CMS

Standard Companion Guide Transaction Information

Instructions related to the 837 Health Care Claim: Professionals based on ASC X12 Technical Report Type 3 (TR3), version 005010A1

Companion Guide Version Number: 3.0 January 30, 2018

Preface

Companion Guides (CGs) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is in conformance with ASC X12's Fair Use and Copyright statements.

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Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data
 set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2. Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guide for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID Name

005010X222A1 Health Care Claim: Professional (837)

3. Instruction Table

This table contains rows for where supplemental instruction information is located. The order of table content follows the order of the implementation transaction set as presented in the corresponding implementation guide.

Category 1. Situational Rules that explicitly depend upon and reference knowledge of the transaction receiver's policies or processes.

Category 2. Technical characteristics or attributes of data elements that have been assigned by the payer or other receiving entity, including size, and character sets applicable, that a sender must be aware of for preparing a transmission.

Category 3. Situational segments and elements that are allowed by the implementation guide but do not impact the receiver's processing. (applies to inbound transactions)

Category 4. Optional business functions supported by an implementation guide that an entity doesn't support.

Category 5. To indicate if there needs to be an agreement between PAYER and the transaction sender to send a specific type of transaction (claim/encounter or specific kind of benefit data) where a specific mandate doesn't already exist.

Category 6. To indicate a specific value needed for processing, such that processing may fail without that value, where there are options in the TR3.

Category 7. TR3 specification constraints that apply differently between batch and real-time implementations, and are not explicitly set in the guide.

Category 8. To identify data values sent by a sender to the receiver.

Category 9. To identify processing schedules or constraints that are important to trading partner expectations.

Category 10. To identify situational data values or elements that are never sent.

005010X222A1 Health Care Claim: Professional

Loop	Defenence	Nome	Codos	Notes (Commonts	Catagory
ID	Reference	Name	Codes	Notes/Comments Errors identified for	Category 9
					9
				business level edits	
				performed prior to the SUBSCRIBER LOOP	
				(2000B) will result in	
				immediate file failure at	
				that point. When this	
				occurs, no further editing	
				will be performed beyond	
				the point of failure.	
				The billing provider must	9
				be associated with an	
				approved electronic	
				submitter. Claims	
				submitted for billing	
				providers that are not	
				associated to an approved	
				electronic submitter will be	
				rejected	
				The maximum number of	2
				characters to be submitted	
				in any dollar amount field	
				is seven characters. Claims	
				containing a dollar amount	
				in excess of 99,999.99 will	
				be rejected.	
				Medicare does not support	4
				the submission of foreign	
				currency. Claims	
				containing the 2000A CUR	
				segment will be rejected.	
				Claims that contain	2
				percentage amounts with	
				values in excess of 99.99	
				will be rejected.	

Loop					
ID	Reference	Name	Codes	Notes/Comments	Category
				For the exception of the	2
				CAS segment, all amounts	
				must be submitted as	
				positive amounts. Negative	
				amounts submitted in any	
				non-CAS amount element	
				will cause the claim to be	
				rejected.	
				Claims that contain	2
				percentage amounts cannot	
				exceed two positions to the	
				left or the right of the	
				decimal. Percent amounts	
				that exceed their defined	
				size limit will be rejected.	
				Contractor name will	2
				convert all lower case	_
				characters submitted on an	
				inbound 837 file to upper	
				case when sending data to	
				the Medicare processing	
				system. Consequently, data	
				later submitted for	
				coordination of benefits	
				will be submitted in upper	
				case.	
				Only loops, segments, and	9
				data elements valid for the	
				HIPAA Professional	
				Implementation Guides	
				will be translated.	
				Submitting data not valid	
				based on the	
				Implementation Guide will	
				cause files to be rejected.	
				Medicare requires the	6
				National Provider Identifier	
				(NPI) be submitted as the	
				identifier for all claims.	
				Claims submitted with	
				legacy identifiers will be	
				rejected. (Non-VA	
				contractors)	
				National Provider	2
				Identifiers will be validated	
				against the NPI algorithm. Claims which fail	
				validation will be rejected.	

Loop	D. C	N T	G 1	N 4 (G	G .
ID	Reference	Name	Codes	Notes/Comments	Category
				Medicare does not require	4
				taxonomy codes be	
				submitted in order to	
				adjudicate claims, but will	
				accept the taxonomy code,	
				if submitted. However,	
				taxonomy codes that are	
				submitted must be valid	
				against the taxonomy code	
				set published at	
				http://www.wpc-	
				edi.com/codes/taxonomy.	
				Claims submitted with	
				invalid taxonomy codes	
				will be rejected.	
			1	All dates that are submitted	2
				on an incoming 837 claim	1
				transaction must be valid	
				calendar dates in the	
				appropriate format based	
				on the respective qualifier.	
				Failure to submit a valid	
				calendar date will result in	
				rejection of the claim or the	
				applicable interchange	
				(transmission).	
					3
				A. You may send up to	3
				four modifiers; however, the last two modifiers will	
				not be considered. The	
				Contractors processing	
				system will only use the	
				first two modifiers for	
				adjudication and payment	
				determination of claims	
				OR-	
				B. You may send up to	
				four modifiers; however,	
				the last three modifiers will	1
				not be considered. The	1
				Contractors processing	
				system will only use the	
				first modifier for	
				adjudication and payment	
				determination of claims.	
	ISA05	Interchange ID Qualifier	27, ZZ	Contractor will reject an	6
				interchange (transmission)	
				that does not contain 27,	1

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				or ZZ in ISA05	
	ISA06	Interchange Sender ID		Contractor will reject an interchange (transmission) that does not contain a valid ID in ISA06.	6
	ISA07	Interchange ID Qualifier	27, ZZ	Contractor will reject an interchange (transmission) that does not contain 27 or ZZ in ISA07.	6
	ISA12	Interchange Control Version Number		Contractor will reject an interchange (transmission) that does not contain 00501 in ISA12.	6
	GS – Segment Rule			Contractor will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one type of GS-GE (Functional Group) within an ISA-IEA (Interchange).	4
	GS – Segment Rule			Contractor will only process one type of transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).	4
	GS03	Application Receiver's Code		Contractor will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.	6
	GS04	Functional Group Creation Date		Contractor will reject an interchange (transmission) that is submitted with a future date.	6
	ST – Segment Rule			Contractor will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				(Transaction Set) will cause the transaction to be rejected.	
	ST02	Transaction Control Set		Contractor will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	6
	BHT02	Transaction Set Purpose Code	00	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	6
	ВНТ06	Claim/Encounter Identifier	СН	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).	6
1000A	NM109	Submitter ID		Contractor will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	5
1000B	NM103	Receiver Name		Contractor will reject an interchange (transmission) that is not submitted with a valid carrier name (NM1).	5
2000B	HL04	Hierarchical Child Code	0	The value accepted is "0". Submission of "1" will cause your file to reject.	6
2000B	SBR01	Payer Responsibility Sequence Number Code	P, S	The values accepted are "P" and "S". Submission of other values will cause your claim to reject.	6
2000B	SBR02, SBR09	Subscriber Information		For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.	6
2000B	PAT08	Patient Weight		The maximum number of characters to be submitted in the patient weight field is four characters to the left of the decimal and two	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				characters to the right. Claims with patient weight in excess of 9,999.99 pounds will be rejected.	
2010AA	REF – Segment Rule	BILLING PROVIDER UPIN/LICENSE INFORMATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2010AC	Loop Rule	PAY TO PLAN LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2010BA	NM102	Subscriber Entity Type Qualifier	1	The value accepted is 1. Submission of value 2 will cause your claim to reject.	6
2010BA	NM108	Subscriber Identification Code Qualifier	MI	The value accepted is "MI". Submission of value "II" will cause your claim to reject.	6
2010BA	DTP02	Subscriber Birth Date		Must not be a future date.	6
2010BA	REF – Segment Rule	SUBSCRIBER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2010BB	NM108	Payer Identification Code Qualifier	PI	The value accepted is "PI". Submission of value "XV" will cause your claim to reject.	6
2010BB	REF – Segment Rule	PAYER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2010BB	REF – Segment Rule	BILLING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2000C	HL – Segment Rule	PATIENT HIERARCHICAL LEVEL		Must not be present. Submission of this segment will cause your claim to reject.	4
2000C	PAT – Segment Rule	PATIENT INFORMATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2010CA	Loop Rule	PATIENT NAME LOOP		Must not be present. Submission of this loop	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				will cause your claim to reject.	
2300	CLM05-3	Claim Frequency Type Code	1	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" will be rejected.	6
2300	CLM20	Delay Reason Code		Data submitted in CLM20 will not be used for processing.	3
2300	DTP03	Onset of Current Illness or Injury Date		Must not be a future date.	6
2300	DTP03	Initial Treatment Date		Must not be a future date.	6
2300	DTP03	Acute Manifestation Date		Must not be a future date.	6
2300	DTP03	Accident Date		Must not be a future date.	6
2300	DTP03	Last Menstrual Period Date		Must not be a future date.	6
2300	DTP03	Last X-Ray Date		Must not be a future date.	6
2300	DTP03	Prescription Date		Must not be a future date.	6
2300	DTP03	Last Worked Date		Must not be a future date.	6
2300	DTP03	Related Hospitalization Admission Date		Must not be a future date.	6
2300	DTP – Segment Rule	ADMISSION DATE		Admission date (DTP 435) is required when the place of service code is "21", "51" or "61". Claims for POS "21", "51", or "61"without the admission date will be rejected.	1
2300	DTP03	Related Hospitalization Discharge Date		Must not be a future date.	6
2300	PWK – Segment Rule	CLAIM SUPPLEMENTAL INFORMATION		Only the first iteration of the PWK, at either the claim level and/or line level, will be considered in the claim adjudication.	4
2300	PWK – Segment Rule	CLAIM SUPPLEMENTAL INFORMATION		All PWK additional documentation relevant to the claim being submitted must be sent at the same time, or immediately after. PWK data sent after the 7-10 day waiting period will not be considered in the	1

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				claim adjudication	
2300	PWK02	Attachment Transmission Code	BM, FX, FT, EL	The only values which may be used in adjudication are "BM", "FX", "FT", "EL".	6
2300	CN1	CONTRACT INFORMATION		Must not be present. Submission of this segment will cause your claim to reject.	4
2300	REF – Segment Rule	MANDATORY MEDICARE (SECTION 4081) CROSSOVER INDICATOR		Must not be present. Submission of this segment will cause your claim to reject.	4
2300	REF – Segment Rule	PAYER CLAIM CONTROL NUMBER		Must not be present. Submission of this segment will cause your claim to reject.	4
2300	CR102	Patient Weight		The maximum number of characters to be submitted in the patient weight field is four characters to the left of the decimal and two characters to the right. Patient weight in excess of 9,999.99 pounds will be rejected.	2
2300	CR106	Transport Distance		The maximum number of characters to be submitted in the transport distance is four characters. Transport distance in excess of 9,999 miles will be rejected.	2
2300	HI – Segment Rule	Health Care Diagnosis Code		All diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes (pointed to or not) will be rejected.	1
2310A	REF – Segment Rule	REFERRING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2310C	REF – Segment Rule	SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				will cause your claim to reject	
2310D	REF – Segment Rule	SUPERVISING PROVIDER SECONDARY IDENTIFIER		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject	4
2320	SBR01	Payer Responsibility Sequence Number Code		The SBR must contain a different value in each iteration of the SBR01. Each value may only be used one time per claim. Repeating a previously used value (in the same claim) will cause the claim to be rejected.	6
2320	SBR09	Claim Filing Indicator Code		The value cannot be "MA" or "MB". Sending the value of "MA" or "MB" will cause the claim to be rejected.	6
2330B	DTP03	Adjudication or Payment Date		Must not be a future date.	6
2330C	Loop Rule	OTHER PAYER REFERRING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330D	Loop Rule	OTHER PAYER RENDERING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330E	Loop Rule	OTHER PAYER SERVICE FACILITY LOCATION LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330F	Loop Rule	OTHER PAYER SUPERVISING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2330G	Loop Rule	OTHER PAYER BILLING PROVIDER LOOP		Must not be present. Submission of this loop will cause your claim to reject.	4
2400	SV101-1	Product or Service ID Qualifier	НС	Must be "HC". Claims for services with any other value will be rejected.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	SV102	Line Item Charge Amount		SV102 must equal the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts.	9
2400	SV103	Unit or Basis for Measurement Code	MJ, UN	SV103 must be "MJ" when SV101-3, SV101-4, SV101-5, or SV101-6 is an anesthesia modifier (AA, AD, QK, QS, QX, QY or QZ). Otherwise, must be "UN".	6
2400	SV104	Service Unit Count	МЈ	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104)	6
2400	SV104	Service Unit Count		The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104)	2
2400	SV104	Service Unit Count		The max value for units (qualifier UN) cannot exceed 4 bytes numeric and one decimal place. Claims for medical services that exceed this value will be rejected. (SV104)	2
2400	SV104	Service Unit Count		SV104 (Service unit counts) (units or minutes) cannot exceed 9999.9.	2
2400	PWK – Segment Rule	DURABLE MEDICAL EQUIPMENT CERTIFICATE OF MEDICAL NECESSITY INDICATOR		Must not be present. Submission of this segment for Part B will cause your claim to reject.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	CR106	Patient Weight		The maximum number of characters to be submitted in the patient weight field is four characters to the left of the decimal and two characters to the right. Patient weight in excess of 9,999.99 pounds will be rejected.	2
2400	CR3 – Segment Rule	Transport Distance		The maximum number of characters to be submitted in the transport distance is four characters. Transport distance in excess of 9,999 miles will be rejected.	2
2400	CRC – Segment Rule	DURABLE MEDICAL EQUIPMENT CERTIFICATION		Must not be present. Submission of this segment for Part B will cause your claim to reject.	4
2400	DTP03	CONDITION INDICATOR/ DURABLE MEDICAL EQUIPMENT		Must not be a future date.	4
2400	DTP03	DATE - SERVICE DATE		Must not be a future date.	6
2400	DTP – Segment Rule	DATE - PRESCRIPTION DATE		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6
2400	DTP03	DATE - CERTIFICATION REVISION/RECERTIFICATION DATE		Must not be a future date.	4
2400	DTP – Segment Rule	Certification Revision Recertification Date		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6
2400	DTP03	DATE – BEGIN THERAPY DATE		Must not be a future date.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	DTP – Segment Rule	Begin Therapy Date		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6
2400	DTP03	DATE - LAST CERTIFICATION DATE		Must not be a future date.	4
2400	DTP03	Last Certification Date		Must not be a future date.	6
2400	DTP03	Last Seen Date		Must not be a future date.	6
2400	DTP03	Test Performed Date		Must not be a future date.	6
2400	DTP03	X-ray date		Must not be a future date.	6
2400	QTY02	Initial Treatment Date		Must be between 1 and 99. Submission of a value less than 1 or greater than 99 will cause your claim to reject.	6
2400	QTY02	Ambulance Patient Count		Must be between 1 and 99. Submission of a value less than 1 or greater than 99 will cause your claim to reject.	2
2400	MEA03	Obstetric Additional Units		Must be one to two positions and can contain one decimal place. Submission of a value greater than 99.9 will cause your claim to reject.	2
2400	CN1 – Segment Rule	Test Result		Must not be present. Submission of this segment for Part B will cause your claim to reject.	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	PS1 – Segment Rule	CONTRACT INFORMATION		Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line level (Loop 2400). Claims which contain a purchased service provider (QB) but that do not contain the PS1 segment data will be rejected.	4
2400	LIN02	PURCHASED SERVICE PROVIDER IDENTIFIER		LIN02 must be qualifier value "N4". Submission of any other value will cause your claim to reject.	1
2410	CTP04	National Drug Unit Count		The max value for international units (qualifier F2), in the CTP segment, cannot exceed seven bytes numeric with three decimal places. Claims for drugs that exceed this value will be rejected.	4
2410	REF – Segment Rule	PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER		If modifier J1 is used to bill the claim, this segment must be submitted.	2
2410	REF – Segment Rule	PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	1
2420A	REF – Segment Rule	RENDERING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2420B	REF – Segment Rule	PURCHASED SERVICE PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420C	REF – Segment Rule	SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420D	REF – Segment Rule	SUPERVISING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420E	REF – Segment Rule	ORDERING PROVIDER SECONDARY IDENTIFICATION		Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.	4
2420F	LQ – Segment Rule	REFERRING PROVIDER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment for Part B will cause your claim to reject.	4
2440	LQ – Segment Rule	FORM IDENTIFICATION CODE		If 2400 PWK01 = CT and PWK02= AD, the LQ segment must be submitted.	4
2440	LQ01	FORM IDENTIFICATION CODE	UT	Must be "UT". Submission of any other value will cause your claim to reject.	1
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		Must not be present. Submission of this segment for Part B will cause your claim to reject.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		When LQ02 = "484.03", occurrences of FRM with FRM01 = ("1A" or "1B") and FRM01 = "1C" and FRM01 = "05" are required.	4
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		When LQ02 = "484.03" and FRM01 = "1A" and FRM03 >= 55.5 and <= 59.4, one occurrence of FRM with FRM01 = "07", "08" or "09" is required.	1
2440	FRM – Segment Rule	SUPPORTING DOCUMENTATION		When LQ02 = "484.03" and FRM01 = "1B" and FRM03 >= 88.5 and <=89.4, one occurrence of FRM with FRM01 = "07", "08" or "09" is required.	1
2440	FRM01	SUPPORTING DOCUMENTATION		When LQ02='484.03' and FRM01='05' is present and the value in FRM03 is > '4', an occurrence of FRM01 with the value of '6A' or '6B' is required.	1
2440	FRM01	Question Number/Letter		When LQ02='484.03' and FRM01='6A' or '6B', an occurrence of FRM01 with the value of '6C' is required.	1
2440	FRM01	Question Number/Letter		When LQ02='484.03' and FRM01='6C', an occurrence of FRM01 with the value of '6A' or '6B' is required.	1
2440	FRM02	Question Number/Letter		When LQ02 = '484.03" and FRM with FRM01 = "04", "07", "08" or "09" is present, then FRM02 must	1

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				be present.	
2440	FRM03	Question Response		When LQ02 = "04.04" and FRM01 = "07B", "09B", "10B" or "10C", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "06.03" and FRM01 = "02" or "03", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "09.03" and FRM01 = "01", "01A", "01B", "01C", "02", "02A", "02B", "02C", "03" or "04", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "10.03" and FRM01 = "03", "03A", "03B", "04", "04A", "04B", "05", "06", "08A", "08C", "08D", "08F", "08G" or "09", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = "484.03" and FRM01 = "02", FRM03 must be present.	1
2440	FRM03	Question Response		When LQ02 = '484.03" and FRM with FRM01 = "1A", "1B", "02", "03" or "05" is present, then FRM03 must be present.	1
2440	FRM04	Question Response		Must not be a future date.	1
2440	FRM04	Question Response		When LQ02 = '484.03" and FRM with FRM01 = "1C" is present, then	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				FRM04 must be present.	
2440	FRM05	Question Response		When LQ02 = "10.03" and FRM01 = "08B", "08E" or "08H", FRM05 must be present.	1
2440	FRM05	Question Response		Must between 0 and 100 and can contain one decimal place. Submission of a value greater than 100.0 will cause your claim to reject.	1
				We suggest retrieval of the ANSI 999 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission OR We suggest retrieval of the ANSI 999 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.	

4. TI Additional Information

4.1 Other Resources

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources of use during the 5010 transition year.

Resource	Web Address
ASC X12 TR3 Implementation Guides	http://store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc- edi.com/content/view/711/401/

Resource	Web Address
Central Version 005010 and D.0 Webpage on CMS website	http://www.cms.gov/Regulations-and- Guidance/Administrative- Simplification/Versions5010andD0/index. html
Educational Resources (including MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from national provider calls)	http://www.cms.gov/Regulations-and- Guidance/Administrative- Simplification/Versions5010andD0/40_E ducational_Resources.html
Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences)	http://www.cms.gov/MFFS5010D0/
Frequently Asked Questions	http://questions.cms.gov
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/