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: 10.1,
May 2024

Disclosure Statement

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

Preface

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

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

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

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1 Introduction

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

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

Medicare Fee-For-Service (FFS) is publishing this Companion Guide (CG) to clarify, supplement, and further define specific data content requirements to be used in conjunction with, and not in place of, the ASC X12N 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

More information on Novitas Solutions expectations (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004551) for the 276/277 Claim Status Request and Response is available within the Novitas Solutions EDI Billing Guide.

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

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

Novitas Solutions, Inc. also has several external communication components in place to reach out to the Trading Partner community. Novitas Solutions, Inc. posts all critical updates, system issues and EDI-specific billing material to their website (https://www.novitas-solutions.com/webcenter/portal/ElectronicBillingEDI_JH). All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. Novitas Solutions, Inc. 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 Novitas Solutions, Inc.'s distribution list (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00007968).

Specific information about the above-mentioned items can be found in the following sections.

2.2 Trading Partner Registration

An EDI Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, employer group, financial institution, etc.) that transmits electronic data to, or receives electronic data from, another entity.

Medicare FFS and Novitas Solutions, Inc. 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 Novitas Solutions, Inc. 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 Novitas Solutions, Inc.

Medicare requires all trading partners to complete EDI registration and sign an EDI Enrollment form (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004532). The EDI enrollment form designates the Medicare contractor as the entity they agree to engage in for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged.

Entities processing paper do not need to complete an EDI registration.

Visit the Novitas Solutions, Inc. website to complete the EDI Enrollment form. This will ensure you are completing and submitting the most recent version of the EDI Enrollment form.

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

Third parties are required to register with Novitas Solutions, Inc. by completing the third-party agreement form (https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004538). 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 Novitas Solutions, Inc.. For a complete reference to security requirements, see Section 4.4.

2.3 Trading Partner Certification and Testing Process

Testing is not required for 276/277 Claim Status Request and Response. Although not required, vendors, billing services and clearinghouses can send test files to validate that their systems will be able to process the files.

The ISA15 control segment of your file should be equal to a “T” for test. After submitting a test, verify the file was accepted on the 999 Functional Acknowledgement.

3 Testing and Certification Requirements

3.1 Testing Requirements

All submitters must produce accurate electronic test files before being allowed to submit claim transactions in production. Test claims are subject to ASC X12N standard syntax and TR3 semantic data edits. Documentation will be provided when this process detects errors. 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 Novitas Solutions, Inc., the vendor/submitter will make the necessary correction(s) prior to submitting a production file.
- Test results will be provided by means of the electronic response reports to the submitter within several minutes of receipt of the file. Once testing certification is passed, production files can be submitted in three business days; during HIPAA version transitions this time period may be extended, not to exceed 10 business days.

Many submitters use the same software, or the same clearinghouse to submit their electronic transactions to Medicare. Billing services and clearinghouses may send generic test files to receive an approval status. Vendors may have one of their customers send test files on their behalf. Once approval status is received, individual customers do not need to test the product again.

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, Novitas Solutions, Inc. does certify vendors, clearinghouses, and billing services by conducting testing with them and maintaining an approved vendor list (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004528).

4 Connectivity / Communications

4.1 Process Flows

The 276/277 transaction can be electronically submitted using Secure File Transfer Protocol (SFTP), Novitasphere portal, or the Hypertext Transfer Protocol Secure (HTTPS) Council for Affordable Quality Healthcare, Inc (CAQH) Committee on Operating Rules for Information Exchange (CORE)-compliant connection.

Connection for authorized trading partners will be to the TIBCO telecommunications platform.

- The 276 Claim Status Request transaction will be forwarded into the EDI translator for further edits and acknowledgement reports will be issued.
- If the file accepts, the 999 Claim Acknowledgement will be returned to the trading partner.
- The 277 Claim Status Response will be available the following business day.
- All generated reports can be retrieved through the TIBCO telecommunications platform.

The following diagrams depicts this process flow:

Figure 1. SFTP/Novitasphere Portal

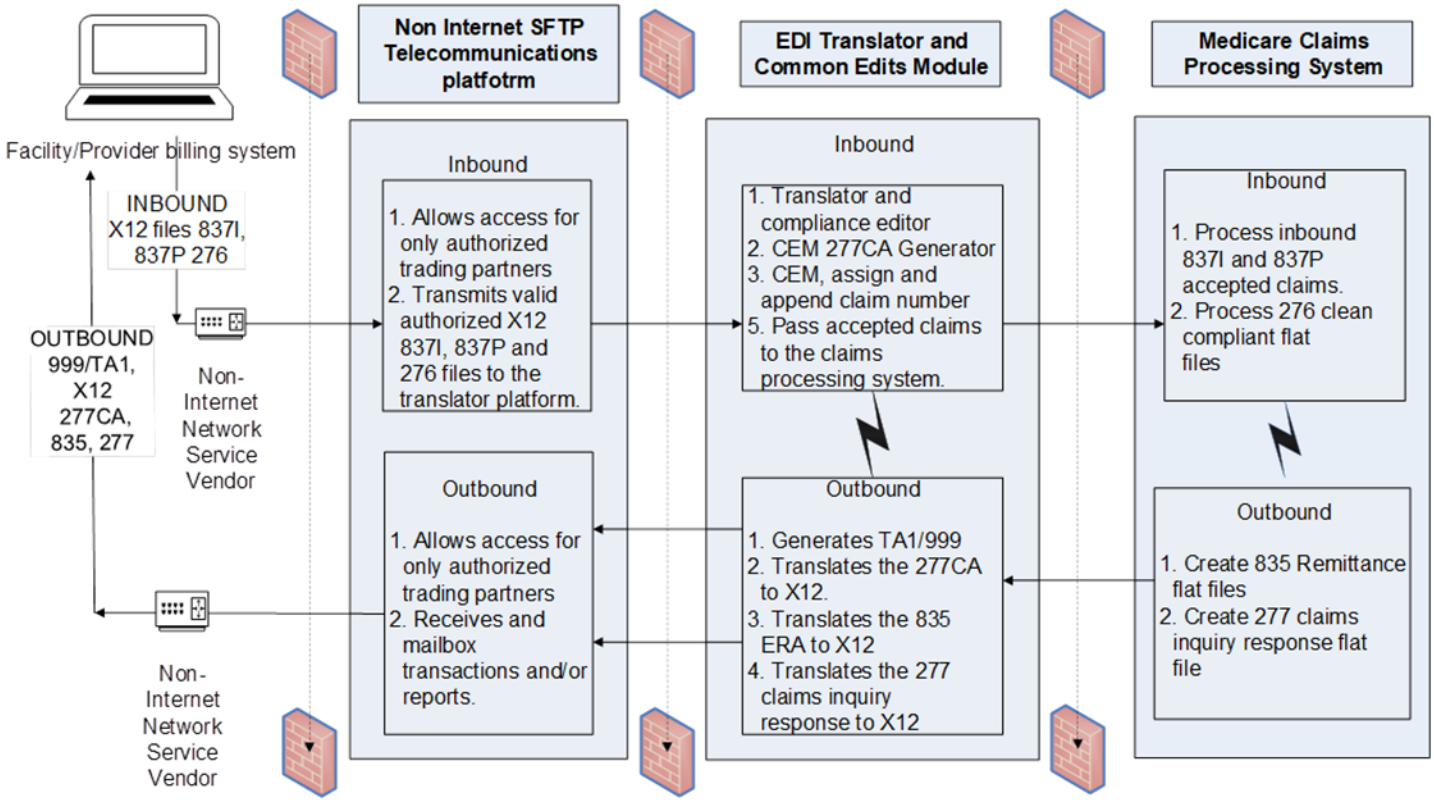
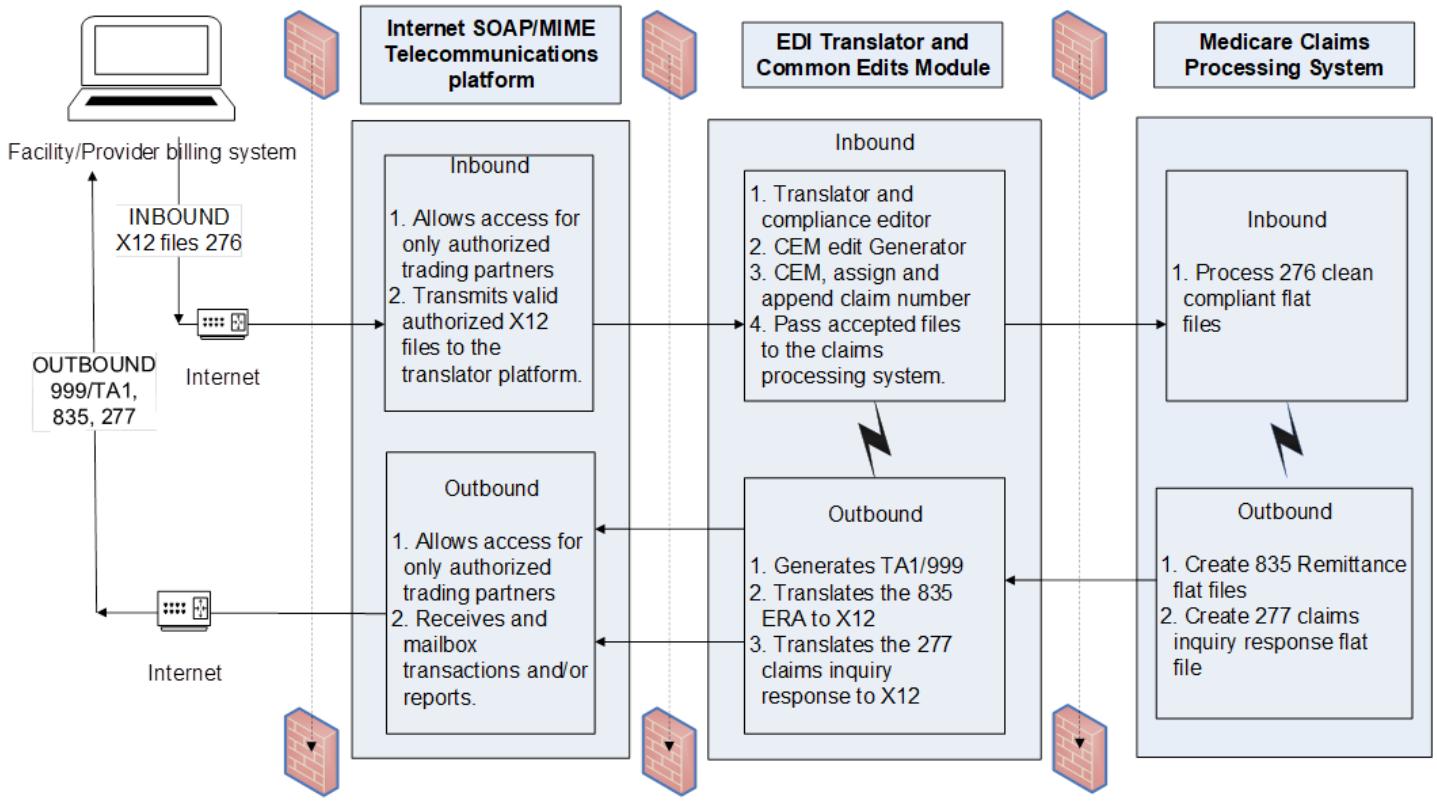


Figure 2. HTTPS CAQH CORE.



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. 277 Status Response files will be uploaded to ITIBCO the next day.

Additional connectivity information can be found on the Novitas Solutions Inc. website (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004782).

4.2.1 Re-transmission Procedures

The process for sending retransmitted files is the same as sending original files. Submitters can retransmit files at their discretion.

4.3 Communication Protocol Specifications

Novitas Solutions, Inc. currently accepts EDI 276/277 transactions through three means of connection: Novitasphere portal, SFTP or HTTPS CAQH CORE-compliant connection for EDI Claim Status Request and Response (276/277).

4.3.1 Novitasphere Portal

Novitasphere (https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH) is a secured web-based Internet Portal that customers may utilize for a more proficient interface with Novitas and the Medicare systems. Currently, Novitasphere is not enrolling Veterans Affairs Providers.

4.3.2 Secure File Transfer Protocol (SFTP) Submission

Secure File Transfer Protocol, or SFTP, is a communications method for delivering and/or receiving data. It allows large volume electronic billers to deliver and receive large volumes of data faster than using conventional transmission methods. Contracting with a third-party vendor for a direct connection to Novitas Solutions, Inc. is required. The third-party vendor will provide the connectivity portal needed to use SFTP. A list of approved third-party vendors (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004536) is available on our website.

Once setup is complete with the third-party vendor and Novitas Solutions, Inc., a software program is needed for creating and receiving electronic claim files. The following is a list of approved SFTP software.

Table 3. Approved SFTP Software

Free Software	Pay Software
WinSCP v4.2.5	Cute FTP 8 Professional v8.3.3
FileZilla Client v3.3.1	WS_FTP Professional v12.2

To set up SFTP, access your SFTP software and complete the following steps:

- Create a site by following the software prompts.
- Access the settings and choose “SFTP/SSH” (Secure Shell).
- Key in the remote port and the host name. (Version 5010 server names and ports are provided when you enroll for SFTP, if necessary.)
- Save the settings.

To send electronic claim files via SFTP, access your SFTP software and complete the following steps:

- Log in.
- You will receive a temporary password when you first enroll. Before connecting for the first time, you must access the EDI Gateway Password Change Tool (https://www.novitas-

solutions.com/webcenter/portal/ElectronicBillingEDI_JH/EDIPasswordChange) to change your password. See section 4.4.2 SFTP Password for additional password details. Passwords can only be reset once in a 24-hour period without contacting the EDI Help Desk.

- Connect to Novitas Solutions, Inc.
- Upload 276 files to:
    - /outbox/X12/EDI/Inbound/Interchange for X12 files.
    - /outbox/EZComm/BC/1.0/Notify for .ZIP files.
- Retrieve the Acknowledgement report responses from:
    - /inbox/X12/EDI/Outbound/Interchange for X12 files.
    - /inbox/EZComm/BC/1.0/Notify for . ZIP files or VA reports.

Important tips for configuring your SFTP file.

- Disable “temp file” in your file transfer software.
- 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.

4.3.3 HTTPS CAQH CORE-Compliant Connection for EDI Claim Status Request and Response (276/277)

HTTPS CAQH CORE-Compliant Connection for EDI is a secure connection for sending the Claim Status Request Transaction (276) and receiving the Claim Status Response (277). Submitters are required to purchase an X.509 Client Certificate and submit it to Novitas Solutions prior to use. More information is available on the Novitas Solutions, Inc. website (https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00147591).

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. Novitas Solutions, Inc. is responsible for notifying all affected Trading Partners as well as reporting the system revocation to CMS.

4.4.1 System Logins

Trading partners submitting files using SFTP will be assigned a login ID and temporary password upon completion of the EDI Enrollment form. The login ID will be mailed to them in an EDI welcome letter.

Trading partners submitting files using Novitasphere Portal will create a user ID, password, and complete identity proofing (https://home.idm.cms.gov) (IDM) for each user. Enrollment information can be found on the Novitas Solutions, Inc. website (https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH).

A provider's EDI login and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation and may not be given to a new owner of the provider's operation.

4.4.2 Password Guidelines

The trading partner should protect password privacy by limiting knowledge of the password to key personnel only. The password should be changed when there are any personnel changes. EDI transactions submitted by unauthorized trading partners will not be accepted.

SFTP Passwords

The password must be eight to twelve characters in length. Must contain numbers three out of four of the following elements:

- One capital letter.
- One lower case letter.
- One number.
- One special character (i.e.: #, $, @, !, %, &, *, ?).
- The password must be changed every 60 days. After three failed attempts you will need to reset the password on the password reset tool. Please make sure to have your login ID, submitter ID, and current password available for password resets.

Novitasphere Passwords

For the full list of Novitasphere password requirements, please visit our Novitasphere Password Help page (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00084015).

5 Contact Information

5.1 EDI Customer Service

Novitas Solutions, Inc. EDI Services
P.O. Box 3093
Mechanicsburg, PA 17055-1801

Telephone Numbers

- EDI Help Desk telephone number: 1-877-252-8782, Option 3
- Novitasphere Help Desk telephone number: 1-855-880-8424
- Fax Number: 1-877-439-5479

Email address

EDI inquiries (excluding Indian Health): WebsiteEDI@novitas-solutions.com

Indian Health EDI inquiries: WebsiteEDIIHS@novitas-solutions.com

Time and Day of Operations

EDI and Novitasphere Help Desks are available Monday through Friday.

The EDI Help Desk is available 8:00 AM until 4:00 PM Eastern Time (ET).

The Novitasphere Help Desk is available 8:00 AM until 5:00 PM ET.

Please check the Novitas Solutions Inc. website for the most up to date hours of availability (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00003665).

When contacting the EDI Help Desk, have your trading partner number (submitter ID), National Provider Identifier (NPI) number, or Provider Transaction Access Number (PTAN) available. Having these numbers available will help resolve your issues quicker.

5.2 EDI Technical Assistance

See section 5.1 for Technical Assistance Information

5.3 Trading Partner Service Number

See section 5.1 for Trading Partner Assistance Information

5.4 Applicable Websites / Email

Novitas Solutions, Inc. Electronic Billing (EDI) Center website (https://www.novitas-solutions.com/webcenter/portal/ElectronicBillingEDI_JH).

6 Control Segments / Envelopes

Enveloping information must be as follows for the 276:

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

Table 4. 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	-	Part A – Reference Table 6. Part B – Reference Table 7.
C.5	ISA11	Repetition Separator	-	Defined by the submitter and must be present.
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 5. GS Functional Group Header (276)

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	-	Submitter number assigned by Novitas.
C.7	GS03	Application Receiver Code	-	Part A – Reference Table 6. Part B – Reference Table 7.
C.7	GS04	Functional Group Creation Date	-	Must not be a future date
C.7	GS08	Version Identifier Code	005010X212	GS08 must also match the ST03.

Table 6. Contractor ID Part A

JH Part A Locale	JH Contractor/Payer ID
Arkansas	07101
Louisiana	07201
Mississippi	07301
Colorado	04111
New Mexico	04211
Oklahoma	04311
Texas	04411
Indian Health Service (IHS)/Tribal Organizations	04411
Veteran Affairs	04411
J01911	04911

Table 7. Contractor ID Part B

JH Part B Locale	JH Contractor/Payer ID
Arkansas	07102
Louisiana	07202
Mississippi	07302
Colorado	04112
New Mexico	04212
Oklahoma	04312

JH Part B Locale	JH Contractor/Payer ID
Texas	04412
Indian Health Service (IHS)/Tribal Organizations	04412
Veteran Affairs	04412

Enveloping information will be sent as follows for the 277:

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

Table 8. 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”.
C.4	ISA06	Interchange Sender ID	-	Part A – Reference Table 6. Part B – Reference Table 7.
C.5	ISA07	Interchange ID Qualifier	ZZ	Medicare will send “ZZ”.
C.5	ISA08	Interchange Receiver ID	-	Novitas assigned Trading Partner ID.
C.5	ISA11	Repetition Separator	-	Must be present.
C.6	ISA14	Acknowledgement Requested	0	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 9. GS Functional Group (277)

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	-	Part A – Reference Table 6. Part B – Reference Table 7.
C.7	GS03	Application Receiver Code	-	Submitter number assigned by Novitas Solutions, Inc..
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 Novitas Solutions, Inc. 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 10. Outbound Transaction Delimiters

Delimiter	Character Used	Dec Value	Hex Value
Data Element Separator	*	42	2A
Repetition Separator	^	94	5E
Component Element Separator	>	62	3E
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 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

- 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.
- 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 Request files.
- The 277 will remain available for 60 days.

7.3 Medicare Specific Business Rules

Novitas Solutions, Inc. has no Medicare specific business rules.

8 Acknowledgments and Reports

Medicare has adopted three new 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. These acknowledgments will replace proprietary reports previously provided by the MACs.

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

8.1 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 adopted 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 Washington Publishing Company website.

8.3 999 Implementation Acknowledgment Error Responses

Technical specifications, including error interpretation, for the ASC X12N 999 are published for the ASC X12N 276/277 Health Care Claim Status Request and Response transactions at the official Washington Publishing Company website.

9 Trading Partner Agreement

EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

Medicare FFS requires all Trading Partners to sign a Trading Partner Agreement with Novitas Solutions, Inc. Novitas Solutions, Inc. provides one fill-and-print EDI Enrollment form (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004532), which includes the Trading Partner Agreement.

Always visit the Novitas Solutions, Inc. website to complete the EDI Enrollment form. This will ensure you are completing and submitting the most recent version of the EDI Enrollment form.

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 Header (276)

The following table contains specific details for the 276 Header.

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

Table 11. ST Transaction Set Header (276)

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

Table 12. BHT Beginning of Hierarchical Transaction (276)

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
37	N/A	BHT02	Transaction Set Purpose Code	13	2	Must equal “13”.

10.1.2 Loop 2000A Information Source Level Structure (276)

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

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

Table 13. 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	-	80	Sender ID must match the value submitted in ISA06 and GS02.

10.1.3 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 14. 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.

10.1.4 Loop 2000C Service Provider Detail Structures (276)

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

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 15. Loop 2100C NM1 Provider Name (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	2100C NM108 must be “XX” except for VA. VA must use “XX” or “SV.”
51	2100C	NM109	Provider Identifier	-	80	None

10.1.5 Loop 2000D Subscriber Level Structures (276)

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

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 table defines specific details associated with Subscriber level Structures.

Note:

- A hyphen in the table below means N/A.
- A new table exists for each segment.

Table 16. 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 17. 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.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
57	2100D	NM108	Identification Code Qualifier	MI	2	Must be "MI".
57	2100D	NM109	Subscriber Identifier	-	80	Refer to Section 7.1 for Medicare-specific information. 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 18. 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.

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

Table 19. 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	Not allowed for CEDI.
60	2200D	REF02	Bill Type Identifier	-	50	None

Table 20. 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 the value directly obtained from the contractor when beginning to exchange information.

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

Table 21. 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	2200D AMT02 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 22. 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, must be present. For Part B and DME, 2200D DTP with DTP01 = “472” must be present when 2210D DTP with DTP01 = “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 23. 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	Part A – "HC", "HP", or "NU" must be used. Part B – "HC" must be used. 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.

10.1.6 Loop 2200E Dependent Level Structures (276)

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

Table 24. 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 25. 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 26. 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.
- A new table exists for each segment.

Table 27. 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".
112	2100A	NM109	Payer Identifier	-	80	Transmitted value from the associated 276.

For Loop 2100A PER – 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 28. 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	For DME only the value “TE” will be used.
114	2100A	PER05	Payer Contact Information	EM	2	For DME, the PER05 is not used.
115	2100A	PER07	Communication Number Qualifier	FX	2	For DME, the PER07 is not used.

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.
- A new table exists for each segment.

Table 29. 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.
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.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
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 30. 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 Loop 2200B STC – 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 31. 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
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

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
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.

Only 1 iteration of the 2100C loop allowed by Medicare.

Note:

- A hyphen in the table below means N/A.
- A new table exists for each segment.

Table 32. 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.
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.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
128	2100C	NM109	Provider Identifier	-	80	Transmitted value from the associated 276.

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 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 34. 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 35. 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.
- A new table exists for each segment.

Table 36. 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 37. 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.

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 38. 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 39. 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 MCS this will be 13 digits. For FISS this will e 14-23 characters.

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

Table 40. 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 41. 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 42. 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 43. 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 44. 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.

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

Table 45. 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.
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.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
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.

Line found: Up to five iterations of the STC are allowed for all occurrences in these transactions.

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

Table 46. 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”.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
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 47. 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 48. 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 49. 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

Complete the following checklist as you prepare to go live with EDI exchange.

Table 50. EDI Implementation Checklist

Action	Additional Information
Choose a Software Product	For more information, refer to the EDI Reference Guide (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004559).
Complete EDI Enrollment form	The EDI Enrollment form is located on the Novitas website (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004532).
Read the CG	This guide helps with the setup of your transactions, testing and viewing reports.
Send a Test File	Test requirements are provided in Section 3 of this CG, Testing and Certification Requirements.
Pull your Reports	Reports are available within a few minutes of transmitting a test file. For more information, see Section 7 of this CG, Acknowledgements and Reports.
Send Production Files	Once your testing has been approved, you will be able to send in production. Change the ISA to “P” and always remember to pull your reports. Incoming file names should not include an apostrophe (‘) as this causes errors in the file being received through TIBCO.
Send a Claim Status Request	Request status of a claim using the 276 Claim Status Request transaction
Read Publications	Novitas Solutions, Inc. sends emails to those who have joined our mailing list. We also publish newsletters on our website. For more information on joining our mailing list, refer to Section 2.1 of this CG, Working Together.

11.2 Transmission Examples

Below are examples of the Control segments and envelopes in the 276 /277 Claim Status Request and Response files. These examples can be used to help set up the Control segments in your file to be sent to Novitas Solutions, Inc. Please note this example is for illustration purposes only and uses the contract ID and version code for a professional (Part B) claim. For institutional (Part A) claims, please replace these with the appropriate codes.

Figure 3. 276 Claim Status Request

```
ISA*00*       *00*       *ZZ*0000000    *ZZ*04412      *190103*1805*^*00501*071279222*0*P*:~
GS*HR*0000000*04412*20190103*1805*10446182*X*005010X212~
ST*276*100190496*005010X212~
SE*106*100190496~
GE*1*10446182~
IEA*1*071279222~
```

Figure 4. 277 Claim Response

```
ISA*00*       *00*       *ZZ*04412      *ZZ*0000000    *190104*2332*^*00501*000000007*0*P*:~
GS*HN*04412*0000000*20190104*23320422*1*X*005010X212~
ST*277*000000001*005010X212~
SE*23*000000001~
GE*1*1~
IEA*1*000000007~
```

11.3 Frequently Asked Questions

Frequently asked questions can be accessed at Medicare FFS EDI Operations (https://www.cms.gov/ElectronicBillingEDITrans/) and on the Novitas website (https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004548)

11.4 Acronym Listing

Table 51. 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

Acronym	Definition
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
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

Acronym	Definition
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 52. 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 – made guides transaction specific	4th Publication Version.
6.0	October 2019	2.2, 9.0	Updated enrollment form hyperlinks.
7.0	March 2020	4.4	Updated link to Novitasphere password requirements.
8.0	May 2020	1.3, 8.2, 8.4, 11.4	Refer to WPC and X12 websites.
9.0	November 2021	All	Updates due to Gateway transition and EIDM to IDM.
10.0	October 2022	All	508 Compliance Updates.

Version	Date	Section(s) Changed	Change Summary
10.1	May 2024	Section 7.2	Added information about Dental Claim responses.