

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13954	Date: September 29, 2026
	Change Request 14590

SUBJECT: Internet Only Manual (IOM) Update, Publication (Pub.) 100-04, Chapter 24 General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update IOM, Pub. 100-04, Chapter 24 General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims to support the new Technical Consolidation of Electronic Data Interchange (TCEDI) gateway.

EFFECTIVE DATE: October 30, 2026

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 30, 2026

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
R	24/10/10.2/Audience for this Chapter
R	24/10/10.4/Acronyms and Definitions
R	24/40/40.1/Centers for Medicare and Medicaid Services - Medicare Fee-For-Service
R	24/40/40.2/Medicare FFS Contractors (A/B MAC, DME MAC, CEDI)
R	24/50/50.1/Telecommunications, Internet and Dial-up
R	24/50/50.2/Translators
R	24/50/50.3/Combined Common Edits/Enhancements Module (CCEM) - General Description Across All Versions
R	24/50/50.3.1/Claim Numbering
R	24/50/50.3.2/Receipt Control and Balancing
R	24/50/50.3.3/Acknowledgements
R	24/50/50.3.3.1/Outbound File Compliance Check
R	24/60/60.1/ A/B MACs, and CEDI Edit Requirements
R	24/70/70.1/General HIPAA EDI Requirements

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:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13954	Date: September 29, 2026	Change Request: 14590
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II. GENERAL INFORMATION

A. Background: This CR encompasses one category of updates: Commercial Off-the-Shelf (COTS) software and translator.

Updates to the sections referencing COTS software and translator functionality are required as part of the new TCEDI gateway project.

B. Policy: This CR does not involve any legislative or regulatory policies.

III. 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	
14590.1	The contractor shall be aware of the manual updates to Pub. 100-04 chapter 24.	X	X	X						CEDI, TCEDI

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

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

VI. CONTACTS

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

VII. 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: 0

Medicare Claims Processing Manual

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims

Table of Contents

(Rev.13954 Issued: 09-29-26)

10.2 - Audience for this Chapter

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

The information contained in this chapter will be of interest to Medicare providers, business associates or other trading partners, as well as others interested in how Medicare has structured its EDI policies. Other Medicare FFS and CMS partners as well as general audiences may use this as a source of information to determine Medicare FFS' EDI practices. Primarily however, this chapter, and related chapters, are used by Medicare contractors for descriptive guidance to contractual responsibilities they have to CMS.

The instructions within this chapter are primarily directed to Medicare Administrative Contractors (MACs) and centralized Medicare FFS EDI gateway operations, including Technical Consolidation of the Electronic Data Interchange (TCEDI) where designated by CMS. The instructions within this chapter are also directed to Durable Medical Equipment Medicare Administrative Contractors (DME MACs), the Common Electronic Data Interchange (CEDI) contractor for DME MACs, and their shared systems, and are in reference to Medicare requirements for their implementation of the current HIPAA compliant version of the Accredited Standards Committee (ASC) X12 Technical Report Type 3 (TR3) also known as an ASC X12 Implementation Guide (IG) and NCPDP Telecommunication Implementation Guide, as well as all Medicare and contractor EDI activities related to these transactions. In order to implement the HIPAA administrative simplification provisions, specific ASC X12 and NCPDP transactions have been named under part 162 of title 45 of the Code of Federal Regulations as electronic data interchange (EDI) standards for Health Care. All other EDI formats for health care became obsolete on October 16, 2003. The Final Rule for Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards published in the <https://www.federalregister.gov/articles/2009/01/16/E9740/health-insurance-reform-modifications-to-the-health-insurance-portability-andaccountability-act>, adopted updated versions of HIPAA mandated electronic transactions. Furthermore, the Final Rule conveys inclusion of errata documents to the transaction standard(s). Medicare FFS therefore incorporates by reference any errata documents by the original mandated regulation compliance date through the Federal Register notice(s). Moving forward, all newly adopted errata documents are to be accepted and integrated as part of the EDI transaction(s). Medicare FFS further adopts the Accredited Standards Committee (ASC) X12 and National Council for Prescription Drug Programs (NCPDP) transaction standards as part of its EDI Acknowledgment Model.

10.4 - Acronyms and Definitions

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

The following is a list of terms and acronyms if assistance is needed to understand the terminology used in this chapter.

- EDI – Electronic Data Interchange - the process of using nationally established standards to exchange electronic information between business entities.
- HIPAA – Health Insurance Portability and Accountability Act of 1996 – legislation that mandated that the healthcare industry use standard formats for electronic claims and claims related transactions.

- MAC – Medicare Administrative Contractor – Section 911 of the Medicare Modernization Act of 2003 mandated that the Secretary for Health & Human Services replaced the contractors administering the Medicare Part A or Part B fee-for-service programs with Medicare Administrative Contractors (MACs). Part A/Part B Medicare Administrative Contractors (MACs) replaced the fiscal intermediaries and carriers and handle administration of both the Medicare Part A and Part B programs in specified geographic regions. For more information, please see the CMS overview of Medicare Contracting Reform.
- A/B MAC – Medicare Administrative Contractor servicing both Part A and Part B lines of business.
- DME MAC – Durable Medical Equipment Medicare Administrative Contractor
- CEDI - Common Electronic Data Interchange – Common front end for DME MACs
- *TCEDI – Technical Consolidation of the Electronic Data Interchange*
- Trading Partner – one of two or more participants in an ongoing business relationship (e.g., provider, billing service, software vendor, employer group, financial institution, etc.).
- Submitter – an entity that owns the healthcare data being submitted. It is most likely the provider, hospital, clinic, etc. A submitter is directly linked to each billing NPI.
- EDI Enrollment – establishes documentation specifying type of transactions and transmission methods to be used in the exchange of electronic administrative transactions.
- EDI Registration – designates the Medicare contractor as the entity they agree to engage with for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged.
- Trading Partner Agreement – 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.
- Third Party Agreement- ensures the confidentiality, security, and integrity of Medicare data being shared by third party agents that represent providers, certain value-added networks, clearinghouses, and billing agents.

40.1 - Centers for Medicare and Medicaid Services - Medicare Fee-For-Service ***(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)***

A/B MACs, along with TCEDI where designated by CMS, must support the exchange, routing, validation, acknowledgment, and processing of HIPAA-compliant EDI transactions. A/B MACs, DME MACs along with the Common *Electronic* Data Interchange (CEDI) contractor must transact versions of the institutional and professional claim (ASC X12 837 claim, institutional, professional and dental), the remittance advice (ASC X12 835 remittance advice), the claim status request and response (ASC X12 276/277 claim status request and response), the eligibility inquiry and response (ASC X12 270/271 eligibility), and the newly adopted error handling transactions (the ASC X12 277 CA claim acknowledgment, the ASC X12 999 implementation acknowledgment and the ASC X12 TA1 interchange acknowledgment) within national standards developed by ASC X12. CEDI must transact versions of the National Council for Prescription Drug Programs (NCPDP) claims transactions.

Medicare FFS supports EDI as exchanged between all covered entities and Medicare FFS contractors. This chapter provides guidance on how these relationships and the transactions generated by them shall be established, maintained and managed.

40.2 - Medicare FFS Contractors (A/B MAC, DME MAC, CEDI)

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

A/B MACs and TCEDI, where designated by CMS, are responsible for supporting CMS-approved electronic transaction exchange, routing, intake processing, and operational monitoring. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS are responsible to support the exchange of CMS approved electronic transactions. This support includes testing, certifying, and retention of an audit trail for the electronic data interchange platforms. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS must maintain environments according to CMS security policy and guidelines. See Section 40.2.1 and 40.2.2 for specific references to this information.

A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide outreach and education to encourage the use of electronic transactions. A/B MACs, CEDI or other contractors if designated by CMS are responsible for managing the EDI enrollment of entities who will be exchanging electronic transactions and providing support to these entities. A/B MACs, DME MACs, or other contractors if designated by CMS are responsible to support contact with new providers, make available User Guidelines for EDI transactions and EDI provider training, to include information on EDI transactions in newsletters, bulletin boards, and Internet publications. See Section 40.2.2 and 40.2.3 for specific references to this information.

A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide limited support to providers in choosing a vendor, determining goals and requirements for the provider in selecting a vendor and assist in evaluating vendor proposals. See Section 40.2.4 for specific references to choosing a vendor.

A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide support to EDI trading partners through technical assistance and training. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will make free claim submission software available to providers and support the software. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will also support the software to convert the ASC X12 835 remittance advice into a print document. See Section 40.2.5 and 40.2.6 for specific references to this information.

50.1 - Telecommunications, Internet and Dial-up

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI and A/B MACs shall support connectivity for EDI functions in accordance with CMS-approved centralized gateway architecture and routing requirements. DME MACs and CEDI will support connectivity for EDI functions. These functions include the exchange of EDI transactions at the CEDI Front End.

Online systems include the Medicare Part A Direct Data Entry (DDE) used for claim entry, claim correction, claim status checks, and beneficiary eligibility. Medicare Part B offers the Provider Professional Telecommunications Network (PPTN) and DME MAC offers Claim Status Inquiry to check the status of claims.

50.2 - Translators

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may perform centralized translation, validation, and flat-file transformation functions for HIPAA-compliant transactions prior to routing transactions to shared systems and A/B MAC processing environments. CEDI must accept HIPAA compliant transactions into their front-end system and translate that data into the appropriate flat file format for the transaction type to enable

processing by their shared system. HIPAA compliant transactions may include Medicare data (data sent to the core shared system) and non-Medicare data (data not sent to the core shared system). Translators are required to validate the syntax compliance of each inbound transaction against the transaction standards adopted under HIPAA and upon which the implementation guides (also adopted under HIPAA) are based. Syntax edits must be limited to those syntax requirements specified in those implementation guides (IGs) adopted under HIPAA.

A/B MACs and CEDI must use the ASC X12 999 implementation acknowledgment to report transaction level errors detected by translators and to acknowledge receipt of claims that did not contain syntax errors, unless the submitter has indicated a preference not to receive acknowledgments for claims without errors. A/B MACs or CEDI may purge ASC X12 999 implementation acknowledgment transactions from submitter mailboxes after five (5) business days in the event not downloaded by the submitting entity, but are encouraged to retain these as long as 30 days if system capacity permits. Once purged, an A/B MACs or CEDI is not required to be able to recreate that ASC X12 999 implementation acknowledgment transactions. A provider or clearinghouse that failed to download the ASC X12 999 implementation acknowledgment in a timely manner may submit a claim status query to obtain comparable information for accepted claims. If that response indicates no record of the claim(s), suggesting front end rejection due to a syntax error, the provider/clearinghouse can resubmit the claim and have a new ASC X12 999 implementation acknowledgment issued. The ASC X12 999 implementation acknowledgment TR3 can be downloaded from the official Washington Publishing Company website. A/B MACs and CEDI are required to meet the ASC X12 999 implementation acknowledgment TR3 requirements when issuing the 999.

When receiving claims in the HIPAA adopted NCPDP formats, CEDI must produce a response file in the NCPDP format containing one Transaction Header and one Transaction Trailer with the appropriate syntax error noted in the message field.

TCEDI and CEDI must accept the entire extended character set. Refer to the ASC X12 TR3 for specifics on the character set. If *TCEDI* and CEDI cannot accept more than 9,999 loops or segments per loop in an ASC X12 transaction due to the limitations of their translator, they may reject the transaction at the translator level and use the ASC X12 999 implementation acknowledgment with the IK304 with a value of “4”. Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) that surround individual transactions so the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure, which could cause software failure when mapping to the flat file. *TCEDI* and CEDI are not required to accept multiple functional groups (GS/GE) with multiple transaction types within one transmission for ASC X12 transactions.

For ASC X12 transactions *TCEDI* and CEDI translators must also:

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in an inbound transaction but which are included in the flat file;
- Map “Not Used” data elements for *TCEDI* and CEDI based upon that segment’s definition only, i.e., if a data element is never used, do not map it. However, if a data element is “required” or “situational” in some segments but not used in others, then it must be mapped; “Not Used” data elements are not to be mapped to the flat file; and
- Accept multiple interchange envelopes within a single transmission. This is only applicable to ASC X12 transactions as NCPDP only processes a single batch per transmission.

- Translate data for outgoing transactions supplied by the shared system in the flat file format into the appropriate, compliant IG standard as adopted under HIPAA. Translation of outgoing transactions is to follow the same character set and case requirements noted for incoming translation. *TCEDI* and CEDI are not required to accept or process ASC X12 999 implementation acknowledgment transactions from trading partners for any outgoing ASC X12 transactions.

See Section 60 for additional *TCEDI* and CEDI translator edit requirements that may be specific to individual standards.

50.3 - Combined Common Edits/Enhancements Module (CCEM) - General Description Across All Versions

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

The CCEM establishes consistent editing, acknowledgments, and error handling of the electronic data interchange (EDI) transactions across Medicare Administrative Contractor (MAC) jurisdictions. *The CCEM may interface with centralized CMS-designated gateway infrastructure, including TCEDI, for intake processing, routing, validation, balancing, and acknowledgment workflows.* The CCEM is implemented by each A/B MAC in their local data center (LDC). The Part A and Part B CCEMs were developed by their corresponding Medicare Shared System Maintainers (SSMs). The Durable Medical Equipment (DME) MACs editing, acknowledgment, and error handling of EDI transactions is processed by the Common Electronic Data Interchange (CEDI) contractor. Each A/B MAC has integrated the CCEM into its Front-End Systems for both inbound and outbound EDI transaction processing. The CCEM, in conjunction with the TCEDI translator and any additional Front End Solution, is responsible for editing current ASC X12 standard transactions established under HIPAA via Technical Report Type 3 (TR3s).

The CCEM provides submitters with quicker acknowledgments for the claim transaction(s) ASC X12 version(s) 005010 and beyond inclusive of any adopted errata under HIPAA. This allows submitters to correct any errors and resubmit their transactions without having to wait for a batch cycle.

The CCEM includes the following capabilities:

- Code set editing
- Medicare-specific editing
- Duplicate submission checking
- Claim Control Number assignment of Internal Control Number (ICN) or Document Control Number (DCN)
- Creation of the ASC X12 277CA claim acknowledgment (flat file)
- Creation of a CCEM-edited transaction flat file
- Receipt/Control/Balancing between the local data centers (LDCs) and EDCs for claims, claim status request and responses, and remittance advice
- Reporting Capabilities based on the Control Record database

50.3.1 - Claim Numbering

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI may perform centralized intake and validation processing prior to CCEM assignment of claim control numbers for accepted Part A/B claims- An accepted claim is a unit of work, 2300 loop followed by a

2400 loop, as described in the ASC X12 837 claim TR3 that has passed all translator syntax/semantic and CCEM Medicare business edits and has been assigned a claim control number. The assigned claim control number will be reported back to the submitter via the ASC X12 277CA claim acknowledgment. This will provide the submitter with the claim control number earlier in the adjudication process, thus enabling the submitter to perform more specific claim status inquiries on individual claims instead of entire submissions via standard HIPAA adopted transactions or via traditional IVR/ARU (Interactive Voice Response/Automated Response Unit methods).

50.3.2 - Receipt Control and Balancing

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

Upon receiving an ASC X12 276 claim status request or ASC X12 837 claim (institutional or professional) current standard transaction adopted under HIPAA. *TCEDI, where designated by CMS, may perform centralized receipt, control, balancing, routing, and intake processing functions prior to delivery of CMS-defined flat files to shared systems.* The CMS defined flat file will include a skeleton Control Record, either a Detail Record (CTRD) or a Resubmission Record (CTRR), for each Interchange Control Header/Interchange Control Trailer (ISA/IEA) present, and the A/B MAC then loads/places this file into the designated folder for the CCEM to pick up and process.

The CTRD/CTRR record is placed in the designated transaction outbound folder for the A/B MAC LDC to move via Network Data Mover (NDM) to the EDC. The EDC will run a receipt/control/balancing process upon receipt of a file to ensure that what was sent by the LDC is what the EDC received. Once the EDCs have checked the files, the "Received" portion of the Control Records will be populated, and a copy of the Control Record shall be sent back to the LDC and logged in the Control Record database. If the file balances, the Control Records will be stripped off and the file will be queued up to be pulled into the next processing cycle. If file does not balance, "Received" portion of the Control Records will be populated, and a copy of the Control Record shall be sent back to the LDC and logged in the Control Record database. An alert will be sent to the LDC to indicate there is a problem with a file, and the bad ISA/IEA will be stripped out of the file. Once the LDC has identified and fixed the issues, they resubmit the bad ISA/IEA.

The Receipt/Control/Balancing process will also be in place for the outbound ASC X12 835 remittance advice and the ASC X12 277 claim status response. The shared system maintainers (SSMs) will create the appropriate CMS defined flat file, based on transaction type. The CMS defined flat file will include the Control Records. The transactions will be sent to the MAC/CEDI local data center, where they will be passed through the receipt/control/balancing process to ensure if the CMS defined flat file is balanced. During the outbound translation process the A/B MACs shall remove the control records prior to translating the CMS defined flat files to ASC X12 EDI format.

50.3.3 - Acknowledgements

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may generate or coordinate ASC X12 acknowledgment transactions, intake validation responses, and operational balancing acknowledgments prior to downstream shared system processing to determine whether an edit failure necessitates the rejection of the entire transaction set via the ASC X12 TA1 interchange acknowledgment or ASC X12 999 implementation acknowledgment edit, back to the submitter or whether those errors are accepted and passed onto the CCEM for claim level rejection via the ASC X12 277CA claim acknowledgment. Errors that the translator passes to the CCEM are referred to as ASC X12 999 implementation acknowledgment “Accepted, but Errors Noted” (ASC X12 999E implementation acknowledgment) edits.

The CCEM will receive CMS defined 837 and 276 flat files from the *TCEDI* translator. The CCEM will flag any 837 flat file data in error and will report that data back to the submitter via the ASC X12 277CA claim acknowledgment. Any 276 flat file data in error will be reported back to the submitter via an ASC X12 277 claim status request response transaction. All accepted data will be sent to the SSM for processing.

1. If the translator sets an edit that does not necessitate rejection of the entire ST-SE transaction set (ASC X12 999E implementation acknowledgment edit), the contractor front end:
 - a. Creates an ‘STC’ segment to document the error and inserts it into the ASC X12 837 claim CMS defined flat file following the segment containing the error.
 - b. Returns the ASC X12 999 implementation acknowledgment to the submitter indicating the affected ST-SE transaction was accepted with errors noted.
 - c. Inserts a receipt date segment (+RC DTP segment) into the ASC X12 837 claim CMS defined flat file.
 - d. Creates a skeleton (350 character space filled) Control Record (CTR segment) and, if desired, populates CTR17. The CTR is placed in front of each ISA segment.
 - e. Submits the ASC X12 837 claim CMS defined flat file containing STC error segments to the CCEM.
2. If the translator does not set any edits, the contractor front end:
 - a. Returns the ASC X12 999 implementation acknowledgment to the submitter indicating the affected ST-SE transaction was accepted.
 - b. Inserts a receipt date segment (+RC DTP segment) into the ASC X12 837 claim CMS defined flat file.
 - c. Creates a skeleton CTR segment and if desired, populates CTR17. The CTR is placed in front of each ISA segment.
 - d. Submits the ASC X12 837 claim CMS defined flat file to the CCEM.

50.3.3.1 - Outbound File Compliance Check

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may perform outbound compliance validation, balancing, and integrity checks for ASC X12 999 implementation acknowledgment and ASC X12 835 remittance advice transactions. The ASC X12 276/277 claim status response and the ASC X12 277CA claim acknowledgment outbound files shall be compliance checked for the following:

- Basic syntactical integrity and specific syntax requirements on all outbound files;

- Balanced field totals, financial balancing of claims or remittance advices, and balancing of summary fields, if appropriate for all outbound file;
- Specific inter-segment situations described in the HIPAA Implementation Guides for all outbound files; and
- Valid TR3 specific code set values and other code sets adopted as HIPAA standards for all outbound files.

60.1 - A/B MACs, and CEDI Edit Requirements

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may perform centralized front-end editing, validation, rejection processing, and transaction intake services prior to shared system processing. CEDI *is* required to edit submitted transactions at the front end to determine whether they are sufficiently complete to enable processing. Transactions that are not legible, or do not include adequate data to be considered an acceptable EDI transaction, must be rejected or returned as unprocessable. “Rejected” or “returned” transactions are not classified as “received” by Medicare.

A/B MACs and CEDI are not required to assign a control number or a receipt date to those transactions rejected or returned as unprocessable. Nor are they required to retain any record of those transactions pending correction and resubmission by the original sender. See § 50 and § 70 of this chapter for further editing and testing requirements.

CEDI is required to assign a control number and a receipt date to those claims transactions accepted by CEDI. They are required to retain any record of those originally submitted transaction pending correction and resubmission by the original sender. See § 50 and § 70 of this chapter for further editing and testing requirements.

A. Translation and Date of Receipt Editing

If a shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file’s submitter (A/B MACs and CEDI) by the shared system with an appropriate error message.

The date of receipt of a claim is the date a claim is received by the A/B MACs and CEDI and not a subsequent date on which the claim may have been received by the shared system. The date of receipt must be an actual calendar date and may not be all zeroes or a future date. See § 80.2.1 of Chapter 1 of this manual for additional information on establishing the date of receipt of a claim.

B. Implementation Guide (IG) Edits: ASC X12 Version 5010 and NCPDP Version D.0

In conjunction with front-end translation, A/B MACs (A) are to also conduct IG edits to identify submitted data elements that do not comply with data element requirements added by the IG developers, using either software available from FISS or other software which is able to edit at this level. A/B MAC (B) shared systems conduct IG edits for transactions sent to the A/B MACs (B). CEDI conducts IG edits for transactions sent to the DME MACs.

In many cases, IG edits are more restrictive than those established by the ASC X12 standard that served as the platform for development of the TR3. For instance, the ASC X12 standard might allow a maximum of 30-digits in a data element, but an IG note could limit the maximum size to 20-digits. Or the number of

valid digits that may be entered in a data element as identified by the qualifiers that apply to the data element, might not permit reporting of more than 15-digits even though the standard permits up to 30-digits.

No national standards have been adopted under HIPAA for acknowledgment or error reporting for any of the HIPAA format transactions. However, Medicare has adopted the ASC X12 999 implementation acknowledgment and ASC X12 277CA claim acknowledgment for this purpose effective with the implementation of version 5010. For Version 5010 DME MACs will continue the use of proprietary error reporting for CMN rejection reports, which are returned to DME submitters through CEDI. IG and Medicare program error reports related to electronic transactions must be sent to the submitters of those transactions electronically. IG level edits typically affect a small number of the transactions in a batch. Whenever not precluded by the standard, A/B MACs and CEDI are expected to reject individual transactions that are identified via IG edits and not reject the entire batch of transactions in which those transactions were submitted.

A/B MACs (A) share IG editing responsibilities with FISS (shared system documentation indicates which IG edits are conducted by the shared system). A/B MACs (B) shared systems are responsible for IG editing of Part B professional transactions. CEDI is responsible for IG editing of DME transactions. When editing for IG compliance, the responsible party must verify that:

- Amounts, percentages, integers, and other fields designated in the IG as numeric are right-justified and zero-filled if the incoming data are smaller than the Medicare flat file field size;
- Fields designated in the IG as alphanumeric are left justified and space filled if the incoming data are smaller than the Medicare flat file field size;
- All non-Medicare data field lengths correspond to the maximum IG length.
- Incoming alphanumeric non-Medicare data are left justified and space filled if the data are smaller than the Medicare flat file field size;
- Incoming numeric non-Medicare data are right justified and zero-filled if the data contain fewer integers than the Medicare flat file field size; and
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are mapped to the Medicare flat file (and later written to the store-and-forward repository (SFR) by the shared system).

70.1 - General HIPAA EDI Requirements

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

As described in section 40.1.1, the A/B MACs, DME MACs and CEDI shall support the current versions adopted under HIPAA of the following transactions and their implementation guides for the electronic exchange of data with Medicare providers/submitters/receivers/COB trading partners. *TCEDI, where designated by CMS, shall support CMS-approved HIPAA-compliant EDI transaction processing, routing, validation, acknowledgment, and flat-file transformation services.* Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected.

- ASC X12 837 claim, institutional, professional and dental
- NCPDP telecommunication and equivalent batch standard for retail prescription drug claims (applicable for CEDI and DME MACs only) and COB (see § 40.1 of this chapter for additional information);
- ASC X12 835 remittance advice (see chapter 22 for additional information); and
- ASC X12 276/277 claim status request and response (see chapter 31 for additional information).

Links to sources of implementation guides for these standards are available at

- www.cms.hhs.gov/ElectronicBillingEDITrans

Although not mandated by HIPAA, as noted in § 40.1.2, CMS also requires that A/B MACs and CEDI issue an ASC X12 999 implementation acknowledgment transaction to electronic claim submitters to acknowledge receipt of claims (except where waived by a submitter) and to report syntax errors related to any ASC X12 transactions submitted to Medicare.

See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing Medicare claim remittance advice print software updates information to providers via the Internet and alternate methods to be used to furnish information to those providers that lack Internet access.

An overview of any changes to existing specifications, including effective dates will be issued to providers via A/B MACs and CEDI bulletins, on contractor Web pages, and will also be available via the Internet as Manual transmittals which can be viewed via a link from

www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp to the separate page for each EDI transaction format supported by Medicare fee-for-service plans.