54. Acronyms Listing and Definitions

Acronym	Definition
276	276 Claim Status Request transaction
277	277 Claim Status Response transaction
277CA	277 Claim Acknowledgement
835	835 Electronic Remittance Advice transaction
837D	837 Dental Claims transaction
999	Implementation Acknowledgment
ASC	Accredited Standards Committee
CAQH CORE	Council for Affordable Quality Healthcare – Committee on Operating Rules for Information Exchange
CEDI	Common Electronic Data Interchange
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
CMN	Certificate of Medical Necessity
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
ERA	Electronic Remittance Advice
FFS	Medicare Fee-For-Service
FISMA	Federal Information Security Management Act
GS/GE	GS – Functional Group Header / GE – Functional Group Trailer
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HTTP	Hyper Text Transfer Protocol
HTTPS	Hyper Text Transfer Protocol Secure
IOM	Internet-only Manual
ISA/IEA	ISA – Interchange Control Header / IEA – Interchange Control Trailer
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier

Acronym	Definition
MIME	Multipurpose Internet Mail Extensions
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
NSV	Network Service Vendor
PDAC	Pricing, Data Analysis and Coding
PECOS	Provider Enrollment Chain and Ownership System
PHI	Protected Health Information
PID	Packet Identifier
sFTP	Secure File Transfer Protocol
SOAP	Simple Object Access Protocol
ST/SE	ST – Transaction Set Header / SE – Transaction Set Trailer
TA1	Interchange Acknowledgment
TR3	Technical Report Type 3
TRN	Transaction Acknowledgment report (CEDI proprietary report)
WSDL	Web Services Description Language
X12	A standards development organization that develops EDI standards and related documents for national and global markets. (See the official ASC X12 website.)
X12N	Insurance subcommittee of X12

11.5Change Summary

The following table details the version history of this CG.

Table 55. Companion Guide Version History

Version	Date	Section(s) Changed	Change Summary
Version	Month CCYY	Identify sections updated	Provide a Summary of changes