1.1 837 Professional (Part B) 5010 expectations

The defined set of statements below supplements the ANSI ASC X12N 837 5010 Technical Report Type 3 (TR3) and clarifies our expectations regarding data submission, processing, and adjudication. The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 Implementation Guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy drug claims. The Implementation Guides for each X12N transaction are adopted as a HIPAA standard available electronically on the [X12 website](https://x12.org/products/technical-reports).

The following information is intended to serve only as a companion document to the ANSI ASC X12N 837 5010 Technical Report Type 3 (TR3) and the 5010 Companion Guides ([JH](https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00197704)) ([JL](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00197705)). The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the Multi-Carrier System (MCS) system for Novitas Solutions, Inc. Part B workloads as follows:

| Language |
| --- |
| Negative values submitted in the following fields will not be processed and will result in the claim being rejected:   * Contract Amount (2300 and 2400 Loop, CN102) * ESRD Paid Amount (2320 Loop, MOA08), * HCPCS Payable Amount (2320 Loop, MOA02) * Line Item Charge Amount (2400 Loop, SV102), Non-Payable Professional Component Billed Amount (2320 Loop, MOA09) * Patient Amount Paid (2300 Loop, AMT02) * Patient Weight (2300 and 2400 Loop, CR102) * Payer Paid Amount (2320 Loop, AMT02) * Purchased Service Charge Amount (2400 Loop, PS102) * Repriced Allowed Amount (2300 and 2400 Loop, HCP02) * Repriced Approved Ambulatory Patient Group Amount (2300 and 2400 Loop, HCP07) * Repriced Per Diem (2300 and 2400 Loop, HCP05) * Repriced Savings Amount (2300 and 2400 Loop, HCP03) * Service Unit Count (2400 Loop, SV104) * Total Claim Charge Amount (2300 Loop, CLM02) * Transport Distance (2300 and 2400 Loop, CR106) |
| The only valid value for CLM05-3 (Claim Frequency Type Code) is '1' (ORIGINAL). Claims with a value other than “1” will be rejected. |
| The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected. For total charge amounts exceeding 99,999.99, the claim must be split into separate claims. When splitting the charge of the service, be sure the dollar amounts are slightly different, as this will prevent the system from assuming the two claims are an exact duplicate. |
| The maximum number of Transaction Sets (ST/SE) within a file should be 10,000. |
| The maximum number of (CLM) segments within any Transaction Set (ST/SE) should be 5,000. |
| Claims in the same batch should be reported in one ST/SE segment. Submitting a different ST/SE segment per claim requires submitters to repeat the submitter and provider loops and causes delays in the processing time. |
| Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected. |
| Claims that contain 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. |
| Data submitted in CLM20 (Delay Reason Code) will not be used for processing. |
| Medicare will 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. |
| You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional TR3. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the carrier translator. |
| The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric. |
| Diagnosis codes have a maximum size of seven (7) characters. Medicare does not accept decimal points in diagnosis codes. |
| Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102). |
| SV104 (Service unit counts) (units or minutes) cannot exceed 9999.9. |
| SV104 (Service unit counts) (units only) can only have up to one place to the right of the decimal when the Unit or Basis for Measurement Code (2400, SV103) is equal to UN. |
| For Medicare, the subscriber is always the same as the patient. (2000B SBR02=18, SBR09=MB) |
| Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line level (Loop 2400). Claims for PDT services that are submitted without the PS1 Segment data at the 2400 Loop may be rejected. |
| All dates that are submitted on an incoming 837 claim 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). |
| Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL). |
| Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE). |
| Medicare will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected. |
| You may send up to 12 diagnosis codes per claim as allowed by the implementation guide. If diagnosis codes are submitted, you must point to the primary diagnosis code for each service line. |
| Only valid qualifiers for Medicare must be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing will cause the claim or the transaction to be rejected. |
| You may send up to four modifiers; however, the last two modifiers may not be considered. The Medicare processing system may only use the first two modifiers for adjudication and payment determination of claims. |
| Medicare will return the version of the 837 inbound transaction in GS08 Version/Release/Industry Identifier Code) of the 999. |
| A nine-digit zip code is required in 2010AA N4 (Billing Provider Address), 2310C (Facility Address) and 2420C N4 (Facility Address). |
| We suggest retrieval of the ANSI 999 functional acknowledgement files on the same day the claim file is submitted. |
| Medicare does not require 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](http://www.wpc-edi.com/reference/) located on the Washington Publishing company’s website at https://nex12.org. Claims submitted with invalid taxonomy codes will be rejected. |
| Medicare will reject an interchange (transmission) that contains a submitter identification number that is not authorized for electronic claim submission. |
| Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes may be rejected. (SV104). |
| Medicare will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements. |
| Professional Review Organization (PRO) information should be submitted in the 2300 or 2400 REF with a G1qualifier. |
| Only loops, segments, and data elements valid for the HIPAA Professional TR3 will be translated. Submitting data not valid based on the TR3 will cause files to be rejected. |
| 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. |
| The format for National Drug Codes (NDC) is 5-4-2 (11 positions). Claims that contain NDC codes in any other format will be rejected.  If the NDC format is 4-4-2, such as 1234-5678-90, a zero is added to the first part making the 5-4-2 form 01234-5678-90.  If the NDC format is 5-3-2, such as 12345-678-90, a zero is added to the second part making the 5-4-2 form 12345-0678-90.  If the NDC format is 5-4-1, such as 10234-5678-9, a zero is added to the third part making the 5-4-2 form 10234-5678-09.  Remove the dashes when reporting the NDC number. |
| The National Provider Identifier (NPI) must be submitted in the NM109 segment with the XX qualifier in the NM108 where applicable within the following loops: 2010AA Billing Provider; 2310A Referring Provider; 2310B Rendering Provider; 2310C Service Facility; 2310D Supervising Provider; 2330C Other Payer Referring Provider; 2330D Other Payer Rendering Provider; 2330E Other Payer Service Facility; 2330F Other Payer Supervising Provider; 2420A Rendering Provider; 2420B Purchased Service Provider; 2420C Service Facility; 2420D Supervising Provider; 2420E Ordering Provider; 2420F Referring Provider. |

* If individual consideration should be given to certain procedures due to unusual circumstances, these circumstances should be reported in the extra narrative segment.
* Multiple surgical procedures performed on the same day should be reported on separate lines of the same claim.
* Ineligible services should not be reported.

Envelope control / Reference number matching for version 5010 claim transitions

With the implementation of Accredited Standards Committee (ASC) X12 Version 5010 transactions for acknowledgements (TA1, 999, and 277CA), Medicare Fee-for-Service is recommending the use of unique numbering for several enveloping control / reference numbers built into the Version 5010 claims transitions. Using unique numbering for the ISA13, ST02, and BHT03 data elements on the inbound 837 Institutional and Professional claims will allow Medicare trading partners to easily match submitted claims with the acknowledgement transactions.

Examples of those pairing include:

* 837 ISA13 is mapped to the TA1 response transaction and located in the TA101 data element
* The implementation guide for the TA1 (ASC X12 TA1 TR3) states for TA101:  “This is the value in ISA13 from the interchange to which this TA1 is responding.”
* 837 ST02 is mapped to the 999 response in the 2000.AK202 data element
* The implementation guide for the 999 (ASC X12 999 TR3) states for AK202:  “Use the value in ST02 from the transaction set to which this 999 transaction set is responding.”
* 837 BHT03 is mapped to the 277CA response in the 2200B.TRN02 data element
* The implementation guide for the 277CA (ASC X12 277CA TR3) states for TRN02:  “This element contains the value submitted in the BHT03 data element from the 837.”

Chart key:

R - Required – Any data element that is needed in order to process a claim (e.g., date of service).

S - Situational – Any data element that must be completed if other conditions exist (e.g., if the insured differs from the patient, the insured’s name must be entered on the claim).

† - If Medicare secondary payer or Medigap is involved, please refer to the X12N 5010 Professional TR3 for further instruction.

\* - Use if different than information given at the claim level. Segments submitted at the claim level apply to the entire claim unless overridden by information at the service line level.

Billing requirements – Part B

| Loop | ANSI 837 | Data element description | Status | Requirements |
| --- | --- | --- | --- | --- |
|  | GS05 | Time | R | Novitas Solutions, Inc. will accept HHMM as a minimum. |
|  | GS06 | Group control number | R | Assigned by provider and must be unique for each file created. |
| 1000A | NM109 | Submitter identifier | R | NM109 will equal the submitter number assigned by the contractor (7 byte submitter ID number). |
| 2000A | PRV | Taxonomy Code | S | Taxonomy codes for solo or Organizational providers without rendering physicians. Taxonomy codes are not required to be reported by Medicare. |
| 2320 | SBR02 | Individual relationship code | S | Required if any other payers are known to potentially be involved in paying this claim. |
| 2010AA | NM109 (85) | Billing provider | R | Enter your provider of service National Provider Identifier (NPI). |
| 2010AA | REF02 (24,34) | Provider Tax ID, Social Security Number or Employer’s ID number indicator | R | Enter your provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number (SSN). |
| 2010AA | PER04 | Provider’s phone number | R | Enter the provider of service/supplier’s phone number. |
| 2010AA or 2010AB | NM103, 04, 05 (85, 87) | Provider last or organizational name, provider first name and provider middle initial | R | Enter the provider of service/supplier’s billing name. |
| 2010AA or 2010AB | N301  N401, N402, N403 | Provider’s address  Provider’s city, State, and Zip Code | S | Enter the provider of service/supplier’s billing address, zip code. The zip code is required to be nine digits.  The 2010AA loop cannot contain a PO Box address. |
| 2010BA | NM103  NM104  NM105 | Subscriber last name  Subscriber first name  Subscriber middle name | R  R  S | Enter the patient’s name as shown on their Medicare card (for Medicare, the patient is always the subscriber). |
| 2010BA | N301  N401, N402, N403 | Subscriber address line  Subscriber city State and Zip | R  S | Enter the patient’s mailing address. |
| 2010BB | NM109 | Payer identifier | R | NM109 will equal the contractor ID number. Refer to the [Novitas Contractor ID/Payer ID Codes](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00157905) for the appropriate Part B contractor ID for your locale. |
| 2300 | CLM11- 1 (AA, EM, OA)  CLM11-2  CLM11-3 | Related causes code | S | Required if Date of Accident (DTP01=439) is used and the service is related to an employment accident, auto accident or other accident. |
| 2300 | CLM11-4 | Auto accident State or Province code | S | Required if Related Cause (CLM11-1, -2 or –3) =Auto Accident (AA) to identify the state in which the automobile accident occurred. |
| 2300 | CLM10  CLM09 | Patient signature source code  Release of information code | S  R | Patient Signature Source Code (CLM10) is required. |
| 2320 | OI03 | Benefits assignment certification indicator | S |  |
| 2300 | DTP03 (439) | Accident date | S | Required if Related Cause Code (CLM11-1, -2 or -3)= Auto Accident (AA), Employment (EM) or Other (OA). |
| 2300  2300 | DTP03 (431)  DTP03 (454) | Onset of current illness or injury date  Initial treatment date | S  S | Required when available.  Required on all claims involving spinal manipulation. |
| 2300 | DTP03 (360)  DTP03 (361) | Disability from date  Disability to date | S  S | Enter the date when patient is employed and unable to work in current occupation. An entry here may indicate employment related insurance coverage. (CCYYMMDD) |
| 2300 | DTP03 (435)  DTP03 (096) | Hospitalization admission date  Hospitalization discharge date | S  S | Enter the date when a medical service is furnished as a result of, or subsequent to, a related hospitalization. |
| 2300  2400\* | NTE02  NTE02 | Extra narrative data | S | Enter all applicable modifiers when modifier –99 (multiple modifiers) is entered. When dental examinations are billed, enter the specific surgery for which the exam is being performed. Enter the date for a global surgery claim when providers share post-operative care. |
| 2300 | REF02 (P4) | Demonstration project identifier | S |  |
| 2300  2400\* | DTP03 (455)  DTP03 (455) | Last x-ray date | S | Required when claim involves spinal manipulation if an x-ray was taken. |
| 2300 | HI01-02 (ABK)  HI02-02 HI03-02 HI04-02 (ABF) | Principal diagnosis Ccode  Diagnosis code | S  S | Required on all claims except claims for which there are no diagnosis. Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed. Enter the patient’s diagnosis/condition. All physician specialties must use an ICD-10-CM code number and code to the highest level of specificity. Enter up to twelve codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures. |
| 2300 | REF02 (LX) | Investigational device exemption number | S | Required when claim involves a Federal Drug Administration (FDA) assigned Investigational Device Exemption (IDE) number. |
| 2300  2400 | REF02 (X4)  REF02 (X4) | CLIA certification number | S | Required on claims for any laboratory performing tests covered by the Clinical Laboratory Improvement Amendment (CLIA) act. Enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA covered procedures. |
| 2300  2400 | CLM05-1  SV105 | Facility type code  Place of service code | R  S | Enter the appropriate place of service code. Identify the location, using a place of service code, for each item used or service performed. For places of service other than office a facility name and address is required. For Health Professional Shortage Area (HPSA) claims a facility name and address is always required no matter what place of service is reported. Information on reporting facility name and address is listed in 2310C NM1 or 2420C NM1. |
| 2300 | AMT02 (F5) | Patient amount paid | S | Required if the patient has paid any amount towards the claim for covered services only. |
| 2300 | CLM06 | Provider or supplier signature indicator | R | Y= provider signature is on file.  N=provider signature is not on file. |
| 2310A or 2420F\* | NM103 (DN)  NM104  NM105  NM109 | Referring provider last name  Referring provider first name  Referring provider middle initial  Referring provider identification code | S  S  S  S | Required if claim involved a referral. When reporting the provider who ordered services such as diagnostic and lab utilize the referring provider name (2310A) loop at the claim level.  Enter the National Provider Identifier Number (NPI) of the referring provider. Required when a referring provider’s name is reported in 2310A or 2420F NM103 |
| 2310B  2420A\* | NM109 (XX)  NM109 (XX) | Rendering provider identification code | S | Enter the carrier assigned NPI when the performing provider/supplier is a member of a group practice. |
| 2310B  2420A | PRV | Taxonomy code | S | Taxonomy codes for group providers with rendering physicians if reported must be submitted at the rendering level (2310B or 2420A) and not the group level (2000A loop). Taxonomy codes are not required to be reported by Medicare. |
| 2400 | PS101 | Purchased (professional) service provider identifier | S | State specific provider number of entity performing the purchased test. |
| 2310C  2420C\* | l NM103 (FA, TL, 77, LI)  N301  N401, 02, 03  NM109 (XX) | Service Facility Location  Service facility address  Service facility city, State and Zip Code  Service facility Location NPI | S  S | Required when the location of health care service is different than that carried in the Billing Provider Name (2010AA) or Pay to Provider (2010AB) loops.  Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed). The zip code is required to be nine digits.  If an independent laboratory is billing, enter the place where the test was performed and the carrier assigned NPI. The reference lab identification number should also be reported here. Only bill one unique facility number per claim. |
| 2400 | REF02 (EW)  REF02 (EW)\* | Mammography certification # |  | If the supplier is a certified mammography screening center, enter the Food and Drug Administration (FDA) approved certification number. This number is also known as the Mammography Quality Standards Act (MQSA) identification number. This is a six-digit numeric number. |
| 2300  2400 | REF02 (G1) | Prior authorization or referral number | S | Enter the Professional Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval. Only bill one unique PRO number per claim. |
| 2310E | NM101(PW) N3, N4 | Point of pick up | S | Required on ambulance claims. Enter the point of pick up. |
| 2310F | NM101(45) N3, N4 | Point of drop-off | S | Required on ambulance claims. Enter the point of drop off |
| 2320  2330A  2320 | SBR03  NM109  SBR05 | Insured group or policy number  Other insured identifier  Insurance type code | S  S | Required if other payers are known to potentially be involved in paying this claim. If there is insurance primary to Medicare, enter the policy or group number of the insured. |
| 2320 | SBR04 | Other insured group name | S | Enter the complete insurance plan or program name. |
| 2330A | NM103  NM104  NM105 | Other insured last name  Other insured first name  Other insured middle name | S  S  S | List the name of the insured if there is insurance primary to Medicare. Leave blank if Medicare is primary. |
| 2330A | N301  N401,02,03 | Other insured address line  Other insured city, State and Zip Code | S  S | Required if any other payers are known to potentially be involved in paying this claim and the information is available. Enter the mailing address of the insured. |
| 2330A | NM103  NM104  NM105 | Other insured last name  Other insured first name  Other Insured middle name | S  S  S | Required if enrolled in a Medigap policy. Enter the name of the enrollee in the Medigap policy. |
| 2330A  2320 | NM109  SBR03 | Other insured identifier  Insured group or policy number | S  S | Enter the policy and/or group number of the Medigap insured. Required if other payers are known to potentially be involved in paying this claim. |
| 2330A | NM109 | Medicaid identification number | S | Enter the patient’s Medicaid number if patient is entitled to Medicaid. |
| 2330B  2320 | NM109  SBR04 | Other payer primary identifier  Other insured group name | S  S | Enter the Medigap insurer’s unique identifier provided by the local Medicare carrier and the name of the Medigap enrollee’s insurance.  Insurance Type Code (SBR05)= Medigap Part B (MI)  Required if other payers are known to potentially be involved in paying this claim. |
| 2400 | CRC02 (70) | Hospice employed provider indicator | S | Required on all claims involving physician services to hospice patients. |
| 2400 | PS102 | Purchased service charge amount | S | Required if there are purchased service components to this claim. |
| 2400 | DTP03 (472) | Service date | R | Enter the service date for each procedure, service, or supply.  If a single date, the Date/Time Qualifier (DTP02) = CCYYMMDD (D8)  If a range of dates, the Date /Time Qualifier (DTP02) = CCYYMMDD-CCYYMMDD (RD8) |
| 2400 | SV101-2  SV101-3  SV101-4    SV101-5  SV101-6  SV101-7 | Procedure code  Procedure modifier 1  Procedure modifier 2  Procedure modifier 3  Procedure modifier 4  Procedure description | R  S  S  S  S  S | In Product/Service ID Qualifier (SV101-1) enter (HC) for HCPCS Codes.  Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS).  Modifiers are required when they clarify/improve the reporting accuracy of the associated procedure codes.  The Medicare Part B processing system you send your claims to may only use the first two modifiers for adjudication and payment determination of claims.  Required when SV101-2 is a non-specific Procedure Code.  Non-specific codes may include in their descriptors terms such as: Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug, Generic; or Prescription Drug, Brand Name. |
| 2400 | SV107-1  SV107-2, SV107-3, SV107-4 | Diagnosis code pointer  Diagnosis code pointer | S  S | A submitter must point to the primary diagnosis for each service line. Use remaining diagnosis pointers in declining level of importance to service line. |
| 2400 | SV102 | Line-item charge amount | R | Enter the charge for each service. |
| 2400 | SV104 (UN)  SV104 (MJ) | Units of service  Anesthesia/Oxygen minutes | R  R | Enter the number of days or units. If a decimal is needed to report units, include it in this element, e.g., 15.6. For anesthesia, show the elapsed time. Convert hours into minutes and enter the total minutes required for the procedure. |

1.2 835 (Electronic remittance advice (ERA)) 5010 expectations

The defined set of statements below supplements the ANSI ASC X12N 835 5010 Technical Report Type 3 (TR3) and clarifies additional information regarding remittance transactions. The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The TR3s for each X12N transaction are adopted as a HIPAA standard available electronically on the [X12 website](https://x12.org/products/technical-reports).

Reason and remark codes

Reason Codes are maintained by the Blue Cross Blue Shield Association in the Joint Claim Adjustment/Claim Status Reason Code Maintenance Committee and Remark Codes are maintained by Centers for Medicare & Medicaid Services (CMS). Reason and Remark Codes are only available on the [X12 website](https://x12.org/products/technical-reports).

Corrections and reversals- Part B

The 835 5010 TR3 outlines the approved method of adjustment processing. Adjustments, under HIPAA, must be performed utilizing the “correction and reversal” process. The initial decision or claim is reversed and then corrected with a complete adjustment claim. All lines on the claim are “reprocessed.”

835 Adjustments Dropped to Paper Remittance (Part B Only)

There are isolated incidences where the “correction and reversal process” cannot be used. Since these types of adjustments are considered “not HIPAA compliant,” the Centers for Medicare & Medicaid Services (CMS) has directed Medicare contractors that these specific claims cannot be carried to the 835 5010 ERA. Rather, a Standard Paper Remittance (SPR) will be generated, which will contain the claim(s) meeting this condition. The Remark Code of N112 (this claim has been removed from your Electronic Remittance Advice (ERA)) will be your notification that this action has occurred. This remark code alerts you that this specific claim has been removed from the ERA. Processing information will be found on the SPR.

Gap fill for Medicare Part B

The X12 835 version 5010 TR3 contains the specific data requirements required to generate a HIPAA-compliant ERA. However, Medicare Part B claims received on paper may lack the required data elements or may not meet all the data attribute requirements needed to prepare a HIPAA compliant X12N 835 5010 ERA.

In the event a claim is received with insufficient data, the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to enter meaningless characters to meet the minimum data element length requirements in order to create a HIPAA-compliant ERA. Please be aware that if you receive 835 version 5010 ERAs, you could receive an ERA with such data, if the incoming claim was not an 837 version 5010 claim. When this occurs, Medicare will notify you when the “gap fill” occurs.

Missing claim forward information

Directions provided in the 835 TR3 document state that if the 2100 CLP02 does not equal 19, 20, 21, or 23, the 2100 NM1 Crossover Carrier Name is suppressed. This does not mean that your claims did not cross over; it just does not provide who they were crossed over to.

1.3 276/277 5010 Expectations

Novitas Solutions, Inc. will process your request for claim status information via batch Central Processing Unit to Central Processing Unit (CPU to CPU).

The 276 transaction must utilize delimiters as defined in the standard. The delimiters selected must not occur in the transmitted data elements. The delimiters used in a 277 response or in an acknowledgment may not necessarily be the same as the delimiters submitted in the original 276 request transaction.

Multiple functional groups (GS to GE segments) can be sent in one interchange (ISA to IEA segments). Multiple 276s or 277s (ST through SE) can be included in a single functional group.

Upon receipt of your 276, we will generate the following:

* TA1 or local reject report for interchange control errors immediately after the transmission.
* 999 for syntax errors immediately after the transmission. A 999 will not be sent for an accepted 276, the 277 will be the response for an accepted 276.
* 277 will be available 24 hours after the acceptance of the 276.

Novitas Solutions, Inc. will process your 276 as identified in the TR3 and create a 277 as identified in the TR3. At least the minimum response data will be sent.

All alphabetic characters in the 277 transaction will be upper case. If lower case characters are included in the 276 request, they will be converted to upper case for data storage and return processing purposes.

The following indicates those segments or data elements in the X12N 276/277 Version TR3 version 5010 that allow Medicare to specify its business requirements.

276 Request transaction - Part B

| Data segment name | Segment or data element | Supported value(s) | Requirement |
| --- | --- | --- | --- |
| Interchange control header | ISA05 | ZZ | Interchange identity qualifier for ISA06.  Submitter uses the “ZZ” value. |
| Interchange control header | ISA06 |  | Interchange sender ID. Submitter chooses and enters a value later used by the contractor for sending back the 277. |
| Interchange control header | ISA07 | 27 | Carrier submitter uses a “27”. |
| Interchange control header | ISA08 |  | Interchange receiver ID. Submitter uses the CMS assigned Medicare contractor ID. Refer to the [Novitas Contractor ID/Payer ID Codes](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00157905) for the appropriate Part B contractor ID for your locale. |
| Functional group header | GS01 |  | Submitter uses code “HR” to designate the 276. |
| Functional group header | GS02 |  | Submitter uses codes agreed to by trading partners. (Submitter number) |
| Functional group header | GS03 |  | Submitter uses the contractor ID. Refer to the [Novitas Contractor ID/Payer ID Codes](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00157905) for the appropriate Part B contractor ID for your locale. |
| Functional group header | GS05 |  | Submitter uses the recommended HHMM format. |
| Payer name | NM108 | PI | Submitter uses the code "PI" to identify that the contractor identifier will follow. |
| Payer name | NM109 |  | Submitter uses the contractor ID. Refer to the [Novitas Contractor ID/Payer ID Codes](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00157905) for the appropriate Part B contractor ID for your locale. |
| Information receiver name | NM108 | 46 | This is the individual or organization requesting to receive the status information. |
| Information receiver name | NM109 |  | Submitter uses identification code as assigned by the contractor. |
| Provider name | NM108 | XX | Submitter uses the “XX” qualifier for the National Provider Identifier in NM109. |
| Provider name | NM109 |  | Submitter enters the National Provider Identifier (NPI). |
| Subscriber name | NM108 | MI | Submitter uses the “MI” qualifier for the patient's Medicare ID number entered in NM109. |
| Subscriber name | NM109 |  | Submitter enters the patient's Medicare ID number. |

277 Response Transaction - Part B

| Data segment Name | Segment or data element | Supported value(s) | Requirement |
| --- | --- | --- | --- |
| Payer name | NM108 | PI | Medicare enters the “PI” qualifier for NM109. |
| Payer name | NM109 |  | Medicare enters contractor ID. Refer to the [Novitas Contractor ID/Payer ID Codes](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00157905) for the appropriate Part B contractor ID for your locale. |

Updated: 03/25/2024