Centers for Medicare & Medicaid Services (CMS)

Standard Companion Guide

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

Based on ASC X12N TR3, Version 005010X212

Companion Guide Version Number: 7.4,
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Disclosure Statement

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

Preface

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

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

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

Table of Contents

List of Tables

List of Figures

1 Introduction

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

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

Medicare Fee-For-Service (FFS) is publishing this Companion Guide (CG) to clarify, supplement, and further define specific data content requirements to be used in conjunction with, and not in place of, the ASC X12N 276/277 Technical Report Type 3 (TR3) Version 005010 mandated by HIPAA and/or adopted by Medicare FFS for EDI.

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

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

- Chapter 24 – General EDI and EDI Support, Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf)
- Chapter 31 – X12 Formats Other than Claims or Remittance (https://www.cms.gov/manuals/downloads/clm104c31.pdf)

1.1 Scope

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

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

1.2 Overview

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

- *Getting Started:* This section includes information related to hours of operation, and data services. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.
- *Testing and Certification Requirements:* This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.
- *Connectivity/Communications:* This section includes information on Medicare's transmission procedures as well as communication and security protocols.
- *Contact Information:* This section includes EDI customer service, EDI technical assistance, Trading Partner services and applicable websites.
- *Control Segments/Envelopes:* This section contains information needed to create the Interchange Control Header/Trailer (ISA/IEA), Functional Group Header/Trailer (GS/GE), and Transaction Set Header/Trailer (ST/SE) control segments for transactions to be submitted to or received from Medicare.
- *Specific Business Rules and Limitations:* This section contains Medicare business rules and limitations specific to the ASC X12N 276/277.
- *Acknowledgments and Reports:* This section contains information on all transaction acknowledgments sent by Medicare and report inventory.
- *Trading Partner Agreement:* This section contains information related to implementation checklists, transmission examples, Trading Partner Agreements and other resources.
- *Transaction Specific Information:* This section describes the specific CMS requirements over and above the information in the ASC X12N 276/277 TR3.

1.3 References

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

Table 1. EDI Transactions and Code Set References

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

1.4 Additional Information

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

Table 2. Additional EDI Resources

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

2 Getting Started

2.1 Working Together

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

First Coast also has several external communication components in place to reach out to the Trading Partner community. First Coast posts all critical updates, system issues and EDI-specific billing material to their website, (https://medicare.fcso.com). All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. First Coast also distributes EDI pertinent information in the form of an EDI newsletter or comparable publication, which is posted to the website every three months. In addition to the website, a distribution list has been established in order to broadcast urgent messages. Please register for First Coast distribution list by signing up for eNews (https://medicare.fcso.com/Header/137525.asp).

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 First Coast 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 First Coast 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 First Coast.

Medicare requires all trading partners to complete an EDI enrollment form (http://medicare.fcso.com/EDI_Forms/) and sign an EDI agreement. The EDI enrollment form designates the Medicare contractor the entity agrees to engage in EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of the information being exchanged.

Once the form is completed, it can be faxed, emailed or mailed to First Coast Medicare EDI. (See Section 5 for contact information). When the EDI enrollment form has been processed, First Coast will notify the entity whether the enrollment has been completed or the form rejected.

Under HIPAA, EDI applies to all covered entities transmitting the following HIPAA-established administrative transactions: 837I and 837P, 835, 270/271, 276/277, and the National Council for Prescription Drug Programs (NCPDP) D.0. Additionally, Medicare Administrative Contractors (MACs) and Common Electronic Data Interchange (CEDI) will use the Interchange Acknowledgment (TA1), Implementation Acknowledgment (999), and 277 Claim Acknowledgement (277CA) error-handling transactions.

Medicare requires that First Coast furnish information on EDI to new Trading Partners that request Medicare claim privileges. Additionally, Medicare requires First Coast 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 First Coast prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. First Coast 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 First Coast which third party agents they will be using on their EDI Enrollment form.

Third parties are required to register with First Coast by completing the third-party agreement form (https://medicare.fcso.com/EDI_forms/190816.pdf). 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.

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 First Coast. For a complete reference to security requirements, see Section 4.4.

2.3 Trading Partner Certification and Testing Process

First Coast does not require testing for 276/277 Claims Status inquiries.

3 Testing and Certification Requirements

3.1 Testing Requirements

All claims' 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. This CG recommends testing the 276/277 prior to production status whenever possible.

- 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.
- TR3 Semantic Data testing validates data required for claims processing, e.g., procedure/diagnosis codes and 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 First Coast, the vendor/submitter will make the necessary correction(s) prior to submitting a production file.

Many submitters use the same software, or the same clearinghouse to submit their electronic transactions to Medicare. Once a vendor or clearinghouse passes the testing process, clients of that entity using the approved software will not be required to test prior to being migrated to production. If a vendor or clearinghouse supports multiple software products, each product will require testing. Third party agents who have passed testing will be required to provide First Coast with their client migration schedule.

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, First Coast does certify vendors, clearinghouses, and billing services by conducting testing with them and maintaining an approved vendor list (https://medicare.fcso.com/Getting_started/206578.asp).

4 Connectivity / Communications

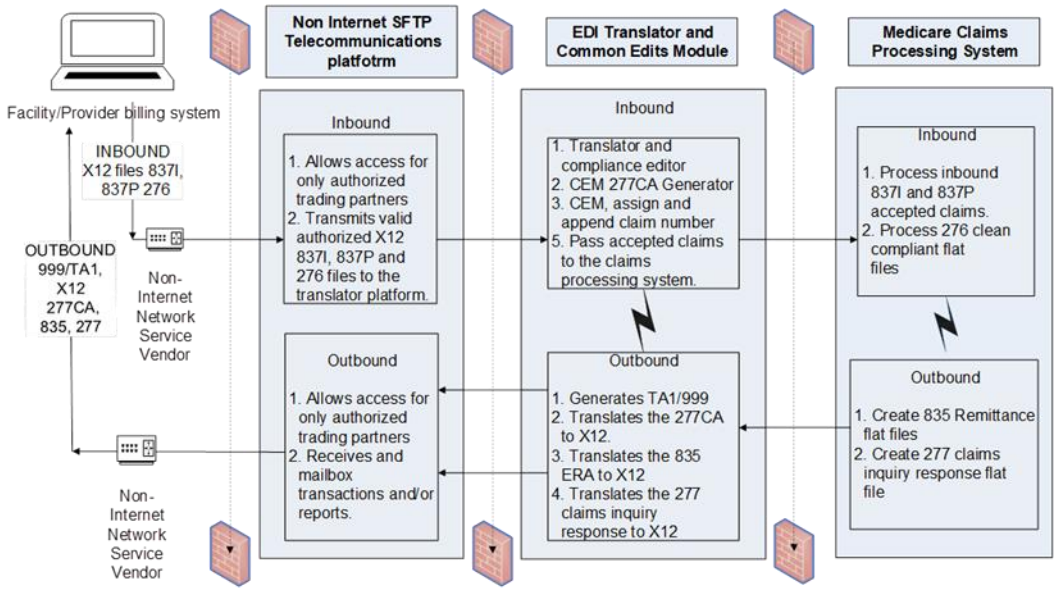
4.1 Process Flows

The Electronic Data Interchange (EDI) Gateway is the system for managing data and communications between its electronic trading partners and the various First Coast lines of business (Medicare A & Medicare B). The EDI Gateway is the only means of exchanging electronic transactions with First Coast. The EDI Gateway receives and delivers transaction data (claims, claim status, remittances, etc.) between First Coast and its trading

partners. The system is available 24 hours a day, 7 days a week. The diagrams below provide a high- level transaction flow for both internet and non-internet EDI transactions.

The following diagrams show how the production and test transactions flow into and out of First Coast.

Figure 1. First Coast Process Flows



Trading Partner submits 276 Claims Status Request to the EDI Gateway. Files are passed through a translator that validates the file is syntactically compliant. If file is not syntactically compliant, a TA1 or 999 Initial Acknowledgment report will be delivered in the outbound data. If the file meets syntax requirements; 276 Claims Status Requests are then passed through the Combined Common Edit Module (CCEM). The data is then sent to the Medicare processing systems. Results are returned on the 277 Claim Status Response.

4.2 Transmission

The EDI front-end platform is accessible 24 hours a day, 7 days a week. EDI Files submitted after 4PM Eastern Time (ET) on any business day are considered “received” the next business day. EDI files submitted on a non-business day are considered “received” the next business day or as published. TIBCO allows for multiple transmission within one day by verifying the unique Interchange Control Number in ISA13 for each transmission. If you are not sure how to assign a unique Interchange Control Number, please contact your vendor or in- house programmer. 277 Status Response files will be uploaded to TIBCO the next day.

4.2.1 Re-transmission Procedures

Submitters can retransmit rejected files at their discretion. To avoid a file duplication reject we suggest - batching of your file to change the control number in the ISA segment.

- Re-batch your file to change the control number in the ISA segment.
- Add or remove a claim.

- Correct the cause of the rejection.

4.3 Communication Protocol Specifications

First Coast Service Options, Inc. supports the following types of Communication Protocols

- Non-Internet
    - Secure File Transfer Protocol (SFTP)
- Internet
    - Hypertext Transfer Protocol (HTTPS)
- Simple Object Access Protocol (SOAP)

All Medicare EDI Trading Partners submissions and retrievals are required to use a Network Service Vendor (NSV) (https://medicare.fcso.com/Getting_started/206578.asp) for connectivity to the EDI Gateway including using the public internet for encrypted Transport Layer Security (HTTP/S) transport, or a Simple Object Access Protocol using X.509 Client Certificates over Secure Socket Layer for 276/277 transactions.

The EDI Gateway is file oriented. All commands and health care transactions that the trading partner sends or receives are in a file and are broken down into the following simple phases of file transfer: LOGON, SUBMIT, OBTAIN, and LOGOFF.

A typical session consists of the following steps:

- Trading Partner connects with Gateway.
- Gateway Sends Session Start Text (“+++”).
- Trading Partner Sends LOGON command file.
- Trading Partner Sends SUBMIT command file.
- Trading Partner Sends data file.
- Trading Partner Sends OBTAIN command file.
- Trading Partner Receives data file.
- Trading Partner Sends LOGOFF command file.
- Trading Partner Receives Session Messages file.
- Mutual Disconnect between Trading Partner and Gateway.

Note: As of April 2017, internet connectivity is now a valid communication protocol for 276/277 Status Inquiry and Response transactions and with CMS prior approval.

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

Trading partners must first complete and submit an EDI enrollment form. Upon successful enrollment, First Coast will assign a submitter ID, unique mailbox ID and an initial password to the provider. Trading partners will need to contact EDI to obtain the initial password.

The mailbox ID and password are used in your logon command in your billing software and must remain current to avoid transmission disruptions.

4.4.1 Login ID Criteria

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.

Login IDs are case sensitive. The login ID is exactly 9 characters long and may contain upper or lower case letters [A-Z, a-z] or numbers [0- 9]. The mailbox ID does not expire and must be entered exactly as given.

4.4.2 Password Criteria

Passwords will expire every sixty days and cannot be changed more than once per day.

- Must be 8 – 12 characters in length.
- Must contain 3 out of the 4 elements:
    - Capital Letter
    - Lowercase Letter
    - Numeric Value
    - Special Character (!, #, $, %, &, *, @, ?)

4.4.3 Password Resources

Password Expiration Tool (https://medicare.fcso.com/Tools_center/EDIPasswordCheck.asp)

Password Change Tool (https://medicare.fcso.com/Tools_center/EDIPasswordChange.asp)

4.4.4 Secure File Transfer Protocol (SFTP) Submission

Upload 276 file to:

- /outbox/X12/EDI/Inbound/Interchange for X12 files.
- /outbox/EZComm/BC/1.0/Notify for .ZIP files.

Retrieve the 277 report responses from:

- /inbox/X12/EDI/Outbound/Interchange for X12 files.
- /inbox/EZComm/BC/1.0/Notify for .ZIP files.

Important tips for configuring your SFTP files:

- Disable “temp file” in your file transfer software.
- The date/time stamp during the file transfer should not be updated.
- A file should not be renamed after the last byte of the file has been transferred.
- Only a file should be zipped, not an entire folder.
- Zip files should not be encrypted, or password protected.

5 Contact Information

5.1 EDI Customer Service

Hours of Operation:

- Monday – Friday from 8:00 am to 5:00 pm Eastern Standard Time.
- First Coast Holidays and Training closures (https://medicare.fcso.com/Contacts/index.asp).

Fax: 904-361-0470

Email Address: MedicareEDI@fcso.com

5.2 EDI Technical Assistance

1-888-670-0940

5.3 Trading Partner Service Number

Not Available

5.4 Applicable Websites / Email

English website (https://medicare.fcso.com/)

Spanish website (https://medicareespanol.fcso.com/)

6 Control Segments / Envelopes

Enveloping information must be as follows for the 276:

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

Table 3. ISA Interchange Control Header (276)

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA01	Authorization Information Qualifier	00, 03	ISA01 must be “00” or “03”.
C.4	ISA02	Authorization Information	-	Medicare expects 10 spaces.
C.4	ISA03	Security Information Qualifier	00, 01	Medicare expects the value to be “00” or “01”.
C.4	ISA04	Security Information	-	Medicare expects 10 spaces.
C.4	ISA05	Interchange ID Qualifier	27, 28, ZZ	ISA05 = “27”, “28”, or “ZZ”.
C.4	ISA06	Interchange Sender ID	-	This value is required to be in the 2100A Loop, NM1 Segment, NM109 data element.
C.5	ISA07	Interchange ID Qualifier	27, 28, ZZ	ISA07 = “27”, “28”, or “ZZ”.
C.5	ISA08	Interchange Receiver ID	-	Contract ID based on region: • Medicare Florida Part A 09102 • Medicare Florida Part B 09102 • Medicare FL Part A Puerto Rico/U.S. Virgin Islands 09201 • Medicare Part B Puerto Rico 09202 • Medicare Part B U.S. Virgin Islands 09302
C.5	ISA11	Repetition Separator	|	ISA 11 must be "|".

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

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

Table 4. GS Functional Group Header (276)

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	-	Submitter number assigned by First Coast.
C.7	GS03	Application Receiver Code	-	First Coast receiver ID.
C.7	GS08	Version Identifier Code	005010X212	GS08 must also match the ST03.

Enveloping information will be sent as follows for the 277:

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

Table 5. ISA Interchange Control Header (277)

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA01	Authorization Information Qualifier	00, 01	Medicare will send “00”.
C.4	ISA02	Authorization Information	-	Medicare will send 10 spaces.
C.4	ISA03	Security Information Qualifier	00	Medicare will send “00”.
C.4	ISA04	Security Information	-	Medicare will send 10 spaces.
C.4	ISA05	Interchange ID Qualifier	ZZ	Medicare will send “ZZ”.

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA06	Interchange Sender ID	-	First Coast payer IDs: • Florida: Part A: 09101 • Florida Part B: 09102 • Puerto Rico Part B: 09202 • US Virgin Islands & Puerto Rico Part A: 09201 • US Virgin Islands Part B: 09302
C.5	ISA07	Interchange ID Qualifier	ZZ	Medicare will send “ZZ”.
C.5	ISA08	Interchange Receiver ID	-	First Coast-assigned Trading Partner ID.
C.5	ISA11	Repetition Separator	|	First Coast EDI repetition separator character "|".
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 6. GS Functional Group (277)

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	-	First Coast payer IDs: Florida: Part A: 09101 Florida Part B: 09102 Puerto Rico Part B: 09202 US Virgin Islands & Puerto Rico Part A: 09201 US Virgin Islands Part B: 09302
C.7	GS03	Application Receiver Code	-	Submitter number assigned by the First Coast.
C.8	GS08	Version Identifier Code	005010X212	GS08 must match ST03.

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

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

6.1 ISA-IEA

Delimiters – Inbound Transactions

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

Delimiters – Outbound Transactions

Trading Partners should contact First Coast 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.

Table 7. Transaction Delimiters

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

Inbound Data Element Detail and Explanation

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

6.2 GS-GE

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

6.3 ST-SE

Medicare FFS follows the HIPAA-adopted TR3 requirements.

7 Specific Business Rules

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

7.1 General Notes

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

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

7.2 General Transaction Notes

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

- 276's sent for dental claims that were processed in the cloud will receive the 'Not Found' on the 277 responses.
- Part A will be returning claim level status information, but not line level status information.
- Information Receiver Status Information (Loop ID 2200B, STC – Segment Rule) has a limitation of up to five iterations allowed for all occurrences in these transactions.
- Dependent level is never used for Medicare.
- Reference TR3 Appendix B.1.1.3.1.2 for notes regarding amount fields in this transaction set.

7.3 Medicare Specific Business Rules

Medicare generates a series of reports based on the incoming transaction. Below are the reports related to the 276 Claim Status Request.

- Upon receipt of the 276 Claim Status Request we will generate a TA1 or 999 if errors are in the file
- The 277 Claim Status Response will be available the next business day for accepted 276 Claim Status files.
- The 277 will remain available for 60 days.

8 Acknowledgments and Reports

Medicare has three acknowledgement transactions with the Version 005010 implementation: the 277CA, the 999, and the TA1 segment – which provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure.

Medicare FFS has 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 TA1 Interchange Acknowledgment

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

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

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

8.2 999 Implementation Acknowledgment

Medicare FFS has elected to use the ASC X12 999. For submissions that are out of compliance with the ASC X12 Version 005010 standard, the appropriate response for such errors will be returned with a 999. Refer to Section 7.3 for Medicare-specific 999-related business rules.

Technical specifications for the ASC X12N 999 are published for the ASC X12N 276/277 Health Care Claim Status Request and Response transactions at the official ASC X12 website.

8.3 Report Inventory

This section does not apply to First Coast

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 (https://medicare.fcso.com/EDI_Forms/) with First Coast.

There are no additional requirements for the Trading Partner Agreement. All procedures are outlined in the EDI enrollment and registration process section 2.2 of this guide.

10 Transaction-Specific Information

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

10.1 Health Care Claim Status Request Transaction (276)

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

10.1.1 Loop 2100A Payer Name (276)

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

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

Table 8. Loop 2100A NM1 Payer Name (276)

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

10.1.2 Loop 2000B Information Receiver Level Structures (276)

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

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

Table 9. Loop 2100B NM1 Information Receiver Name (276)

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

10.1.3 Loop 2000C Service Provider Detail Structures (276)

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

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

Table 10. Loop 2100C NM1 Service Provider Detail (276)

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

10.1.4 Loop 2000D Subscriber Level Structures (276)

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

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

Table 11. Loop 2000D DMG Subscriber Demographic Information (276)

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

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

Table 12. Loop 2100D NM1 Subscriber Name (276)

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

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

Table 13. Loop 2200D REF Payer Claim Control Number (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
59	2200D	REF02	Payer Claim Control Number	-	50	For DME, must be 14 digits. For MCS, must be 13 digits. For Fiscal Intermediary Standard System (FISS), must be 14 - 23 characters.

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

Table 14. Loop 2200D REF Institutional Bill Type Identification (276)

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

Table 15. Loop 2200D REF Application or Location System Identifier (276)

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

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

Table 16. Loop 2200D AMT Total Claim Charge Amount (276)

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

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

Table 17. Loop 2200D DTP Claim Service Date (276)

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

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

Table 18. Loop 2210D SVC Service Line Information (276)

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

10.1.5 Loop 2200E Dependent Level Structures (276)

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

Table 19. Loop 2200E Dependent Level Detail (276)

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

10.2 Health Care Claim Response Transaction (277)

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

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

10.2.1 Header (277)

The following table contains specific details for the 277 Header.

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

Table 20. ST Transaction Set Header (277)

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

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

Table 21. BHT Beginning of Hierarchical Transaction (277)

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

10.2.2 Loop 2000A Information Source Level Structures (277)

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

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

Table 22. Loop 2100A NM1 Payer Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
112	2100A	NM108	Identification Code Qualifier	PI	2	Medicare generates the value of "PI".

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
112	2100A	NM109	Payer Identifier	[Identifier]	80	Transmitted value from the associated 276.

For the table referenced below, the telephone number will always be transmitted in the first communication number set, an email address will be sent in the second communication number set, if the information is applicable and available. The third communication number set will not be transmitted.

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

Table 23. Loop 2100A PER Payer Contact Information (277)

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

10.2.3 Loop 2000B Information Receiver Level Structures (277)

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

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

Table 24. Loop 2100B NM1 Information Receiver Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
118	2100B	NM101	Entity Identifier Code	-	3	Transmitted value from the associated 276.
118	2100B	NM102	Entity Type Qualifier	-	1	Transmitted value from the associated 276.

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

Table 25. Loop 2200B TRN Information Receiver Trace Identifier (277)

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

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

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

Table 26. Loop 2200B STC Information Receiver Status Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
121	2200B	STC01-1	Health Care Claim Status Category Code	-	41	None

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

10.2.4 Loop 2000C Service Provider Level Structures (277)

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

For the table below, only 1 iteration of the 2100C loop allowed by Medicare.

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

Table 27. Loop 2100C NM1 Provider Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
127	2100C	NM101	Entity Identifier Code	-	3	Transmitted value from the associated 276.
127	2100C	NM102	Entity Type Qualifier	-	1	Transmitted value from the associated 276.
127	2100C	NM103	Provider Last or Organization Name	-	60	Transmitted value from the associated 276.
127	2100C	NM104	Provider First Name	-	35	Transmitted value from the associated 276.
127	2100C	NM105	Provider Middle Name	-	25	Transmitted value from the associated 276.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
127	2100C	NM107	Provider Name Suffix	-	10	Transmitted value from the associated 276.
128	2100C	NM108	Identification Code Qualifier	-	2	Transmitted value from the associated 276.
128	2100C	NM109	Provider Identifier	-	80	Transmitted value from the associated 276.

For the table below, up to five iterations of the STC will be allowed for all occurrences in these transactions.

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

Table 28. Loop 2200C STC Provider Status Information (277)

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

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

Table 29. Loop 2200C STC10 Health Care Claim Status (277)

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

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

Table 30. Loop 2200C STC11 Health Care Claim Status (277)

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

10.2.5 Subscriber Level Structures (277)

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

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

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

Table 31. Loop 2100D NM1 Subscriber Name (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
135	2100D	NM102	Entity Type Qualifier	1	1	None
136	2100D	NM103	Subscriber Last Name	-	60	Transmitted value from the associated 276.
136	2100D	NM104	Subscriber First Name	-	35	Transmitted value from the associated 276.
136	2100D	NM105	Subscriber Middle Name or Initial	-	25	Transmitted value from the associated 276.
136	2100D	NM107	Subscriber Name Suffix	-	10	Transmitted value from the associated 276.
136	2100D	NM108	Subscriber Name	-	2	Transmitted from the associated 276.
136	2100D	NM109	Subscriber Identifier	-	80	For the MBI: Must be 11 positions in the format of C A AN N A AN N A A N N where "C" represents a constrained numeric 1 thru 9; "A" represents alphabetic character A - Z but excluding S, L, O, I, B, Z; "N" represents numeric 0 thru 9; "AN" represents either "A" or "N".

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

Table 32. Loop 2200D TRN Claim Status Tracking Number (277)

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

For the table below, up to five iterations of the STC will be allowed for all occurrences in these transactions.

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

Table 33. Loop 2200D STC Claim Level Status Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
138	2200D	STC01-1	Health Care Claim Status Category Code	-	30	**Claim Found:** Any valid Health Care Claim Status Code Category, except "R". **Claim Not Found:** Category Code of "A4" will be generated.
138	2200D	STC01-2	Status Code	-	30	Valid Claim Status Code. **Claim Not Found:** Status code "35" will be generated.
144	2200D	STC01-4	Code List Qualifier Code	-	3	Not present
145	2200D	STC02	Status Information Effective Date	-	8	**Claim Found:** Date the claim moved to the current location status from the internal system, in CCYYMMDD format. **Claim Not Found:** Current (system) date, in CCYYMMDD format.
145	2200D	STC04	Total Claim Charge Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.
145	2200D	STC05	Claim Payment Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
145	2200D	STC06	Adjudication Finalized Date	-	8	None
146	2200D	STC08	Remittance Date	-	8	None
146	2200D	STC09	Remittance Trace Number	-	16	None
146	2200D	STC10-1	Health Care Claim Status Category Code	-	30	Any valid Health Care Claim Status Code Category, except "R".
147	2200D	STC10-4	Code List Qualifier Code	-	3	Not present
148	2200D	STC11-4	Code List Qualifier Code	-	3	Not present
148	2200D	STC12	Free-form Message Text	-	264	Not present

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

Table 34. Loop 2200D REF Payer Claim Control Number (277)

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

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

Table 35. Loop 2200D REF Patient Control Number (277)

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

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

Table 36. Loop 2200D REF Pharmacy Prescription Number (277)

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

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

Table 37. Loop 2200D REF Voucher Identifier (277)

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

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

Table 38. Loop 2200D REF Claim Identification Number for Clearinghouses (277)

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

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

Table 39. Loop 2200D DTP Claim Service Date (277)

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

For the table below, The appropriate Part A Claim Level Only Processing = E4 Cat & 247 – Claim Status Code indicates only claim level processing to occur.

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

Table 40. Loop 2220D SVC Service Line Information (277)

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

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
159	2220D	SVC01-5	Procedure Modifier	-	2	**Claim Found:** If applicable, third procedure modifier used to adjudicate the claim (from the internal system). **Claim Not Found:** Transmitted value from associated 276.
160	2220D	SVC01-6	Procedure Modifier	-	2	**Claim Found:** If applicable, fourth procedure modifier used to adjudicate the claim (from the internal system). **Claim Not Found:** Transmitted value from the associated 276.
160	2220D	SVC02	Line Item Charge Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.
160	2220D	SVC03	Line Item Payment Amount	-	10	Refer to TR3 Section B.1.1.3.1.2.
160	2220D	SVC04	Revenue Code	-	48	**Claim Found:** If 2220D SVC01-2 is present then SVC04 may be present. **Claim Not Found:** Transmitted value from the associated 276.
160	2220D	SVC07	Units of Service Count	-	15	**Claim Found:** Units from the internal system. **Claim Not Found:** Transmitted value from the associated 276.

For the table below, up to five iterations of the STC will be allowed for all occurrences in these transactions. Part A only returns Claim Level status information.

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

Table 41. Loop 2220D STC Service Line Status Information (277)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
161	2220D	STC01-1	Health Care Claim Status Category Code	A4	30	**Line Not Found:** "A4".
161	2220D	STC01-2	Health Care Claim Status Code	35, 247	30	**Line found:** Any valid Claim Status Code. **Line not found:** "35" for Part B or CEDI. "247" for Part A.
167	2220D	STC01-4	Code List Qualifier Code	-	3	Not used by Medicare.
168	2220D	STC02	Status Information Effective Date	-	8	**Line found:** Date the claim moved to the current location status from the internal system, in CCYYMMDD format. **Line Not Found:** Current (system) date in CCYYMMDD format.
169	2220D	STC10-4	Code List Qualifier Code	-	3	Not used by Medicare.
170	2220D	STC11-4	Code List Qualifier Code	-	3	Not used by Medicare.

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

Table 42. Loop 2220D REF Service Line Item Identification (277)

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

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

Table 43. Loop 2220D DTP Service Line Date (277)

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

10.2.6 Loop 2200E Dependent Level Structures (277)

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

Table 44. Loop 2200E Dependent Level Detail (277)

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

11 Appendices

11.1 Implementation Checklist

First Coast provides a step-by-step guide (https://medicare.fcso.com/Getting_started/138080.asp) to trading partners on how to submit electronic transactions.

11.2 Transmission Examples

11.2.1 TA1 Interchange Acknowledgment – File Rejected

Figure 2. TA1 Interchange Acknowledgment - File Rejected

```
ISA*00*  *00*       *ZZ*09102          *ZZ*P9999          *980903*1215*^*00501*100469823*1*P*>~
TA1*000000003*991229*1650*R*024~ IEA*0*100469823~
```

11.2.2 999 File Accepted

Figure 3. 999 File Accepted

```
ISA*00*  *00*       *ZZ*09102          *ZZ*P9999          *980903*1215*^*00501*100469823*0*P*>~
GS*FA*09102*P9999*20190225*160139*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HR*20198773*005010X212~
AK2*276* 000000001 *005010X212~
IK5*A~ AK9*A*1*1*1~
SE*6*0001~
GE*1*1~
IEA*1*000000001~
```

11.2.3 999 File Rejected

Figure 4. 999 File Rejected

```
ISA*00*  *00*       * ZZ*09102         *ZZ*P9999          *190226*0855*^*00501*000000001*1*P*:~
GS*FA*09102*P9999*20190226*085508*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HR*100000016*005010X212~
AK2*276*6R92000Dx*005010X212~
IK3*NM1*4*2100*8~
IK4*1*98*7*RP~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~
```


11.2.4 276 Inbound Claim Status Request

Figure 5. 276 Inbound Claim Status Request

```
ISA*00*  *00*       * 27*P9999          *ZZ*09102          *190220*0301*^*00501*012074022*1*P*:~
GS*HR*09102*P9999*20190220*0301*12074022*X*005010X212~
ST*276*RCM9T5001*005010X212~
BHT*0010*13*012074022*20190220*0301~
HL*1**20*1~
NM1*PR*2*MEDICARE   FLORIDA*****PI*09102~
HL*2*1*21*1~
NM1*41.2*DOCOTORS   OFFICE*****46*P9999~
HL*3*2*19*1~
NM1*1P*2* DOCOTORS OFFICE *****XX*9999999999~
HL*4*3*22*0~ DMG*D8*19480312*F~
NM1*IL*1*PATIENT'EXAMPLE****MI*100000000A~
TRN*1*11868249TB49824~
AMT*T3*8800~
DTP*472*DS*20190111~
SE*15*RCM9TB001~
GE*1*12074022~
IEA*1*012074022~
```

11.2.5 277 Claim Status Outbound Response

Figure 6. 277 Claim Status Outbound Response

```
ISA*00*  *00*       * ZZ*09102          *ZZ*P9999          *190226*0855*^*00501*000000001*0*P*:~
GS*HN*09102*P9999*20190220*22482565*1*X*005010X212~
ST*277*000000001*005010X212~
BHT*0010*08*20190510001*20190220*22482565*DG~
HL*1**20*1~
NM1*PR*2*FIRST COAST SERVICE OPTIONS PI*09102~
PER*IC*MEDICARE EDI*TE*8888670940~
HL*2*1*21*1~
NM1*41*2*DOCTORS OFFICE 46*P9999~
HL*3*2*19*1~
NM1*1P*2* DOCTORS OFFICE **'*XX*9999999999~
HL*4*3*22*0~
NM1*IL*1*PATIENT*EXAMPLE****MI*100000000A~
TRN*1*11868249TB49824~
STC*A3^21*20190124**8800**20190124**20190124*338384097*A3^1~
REF*1K*1019018683730~
DTP*472*D8*20190111~
SVC*HC^29888ALT*4600*0****1~
STC*F2^107*20190124~
SE*32*000000001~
GE*1*1~ IEA*1*000000004~
```

11.3 Frequently Asked Questions

First Coast EDI specific FAQs (http://medicare.fcso.com/FAQs/index.asp)

11.4 Acronym Listing

Table 45. Acronyms List

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

Acronym	Definition
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
NSC	National Supplier Clearinghouse
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 Acknowledgement report (CEDI proprietary report)
WSDL	Web Services Description Language
X12	A standards development organization that develops EDI standards and related documents for national and global markets. (See the Official ASC X12 website.)
X12N	Insurance subcommittee of X12

11.5 Change Summary

The following table details the version history of this CG.

Table 46. Companion Guide Version History

Version	Date	Section(s) Changed	Change Summary
1.0	November 5, 2010	All	Initial Draft.
2.0	January 3, 2011	All	1st Publication Version.
3.0	April 2011	6.0	2nd Publication Version.
4.0	September 2015	All	3rd Publication Version.
5.0	March 2019	All	4th Publication Version.
6.0	May 2020	1.3, 8.2 and 11.4	5th Publication Version.

Version	Date	Section(s) Changed	Change Summary
7.0	September 2021	All	Updates for the EDI Gateway transition.
7.1	May 2022	All	508 Compliance.
7.2	February 2023	Page 32	Updated third to fourth in the Note/Comment for SVC01-6.
7.3	May 2024	Section 7.2	Added information about Dental Claim responses.
7.4	June 2024	Pages 5, 6 and 36	Updated hyperlinks for the Third Party Agreement, Vendor List and removed link to the Medicare FFS EDI Operations page.