Centers for Medicare & Medicaid Services (CMS)

Standard Companion Guide

Health Care Claim: Payment/Advice (835)

Based on ASC X12N TR3, Version 005010X221A1

Companion Guide Version Number: 7.5,
September 2025

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.

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Preface

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

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

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

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1 Introduction

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

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

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

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

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

- Chapter 22 – Remittance Advice (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf)
- Chapter 24 – General EDI and EDI Support, Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf)

1.1 Scope

EDI addresses how Trading Partners exchange professional and institutional claims, claim acknowledgments, claim remittance advice, claim status inquiry and responses, and eligibility inquiry and responses electronically with Medicare. This CG also applies to ASC X12N 835 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 835 Health Care Claim: Payment/Advice transaction Version 005010x221A1.

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

- *Getting Started:* This section includes information related to hours of operation, and data services. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.
- *Testing and Certification Requirements:* This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.
- *Connectivity/Communications:* This section includes information on Medicare's transmission procedures as well as communication and security protocols.
- *Contact Information:* This section includes EDI customer service, EDI technical assistance, Trading Partner services and applicable websites.
- *Control Segments/Envelopes:* This section contains information needed to create the Interchange Control Header/Trailer (ISA/IEA), Functional Group Header/Trailer (GS/GE), and Transaction Set Header/Trailer (ST/SE) control segments for transactions to be submitted to or received from Medicare.
- *Specific Business Rules and Limitations:* This section contains Medicare business rules and limitations specific to the ASC X12N 835.
- *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 835 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

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1.4 Additional Information

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

Table 2. Additional EDI Resources

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

2 Getting Started

2.1 Working Together

First Coast Service Options Inc. (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 accepted 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/enews/subscribe)

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

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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 (https://medicare.fcso.com/edi/edi-tools-and-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.

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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. This will ensure that their connectivity is completed properly, however they may need to enroll in mailing lists separately in order to receive all publications and email notifications.

Additional third-party billing information can be found at (https://medicare.fcso.com/edi/step-step-guide-getting-started-submitting-electronic-claims-third-party-entities).

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 835 Electronic Remittance Advice (ERA) transactions.

3 Testing and Certification Requirements

3.1 Testing Requirements

First Coast does not require testing for 835 Electronic Remittance Advice (ERA) transactions

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4 Connectivity / Communications

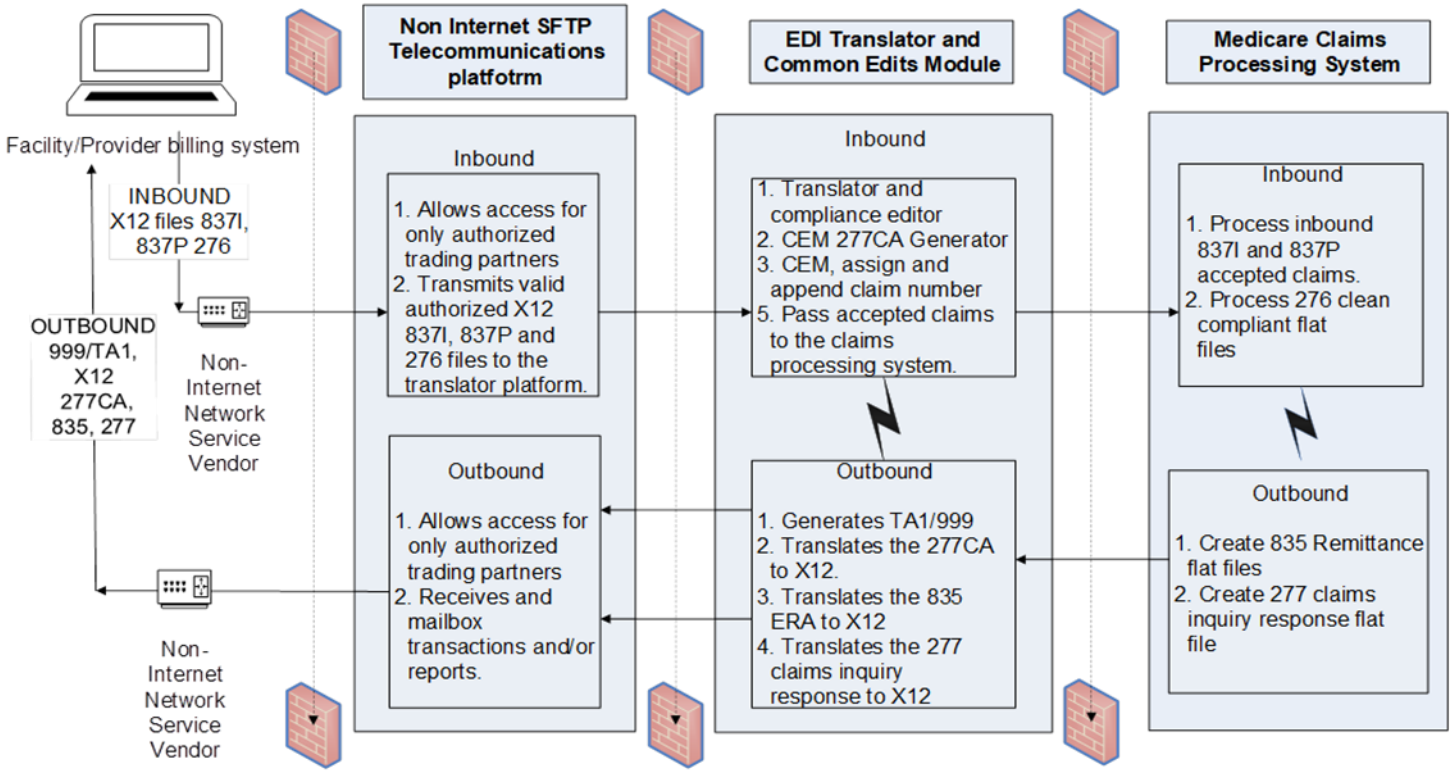
4.1 Process Flows

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.

Trading Partner submits Electronic Media Claim (EMC) to EDI Gateway Files are passed through the translator and validates that file is syntactically compliant. If file is not syntactically compliant, a TA1 or 999 Initial Acknowledgement report will be delivered in the outbound data. If the file meets syntax requirements; claims are then passed through Combined Common Edit Module (CCEM). The CCEM validates the data elements and returns the 277 Claim Acknowledgment. Once claims pass the 277CA, they are then forwarded to the Medicare processing system for adjudication and results are returned on the 835 Electronic Remittance Advice (ERA).

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

Figure 1. First Coast Process Flows



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4.2 Transmission

The EDI front-end platform (TIBCO) 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 transmissions 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 for instructions.

4.2.1 Re-transmission Procedures

Not Applicable

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/edi/first-coasts-approved-5010-vendor-list) 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 batches and 835 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

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- Trading Partner Sends LOGOFF command file
- Trading Partner Receives Session Messages file

NOTE: As of April 2017, internet connectivity is now a valid communication protocol for the following transactions only 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 unique submitter ID, login ID an initial password. Trading partners will need to contact EDI to obtain the initial password.

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

4.5 Login ID Criteria

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 login ID does not expire and must be entered exactly as given.

4.5.1 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 following 4 elements.
    - Capital letter
    - Lowercase letter
    - Numeric value
    - Special character (!, #, $. %. &, *, @, ?)

4.5.2 Password Change

- Password Expiration Tool (https://medicare.fcso.com/edi-tibco-gateway-password-expiration-check)
- Password Change Tool (https://medicare.fcso.com/edi-tibco-gateway-password-change)

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4.5.3 Secure File Transfer Protocol (SFTP) Report Retrieval

Retrieve the 835 report from:

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

Important tips for configuring your SFTP file

- Disable temp file for configuring your SFTP file
- The date/time stamp during 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/contact-center)

5.2 EDI Technical Assistance

1-888-670-0940

5.3 Applicable Websites / Email

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

Spanish website (https://medicare.fcso.com/es/)

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6 Control Segments / Envelopes

Enveloping information must be as follows:

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

Table 3. ISA Interchange Control Header

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA01	Authorization Information Qualifier	00	Medicare expects the value to be 00.
C.4	ISA02	Authorization Information	-	ISA02 shall contain 10 blank spaces.
C.4	ISA03	Security Information Qualifier	00	Medicare expects the value to be 00.
C.4	ISA04	Security Information	-	Medicare will send spaces.
C.4	ISA05	Interchange ID Qualifier	27, 28, ZZ	Medicare will send 27.
C.4	ISA06	Interchange Sender ID	-	First Coast assigned Sender ID.
C.5	ISA07	Interchange ID Qualifier	29	Medicare will send 29.
C.5	ISA08	Interchange Receiver ID	-	Submitter number assigned by First Coast
C.5	ISA11	Repetition Separator	-	First Coast repetition separator character
C.6	ISA14	Acknowledgement Requested	0	Medicare will send 0.

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

Table 4. GS Functional Group Header

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	-	First Coast Payer ID
C.7	GS03	Application Receiver's Code	-	Trading Partner / Receiver ID assigned by First Coast
C.8	GS08	Version Identifier Code	005010X221A1	Medicare will send 05010X221A1

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

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6.1 ISA-IEA

Delimiters – Outbound Transactions

Medicare recommends the use of the following delimiters in all outbound transactions; trading partners/submitters should contact their local A/B MAC or CEDI for any deviations. Note that these characters will not be used in data elements within an ISA/IEA Interchange Envelope.

Table 5. GS Functional Group Header

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

Data Element Detail and Explanation

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

6.2 GS-GE

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

6.3 ST-SE

Medicare FFS follows the HIPAA-adopted TR3 requirements.

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7 Specific Business Rules

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

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

Table 6. ST Transaction Set Header

Page #	Loop ID	Reference	Name	Codes/Content	Notes/Comments
111	2000	LX	LX – Header Number	-	Required for Medicare. Fiscal Intermediary Standard System (FISS) uses TTYYMM - Facility Code/Year/Month. MCS uses “1” for assigned and “0” for non-assigned.
171	2100	REF	Rendering Provider Identification	-	Segment not used by Medicare.
206	2110	REF	Service Identification – Reference Identification Qualifier	LU, 1S, APC, RB	Medicare does not use “BB”, “E9”, “G1”, or “G3”.
207	2110	REF	Rendering Provider Information – Reference Identification Qualifier	HPI, SY, TJ, 1C	Medicare does not use REF01 Codes “0B”, “1A”, “1B”, “1D”, “1H”, “1J”, “D3” or “G2”.
209	2110	REF	Health Care Policy Identification	0K	Medicare will report the LCD/NCD code in Loop 2110, Segment REF, REF02.
140	2100	NM1	Insured Name	-	Segment not used by Medicare.

8 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/edi-tools-and-forms) with First Coast.

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9 Transaction-Specific Information

This section defines specific CMS requirements over and above the standard information in the ASC X12N 835 TR3.

9.1 Header

The following table contains specific details for the Header.

Table 7. BPR Financial Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
71	N/A	BPR03	Credit or Debit Flag Code	C	1	Code “D” does not apply to Medicare.
72	N/A	BPR04	Payment Method Code	ACH, CHK, NON	3	Codes “BOP” and “FWT” do not apply to Medicare.
73	N/A	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	01	2	Code “04” does not apply to Medicare.
75	N/A	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	01	2	Code “04” does not apply to Medicare.

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9.2 Detail Structures

This section describes the specific details associated with Detail Structures.

9.2.1 Loop 2100 Claim Payment Information

The following tables describe the specific details associated with the Claim Payment Information structure.

Table 8. Loop 2100 CLP Claim Payment Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
124	2100	CLP02	Claim Status Code	1, 2, 3, 4, 19, 20, 21, 22, 23	2	"25" (Predetermination Pricing Only - No Payment) does not apply to Medicare.
126	2100	CLP06	Claim Filing Indicator Code	MA, MB	2	Medicare will send "MB" for Part B and "MA" for Part A.

Table 9. Loop 2100 CAS Claim Adjustment

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
131	2100	CAS01	Claim Adjustment Group Code	CO, OA, PR	2	Medicare contractors are limited to use of the "CO", "OA", and "PR" group codes; "PI" is not used.

Table 10. Loop 2100 CAS Claim Adjustment

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
139	2100	NM108	Patient Name	MI	2	Medicare will send "MI".

In the table below, COB transmissions with more than one secondary payer shall indicate remark code "N89" in a claim level remark code data element.

Table 11. Loop 2100 NM1 Crossover Carrier Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
151	2100	NM108	Identification Code Qualifier	PI, XV	2	"AD", "FI", "NI", and "PP" do not apply to Medicare.

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Table 12. Loop 2100 REF Other Claim Related Identification

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
169	2100	REF01	Reference Identification Qualifier	28, 6P, EA, F8	2	Medicare does not use “1L”, “1W”, “9A”, “9C”, “BB”, “CE”, “G1”, “G3”, or “IG”.

Table 13. Loop 2100 AMT Amount Qualifier Code

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
182	2100	AMT01	Amount Qualifier Code	AU, DY, F5, I, NL, ZK, ZL, ZM, ZN, ZO	3	Medicare does not use “D8”, “T” or “T2”.

Table 14. Loop 2100 QTY Claim Supplement Information Quantity

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
184	2100	QTY01	Quantity Qualifier	CA, CD, LA, OU, ZK, ZL, ZM, ZN, ZO	2	Medicare does not use “LE”, “NE”, “NR”, “PS”, or “VS”.

9.2.2 Loop 2110 Service Payment Information

The following tables describe the specific details associated with the Service Payment Information structure.

Table 15. Loop 2110 SVC Service Payment Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
187	2110	SVC01-1	Product or Service ID Qualifier	HC, NU, N4, HP	2	Only “HC”, “NU”, “N4”, and “HP” apply to Medicare.
191	2110	SVC06-1	Product or Service ID Qualifier	HC, NU, N4, HP	2	Only “HC”, “NU”, “N4”, and “HP” apply to Medicare.

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Table 16. Loop 2110 CAS Service Adjustment

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
198	2110	CAS01	Claim Adjustment Group Code	CO, OA, PR	2	Medicare contractors are limited to use of the “CO”, “OA”, and “PR” group codes; “PI” is not used.

Table 17.Loop 2110 AMT Amount Qualifier Code

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
211	2110	AMT01	Amount Qualifier Code	B6, KH, 2K, ZL, ZM, ZN, ZO	3	Medicare does not use “T” or “T2”.

Table 18. Loop 2110 LQ Health Care Remark Codes

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
215	2110	LQ01	Code List Qualifier Code	HE	3	Only “HE” applies to Medicare.

9.3 Summary

The following table describes the specific details associated with the Summary structure.

Table 19. PLB Provider Adjustment

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
217	N/A	PLB03-1	Adjustment Reason Code	50, 51, 72, 90, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU	2	Medicare does not use “AH”, “AM”, “CR”, “CT”, “CW”, or “FC”.

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10 Appendices

10.1 Implementation Checklist

First Coast step-by-step guide to getting started submitting electronic claims (https://medicare.fcso.com/edi/step-step-guide-getting-started-submitting-electronic-claims-providers)

10.2 Transmission Examples

EDI Transactions (http://www.cms.gov/ElectronicBillingEDITrans/)

10.3 Frequently Asked Questions

First Coast FAQs (https://medicare.fcso.com/faqs)

10.4 Acronym Listing

Table 20. Acronym List

Acronym	Definition
276	276 Claim Status Request transaction
277	277 Claim Status Response transaction
277CA	277 Claim Acknowledgement
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
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
ERA	Electronic Remittance Advice

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Acronym	Definition
FFS	Medicare Fee-For-Service
FISMA	Federal Information Security Management Act
FISS	Fiscal Intermediary Standard System
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
MIME	Multipurpose Internet Mail Extensions
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
PECOS	Provider Enrollment Chain and Ownership System
PHI	Protected Health Information
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
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

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10.5 Change Summary

The following table contains version information of this CG.

Table 21. 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 and 11.4	5th Publication Version
7.0	September 2021	All	Updates for the EDI Gateway transition
7.1	May 2022	All	508 Compliance
7.2	February 2023	1.2	Corrected TR3 reference from 837P to 835
7.3	June 2024	Pages 5, 9 and 17	Updated Third party Billing Information hyperlink, Corrected typo on page 9, corrected hyperlinks in sections 10.2 and 10.3.
7.4	September 2025	All	Updated links throughout for updated First Coast website.
7.5	September 2025	Page 17	Updated website link

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