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| **General Statements** | | | | | |
| | | | R | The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 [will/may] be rejected. | |
| | | | R | Claims that contain percentage amounts with values in excess of 99.99 [will/may] be rejected. | |
| | | | R | 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. | |
| | | | R | [Contractor name] 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. | |
| | | | R | Only loops, segments, and 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. | |
| | | | O | The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, \|, and :. Submitting delimiters not supported within this list [will/may] cause an interchange (transmission) to be rejected. | |
| | | | R | You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. 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 [will/may] cause the interchange (transmission) to be rejected at the carrier translator. | |
| | | | R | When applicable, the National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). | |
| | | | R | 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 published at http://www.wpc-edi.com/codes/taxonomy. Claims submitted with invalid taxonomy codes will be rejected. | |
| | | | R | 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). | |
| | | | O | [Contractor name] [will/may] reject an interchange (transmission) submitted with more than 9,999 loops. | |
| | | | O | [Contractor name] will reject an interchange (transmission) submitted with more than 9,999 segments per loop. | |
| | | | O | [Contractor name] [will/may] reject an interchange (transmission) with more than [contractor supplies | |

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| | | | | value] CLM segments (claims) submitted per transaction. | |
| | | | R/O | A. Compression of files is not supported for transmissions between the submitter and [Contractor name] -OR-<br>B. Compression of files using [name of software] is supported for transmissions between the submitter and [Contractor name]. | |
| | | | R/O | A. Only valid qualifiers for Medicare must be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing which are not defined for use in Medicare billing [will/may] cause the claim or the transaction to be rejected -OR-<br>B. Only valid qualifiers for Medicare should be submitted for Medicare processing on incoming 837 claim transactions. Any qualifiers submitted which are not defined for use in Medicare billing [will/may] cause the claim to be rejected. | |
| | | | R/O | A. You may send up to four modifiers; however, the last two modifiers [will/may] not be considered. The [Contractor name] processing system [will/may] only use the first two modifiers for adjudication and payment determination of claims. -OR-<br>B. You may send up to four modifiers; however, the last modifier [will/may] not be considered. The [Contractor name] processing system [will/may] only use the first three modifiers for adjudication and payment determination of claims. | |
| | | | O | [Contractor name] will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guides. | |
| **Interchange Control Header** | | | | | |
| | ISA05 | Interchange ID Qualifier | O | [Contractor name] will reject an interchange (transmission) that does not contain [qualifier] in ISA05. | B.4 |
| | ISA06 | Interchange Sender ID | O | [Contractor name] will reject an interchange (transmission) that does not contain a valid ID in ISA06. | B.4 |
| | ISA07 | Interchange ID Qualifier | O | [Contractor name] will reject an interchange (transmission) that does not contain [qualifier] in ISA07. | B.4 |
| | ISA08 | Interchange Receiver ID | O | [Contractor name] will reject an interchange (transmission) that does not contain [carrier code] in ISA08. Each individual Contractor determines this code. | B.5 |
| **Functional Group Header** | | | | | |
| | | | O | [Contractor name] will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange). | |
| | | | O | [Contractor name] will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group). | |
| | GS03 | Application Receiver's | O | [Contractor name] [will/may] reject an interchange (transmission) that is submitted with an invalid | B.8 |

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| | | Code | | value in GS03 (Application Receivers Code) based on the carrier definition. | |
| **Loop** | **Transaction Set** | | | | |
| | | | O | [Contractor name] 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/may] cause the transaction to be rejected. | |
| | ST02 | Transaction Control Set | O | [Contractor name] will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements. | 62 |
| | BHT02 | Transaction Set Purpose Code | O | Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL). | 64 |
| | BHT06 | Claim/Encounter Identifier | O | Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE). | 65 |
| | REF02 | Transmission Type Identification | O | The 837 Professional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 [will/may] cause the file to be rejected. | 66 |
| 1000A | NM109 | Submitter ID | R | [Contractor name] will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission. | 69 |
| 1000B | NM103 | Receiver Name | O | [Contractor name] [will/may] reject an interchange (transmission) that is not submitted with a valid carrier name (NM1). | 75 |
| 1000B | NM109 | Receiver Primary Identifier | O | [Contractor name] [will/may] reject an interchange (transmission) that is not submitted with a valid carrier code (NM1). Each individual Contractor determines this code. | 75 |
| 2000B | HL | Subscriber Hierarchical Level | O | The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric. | 108 |
| 2000B | SBR02, SBR09 | Subscriber Information | R | For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used. | 111 |
| 2010BD | | Credit/Debit Card Information | R | Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop). | 150 |
| **Loop** | **Claim Information** | | | | |
| 2300 | CLM02 | Total Submitted Charges | R | Negative values submitted in CLM02 [will/may] not be processed and [will/may] result in the claim being rejected. | 172 |
| 2300 | CLM02 | Total Submitted Charges | R | Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102). | 172 |
| 2300 | CLM05-3 | Claim Frequency Type Code | R | The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" [will/may] be rejected. | 173 |
| 2300 | CLM20 | Delay Reason Code | R | Data submitted in CLM20 will not be used for processing. | 179 |
| 2300 | PWK | Claim Supplemental Information | O | Any data submitted in the PWK (Paperwork) segment [will/may] not be considered for processing. | 214 |

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| 2300 | AMT01 | Credit/Debit Card Maximum Amount | R | Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop). | 219 |
| 2300 | AMT02 | Patient Amount Paid | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: AMT02. | 220 |
| 2300 | AMT02 | Total Purchased Service Amount | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: AMT02. | 221 |
| 2300 | REF02 | Prior Authorization and Referral Number | O | Peer Review Organization (PRO) information should be submitted at the header claim level (Loop 2300). PRO information submitted at the detail line level (Loop 2400) will be ignored. | 227 |
| 2300 | CR102, CR106 | Ambulance Transport Information | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: CR102, CR106. | 249,250 |
| 2300 | HI | Health Care Diagnosis Code | R | Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes. | 265 |
| 2300 | HI | Health Care Diagnosis Code | R | Effective October 2004, 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. | 265 |
| 2300 | HI | Health Care Diagnosis Code | R/O | A. You may send up to eight diagnosis codes per claim. If diagnosis codes are submitted, you must point to the primary diagnosis for each service line. -OR-<br>B. You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes [will/may] not be considered in processing. | 265 |
| 2320 | AMT02 | Coordination of Benefits Amounts | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: AMT02. | 332<br>333 |
| 2400 | SV102 | Line Item Charge Amount | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: SV102. | 402 |
| 2400 | SV104 | Professional Service | R (for Carriers) | Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes [will/may] be rejected. (SV104) | 403 |
| 2400 | SV104 | Professional Service | O | 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) | 403 |
| 2400 | SV104 | Professional Service | O | The max value for units (qualifier UN) cannot exceed three bytes numeric with one decimal place. Claims for medical services that exceed this value will be rejected. (SV104) | 403 |
| 2400 | SV104 | Professional Service | R | SV104 (Service unit counts) (units or minutes) cannot exceed 999.9. | 403 |
| 2400 | SV104 | Professional Service | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: SV104. | 403 |
| 2400 | CR102, CR106 | Ambulance Transport Information | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: CR102, CR106. | 413, 414 |
| 2400 | PS1 | Purchased Service | O | Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line | 489 |

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| | | | | level (Loop 2400). Claims for PDT services that are submitted without the PS1 segment data at the 2400 loop [will/may] be rejected. | |
| 2400 | PS102 | Purchased Service | R | Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: PS102. | 490 |
| 2410 | CTP04 | Professional Service | O | 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. | 403 |
| **997 - Functional Acknowledgement** | | | | | |
| | | | R/O | A. We suggest retrieval of the ANSI 997 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-<br>B. We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission. | B.15 |
| | | | R/O | A. [Contractor name] will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997 -OR-<br>B. [Contractor name] will return [X] as the version in GS08 (Version/Release/Industry Identifier Code) of the 997. | |