



# **ANSI ASC X12N 837 Version 4010A1 Companion Document**



**Palmetto GBA**

PARTNERS IN EXCELLENCE™

A CMS Medicare  
Administrative Contractor

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**PLEASE NOTE:** The *ANSI ASC X12N 837 v4010A1 Companion Document* is subject to change. We will post updated versions of this and other EDI-related documents on our Web site. Please visit us regularly at [www.PalmettoGBA.com/Medicare](http://www.PalmettoGBA.com/Medicare). Select your line of business and click on the Electronic Data Interchange (EDI) category for news and updates to EDI documentation.

## INTRODUCTION

### ANSI Transaction Sets

The Health Insurance Portability and Accountability Act of 1996 is referred to by the acronym HIPAA. This legislation includes several provisions, including the Administrative Simplification Act. This Act mandates new standard formats for electronically submitted health care transactions. These transaction standards were developed by the American National Standard Institute (ANSI). The Medicare-applicable transaction sets include the following:

| ANSI      | Transaction                     |
|-----------|---------------------------------|
| 270 / 271 | Eligibility Request / Response  |
| 276 / 277 | Claim Status Request / Response |
| 835       | Remittance Advice               |
| 837       | Claim and COB                   |
| 997       | Acknowledgement                 |

The Department of Health and Human Services is the branch of the federal government overseeing the Administration Simplification Act. The Centers for Medicare & Medicaid Services is responsible for providing guidelines for how HIPAA and the Administrative Simplification Act will impact the Medicare program.

### Getting Your Implementation Guides

HIPAA Implementation Guides may be downloaded from the Washington Publishing Company (WPC) Web site. The guides are also available as bound copies and on CD-ROM. For more information, visit the WPC Web site ([www.wpc-edi.com/HIPAA](http://www.wpc-edi.com/HIPAA)).

### Communications

Palmetto GBA has standardized telecommunications so that all submissions are received via our “gateway” called GPNNet. For more information, please refer to the *GPNNet Communications Manual* located on the [PalmettoGBA.com/Medicare](http://PalmettoGBA.com/Medicare) Web site under your line of business, EDI, and Software & Manuals.

### EDI Updates

Register on the Palmetto GBA Web site ([www.PalmettoGBA.com/Medicare](http://www.PalmettoGBA.com/Medicare)) to receive EDI news electronically. By selecting E-mail Updates and completing a user profile, you will be notified via e-mail when new or important EDI information is added to our Web site. If you have already registered, please ensure your profile has been updated for all new applicable EDI categories, including the EDI topic located under the line of business category (J1, J11, J11HHH, Railroad and LA & MS Part A). Users of Palmetto GBA-provided PC-ACE Pro32, Passport, PC-Print or Medicare Remittance Easy Print (MREP) software should select the Palmetto GBA Software Users topic located under the General category. This category also includes a special topic created for Vendors, Clearinghouses and Billing Services.

### Technical Support

If you have questions regarding HIPAA and its implementation requirements, please call the Palmetto GBA Technology Support Center at 1-866-749-4301

## ANSI 837 V4010A1 COMPLETION INFORMATION

To ensure that your claim files are processed correctly, please include the following information in the appropriate ANSI fields:

| ANSI Field                                                                                                        |                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ISA06                                                                                                             | Enter your <b>Submitter ID</b> .                                                                                                                                                                                          |
| ISA08                                                                                                             | Leave blank except for Railroad Medicare.<br><b>Railroad Medicare</b> – Enter Payer ID <b>C00882</b> .                                                                                                                    |
| <b>State</b>                                                                                                      |                                                                                                                                                                                                                           |
|                                                                                                                   | <b>Payer ID</b>                                                                                                                                                                                                           |
| Louisiana Part A                                                                                                  | 00233                                                                                                                                                                                                                     |
| Mississippi Part A                                                                                                | 00233                                                                                                                                                                                                                     |
| Railroad Medicare                                                                                                 | C00882                                                                                                                                                                                                                    |
| <b>Jurisdiction 1 A/B MAC</b>                                                                                     |                                                                                                                                                                                                                           |
|                                                                                                                   | <b>Payer ID</b>                                                                                                                                                                                                           |
| California, Nevada, Hawaii, American Samoa, Guam & Northern Mariana Island Part A                                 | 01001                                                                                                                                                                                                                     |
| California, Nevada, Hawaii, American Samoa, Guam & Northern Mariana Island Part A – transitioned 4/2010 into J1A2 | 01901                                                                                                                                                                                                                     |
| Northern California Part B                                                                                        | 01102                                                                                                                                                                                                                     |
| Southern California Part B                                                                                        | 01192                                                                                                                                                                                                                     |
| Hawaii, American Samoa, Guam & Northern Mariana Island Part B                                                     | 01202                                                                                                                                                                                                                     |
| Nevada Part B                                                                                                     | 01302                                                                                                                                                                                                                     |
| <b>Jurisdiction 11 A/B MAC</b>                                                                                    |                                                                                                                                                                                                                           |
|                                                                                                                   | <b>Payer ID</b>                                                                                                                                                                                                           |
| Home Health and Hospice                                                                                           | 11001                                                                                                                                                                                                                     |
| South Carolina Part A                                                                                             | 11001                                                                                                                                                                                                                     |
| South Carolina Part B                                                                                             | 11202                                                                                                                                                                                                                     |
| Virginia Part B                                                                                                   | 11302                                                                                                                                                                                                                     |
| West Virginia Part B                                                                                              | 11402                                                                                                                                                                                                                     |
| North Carolina Part A                                                                                             | 11501                                                                                                                                                                                                                     |
| North Carolina Part B                                                                                             | 11502                                                                                                                                                                                                                     |
| ISA13                                                                                                             | Please ensure the <b>nine-digit File ID</b> field is a <b>unique number</b> that has not been submitted within the past 12 months.                                                                                        |
| ISA15                                                                                                             | Enter <b>T</b> when submitting a <b>test</b> claim file.<br>Enter <b>P</b> when submitting a <b>production</b> claim file.                                                                                                |
| REF02                                                                                                             | <b>Institutional Claims (Part A)</b><br>Enter 004010X096A1 when submitting a test or production claim file.<br><b>Professional Claims (Part B)</b><br>Enter 004010X098A1 when submitting a test or production claim file. |
| LIN03                                                                                                             | The format for National Drug Codes (NDC) is 5-4-2 (11 positions with no dashes). Claims that contain NDC codes in any other format will be rejected.                                                                      |

# ANSI ASC X12N 837 V4010A1 INSTITUTIONAL COMPANION DOCUMENT

## Overview

HIPAA requires that Medicare, and all other health benefit payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 Implementation Guides (IGs) have been established as the standards of compliance for claim transactions. The IGs for each transaction are available electronically at [www.wpc-edi.com](http://www.wpc-edi.com).

The following information is intended to serve only as a companion document to the ANSI 837 IGs adopted for national use under HIPAA. 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 following Palmetto GBA systems:

| Line of Business                                                                                                  | Payer ID |
|-------------------------------------------------------------------------------------------------------------------|----------|
| Louisiana & Mississippi Part A                                                                                    | 00233    |
| California, Nevada, Hawaii, American Samoa, Guam & Northern Mariana Island Part A                                 | 01001    |
| California, Nevada, Hawaii, American Samoa, Guam & Northern Mariana Island Part A – transitioned 4/2010 into J1A2 | 01901    |
| J11 Home Health and Hospice                                                                                       | 11001    |
| South Carolina Part A                                                                                             | 11001    |
| North Carolina Part A                                                                                             | 11501    |

The information in this section is subject to change. Changes will be communicated in the *Part A Medicare Advisory* monthly news bulletins and on the Palmetto GBA Web site: [www.PalmettoGBA.com/Medicare](http://www.PalmettoGBA.com/Medicare). Separate companion documents have been or will be issued for use with other HIPAA transaction standard Igs.

## Supplemental Information

### GENERAL STATEMENTS

| Language                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The maximum size for the fields containing number of days information (covered, lifetime reserve, etc.) in the Medicare system is four characters. Claims submitted with data that exceed will be returned to the provider (RTP'd) or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                    |
| The maximum size for dollar amount fields in the Medicare system is 10 characters. Claims submitted with dollar amounts in excess of 99,999,999.99 will be RTP'd or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                                                                                      |
| Claims submitted with attending, other, or operating physician UPIN data will be RTP'd or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                                                                                                                                                                |
| Claims with external code set data that does not conform to the format requirements of the external code set maintainer will be RTP'd or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                                                                                                                 |
| Data elements referencing external code sets are limited to the size of the data as defined by the code set maintainer. For example, the element in the Implementation Guide designated for HCPCS information may contain up to 30 positions but the HCPCS external code list allows only 5 positions (claims with more than 5 positions of HCPCS data in this element would be RTP'd or will be errored back to the submitter by Palmetto GBA. |

| Language                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will be RTP'd or will be errored back to the submitter by Palmetto GBA. Claims submitted with decimal data will be rounded to the closest whole number before being processed.                                                                                                                                                                                                                         |
| The Medicare system does not process decimal points in diagnosis codes or ICD9-CM procedure codes. Medicare will strip out decimal points submitted in valid diagnosis before processing. Medicare will strip out decimal points submitted in valid procedure codes before processing.                                                                                                                                                                                                                                                              |
| You may send as many diagnosis codes as allowed in the implementation guide. However, only the primary/principal and first 8 other diagnosis codes will be considered for adjudication and payment determination.                                                                                                                                                                                                                                                                                                                                   |
| Hospital other (14X) claims that lack diagnosis information when required for CMS adjudication (2300 HI Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) will be RTP'd or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                                                                                                                                                    |
| Claims that lack a patient status code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                                                                                                                                                                                                                                                                   |
| Claims that lack an admission source code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                                                                                                                                                                                                                                                                |
| Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by Palmetto GBA.                                                                                                                                                                                                                                                                                                                                                                                                         |
| Medicare will process only HL structures as described in the implementation guide front matter (Billing Provider HL (parent) followed by the appropriate Subscriber HL (child)).                                                                                                                                                                                                                                                                                                                                                                    |
| Since the date care starts is considered for billing purposes to be the date the beneficiary is admitted to Home Health Agency (HHA) care, HHAs must enter the Home Health Start of Care Date as Admission Date (2300 DTP Admission Date/Hour) for Medicare processing purposes. Any compliant time is acceptable in this field.                                                                                                                                                                                                                    |
| Palmetto GBA 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.                                                                                                                                                                                                                                                                                            |
| Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.                                                                                                                                                                                                                                                                                                                                    |
| The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^,  , and:. Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.                                                                                                                                                                                                                                                                                                                                         |
| You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Institutional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and 837 v. 4010A1 Inbound Institutional Claim Companion Document ATTACHMENT Description Language Page 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 intermediary's translator. |
| <b>Effective January 1, 2008, the National Provider Identifier (NPI) must be submitted in all primary loops.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>After May 23, 2008, the National Provider Identifier (NPI) must be submitted in all NM109 data elements (NM108 = XX) where NM109 is required and in the Service Facility (2310E) NM109 if known.</b>                                                                                                                                                                                                                                                                                                                                             |
| 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 <a href="http://www.wpc-edi.com/codes/taxonomy">www.wpc-edi.com/codes/taxonomy</a> . Claims submitted with invalid taxonomy codes will 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).                                                                                                                                                                                                                                                             |

| Language                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Compression of files using PKZIP is supported for transmissions between the submitter and Palmetto GBA.                                                                                                                                           |
| 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 may cause the claim or the transaction to be rejected |
| Do not use Credit/Debit card information to bill Medicare. Credit/Debit card information will be ignored.                                                                                                                                         |

## INTERCHANGE CONTROL HEADER

| Loop | Segment | Description              | Language                                                                                                                                                                               | Page |
|------|---------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|      | ISA05   | Interchange ID Qualifier | Palmetto GBA may reject an interchange (transmission) that does not contain 28 in ISA05.                                                                                               | B.4  |
|      | ISA06   | Interchange Sender ID    | Palmetto GBA will reject an interchange (transmission) that does not contain a valid ID in ISA06.                                                                                      | B.4  |
|      | ISA07   | Interchange ID Qualifier | Palmetto GBA may reject an interchange (transmission) that does not contain 28 in ISA07.                                                                                               | B.4  |
|      | ISA08   | Interchange Receiver ID  | Palmetto GBA will reject an interchange (transmission) that does not contain the appropriate intermediary code (see page 2) in ISA08. Each individual contractor determines this code. | B.5  |

## FUNCTIONAL GROUP HEADER

| Loop  | Segment | Description                      | Language                                                                                                                                                                                                                                      | Page |
|-------|---------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|       |         |                                  | Palmetto GBA 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).                                                |      |
|       |         |                                  | Palmetto GBA will only process one transaction per functional group; a submitter may submit more than one ST-SE (Transaction Set) within a GS-GE (Functional Group).                                                                          |      |
|       | GS03    | Application Receiver's Code      | Palmetto GBA may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the intermediary definition.                                                                      | B.8  |
|       |         |                                  | Palmetto GBA will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.                                   |      |
|       | ST02    | Transaction Control Set          | Palmetto GBA will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.                                                                                        | 56   |
|       | BHT02   | Transaction Set Purpose Code     | Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).                                                                                                                                                                              | 58   |
|       | BHT06   | Claim/Encounter Identifier       | Palmetto GBA will accept and process transmissions with a Claim or Encounter Indicator (BHT06) of 'CH' (Chargeable). Palmetto GBA will accept but will ignore a Claim or Encounter Indicator (BHT06) if 'RP' (Reporting) during adjudication. | 59   |
|       | REF02   | Transmission Type Identification | The 837 Institutional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 will cause the file to be rejected.                                                          | 60   |
| 1000A | NM109   | Submitter ID                     | Palmetto GBA will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.                                                                       | 63   |
| 1000B | NM103   | Receiver Name                    | Palmetto GBA will reject an interchange (transmission) that is not submitted with a valid intermediary name (NM1).                                                                                                                            | 68   |

| Loop  | Segment      | Description                                   | Language                                                                                                                                                                          | Page       |
|-------|--------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 1000B | NM109        | Receiver Primary Identifier                   | Palmetto GBA will reject an interchange (transmission) that is not submitted with a valid intermediary code (NM1). Each individual contractor determines this code.               | 68         |
| 2000A | PRV          | Billing/Pay-To Provider Specialty Information | Providers shall be in compliance with CR 5243: Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims                                                  | Addenda 12 |
| 2000B | HL           | Subscriber Hierarchical Level                 | The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.                                                                        | 99         |
| 2000B | SBR02, SBR09 | Subscriber Information                        | For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). The Patient Hierarchical Level (2000C loop) is not used.                                     | 103        |
| 2300  | CLM02        | Total Submitted Charges                       | Negative values submitted in CLM02 may not be processed and may result in the claim being rejected.                                                                               | 159        |
| 2300  | CLM02        | Total Submitted Charges                       | Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV203).                                                                                       | 159        |
| 2300  | CLM20        | Delay Reason Code                             | Data submitted in CLM20 will not be used for processing.                                                                                                                          | 179        |
| 2300  | HI           | Health Care Diagnosis Code                    | 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 will be rejected. | 228        |
| 2410  | LIN03        | Drug Identification                           | The format for National Drug Codes (NDC) is 5-4-2 (11 positions with no dashes). Claims that contain NDC codes in any other format will be rejected.                              | Addenda 37 |

**997 – FUNCTIONAL ACKNOWLEDGEMENT**

| Loop | Segment | Description | Language                                                                                                                                                                                        | Page |
|------|---------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|      |         |             | 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 5 days after the file submission. | B.15 |
|      |         |             | Palmetto GBA will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.                                                              |      |

# ANSI ASC X12N 837 V4010A1

## PROFESSIONAL COMPANION DOCUMENT

### Overview

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 claim transactions. The implementation guides for each transaction are available electronically from the following Web site: [www.wpc-edi.com](http://www.wpc-edi.com).

The following information is intended to serve only as a companion document to the HIPAA X12N 837 implementation guides. 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 following Palmetto GBA systems:

| Line of Business                                              | Payer ID |
|---------------------------------------------------------------|----------|
| Railroad Medicare                                             | C00882   |
| Northern California Part B                                    | 01102    |
| Southern California Part B                                    | 01192    |
| Hawaii, American Samoa, Guam & Northern Mariana Island Part B | 01202    |
| Nevada Part B                                                 | 01302    |
| South Carolina Part B                                         | 11202    |
| Virginia Part B                                               | 11302    |
| West Virginia Part B                                          | 11402    |
| North Carolina Part B                                         | 11502    |

The information in this section is subject to change. Changes will be communicated in monthly news bulletins and on the Palmetto GBA Web site: [www.PalmettoGBA.com/Medicare](http://www.PalmettoGBA.com/Medicare).

Separate companion documents have been or will be issued for use with other HIPAA transaction standard IGs. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

### Supplemental Information

#### GENERAL STATEMENTS

| Language                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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.                                                                                                         |
| Claims that contain percentage amounts 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.                                                                       |
| Palmetto GBA 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. |
| 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.                                          |
| The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^,  , and :. Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.                                             |

| Language                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 may cause the interchange (transmission) to be rejected at the carrier translator. |
| Effective March 1, 2008, the National Provider Identifier (NPI) must be submitted in the primary loops.                                                                                                                                                                                                                                                                                                                                   |
| Effective May 23, 2008, the National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108=XX).                                                                                                                                                                                                                                                                                                                         |
| 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 <a href="http://www.wpc-edi.com/codes/taxonomy">www.wpc-edi.com/codes/taxonomy</a> . Claims submitted with invalid taxonomy codes will 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).                                                                                                                                                   |
| Palmetto GBA may reject an interchange (transmission) submitted with more than 9,999 loops.                                                                                                                                                                                                                                                                                                                                               |
| Palmetto GBA may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.                                                                                                                                                                                                                                                                                                               |
| Compression of files using PKZIP is supported for transmissions between the submitter and Palmetto GBA.                                                                                                                                                                                                                                                                                                                                   |
| 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 may cause the claim to be rejected.                                                                                                                                                                                                         |
| Palmetto GBA 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

| Loop | Segment | Description              | Language                                                                                                                                                                         | Page |
|------|---------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|      | ISA05   | Interchange ID Qualifier | Palmetto GBA may reject an interchange (transmission) that does not contain 27 in ISA05.                                                                                         | B.4  |
|      | ISA06   | Interchange Sender ID    | Palmetto GBA will reject an interchange (transmission) that does not contain a valid ID in ISA06.                                                                                | B.4  |
|      | ISA07   | Interchange ID Qualifier | Palmetto GBA may reject an interchange (transmission) that does not contain 27 in ISA07.                                                                                         | B.4  |
|      | ISA08   | Interchange Receiver ID  | Palmetto GBA may reject an interchange (transmission) that does not contain the appropriate carrier code (see page 2) in ISA08. Each individual Contractor determines this code. | B.5  |

## FUNCTIONAL GROUP HEADER

| Loop | Segment | Description                 | Language                                                                                                                                                                                       | Page |
|------|---------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|      |         |                             | Palmetto GBA 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). |      |
|      | GS03    | Application Receiver's Code | Palmetto GBA may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.                            | B.8  |

**TRANSACTION SET**

| Loop   | Segment      | Description                      | Language                                                                                                                                                                                                    | Page |
|--------|--------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|        |              |                                  | Palmetto GBA will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected. |      |
|        | ST02         | Transaction Control Set          | Palmetto GBA 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     | Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).                                                                                                                                            | 64   |
|        | BHT06        | Claim/Encounter Identifier       | Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).                                                                                                                                          | 65   |
|        | REF02        | Transmission Type Identification | The 837 Professional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 will cause the file to be rejected.                         | 66   |
| 1000A  | NM109        | Submitter ID                     | Palmetto GBA will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.                                     | 69   |
| 1000B  | NM109        | Receiver Primary Identifier      | Palmetto GBA will 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    | 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           | 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    | Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).                                                                                                            | 150  |

**CLAIM INFORMATION**

| Loop | Segment | Description                      | Language                                                                                                                    | Page |
|------|---------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------|
| 2300 | CLM02   | Total Submitted Charges          | Negative values submitted in CLM02 will not be processed and will result in the claim being rejected.                       | 172  |
| 2300 | CLM02   | Total Submitted Charges          | Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).                                 | 172  |
| 2300 | CLM05-3 | Claim Frequency Type Code        | The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" may be rejected.                     | 173  |
| 2300 | CLM20   | Delay Reason Code                | Data submitted in CLM20 will not be used for processing.                                                                    | 179  |
| 2300 | PWK     | Claim Supplemental Information   | Any data submitted in the PWK (Paperwork) segment may not be considered for processing.                                     | 214  |
| 2300 | AMT01   | Credit/Debit Card Maximum Amount | Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).                            | 219  |
| 2300 | AMT02   | Patient Amount Paid              | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02. | 220  |
| 2300 | AMT02   | Total Purchased Service Amount   | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02. | 221  |

| Loop | Segment      | Description                             | Language                                                                                                                                                                                                                         | Page     |
|------|--------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| 2300 | REF02        | Prior Authorization and Referral Number | 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         | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: CR102, CR106.                                                                                               | 249, 250 |
| 2300 | HI           | Health Care Diagnosis Code              | 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              | 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              | You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes may not be considered in processing.                                                                                                  | 265      |
| 2320 | AMT02        | Coordination of Benefits Amounts        | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02.                                                                                                      | 332, 333 |
| 2400 | SV102        | Line Item Charge Amount                 | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: SV102.                                                                                                      | 402      |
| 2400 | SV104        | Professional Service                    | Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104)                                                                            | 403      |
| 2400 | SV104        | Professional Service                    | 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                    | 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                    | SV104 (Service unit counts) (units or minutes) cannot exceed 999.9.                                                                                                                                                              | 403      |
| 2400 | SV104        | Professional Service                    | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: SV104                                                                                                       | 403      |
| 2400 | CR102, CR106 | Ambulance Transport Information         | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: CR102, CR106.                                                                                               | 413, 414 |
| 2400 | PS1          | Purchased Service                       | 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. | 489      |
| 2400 | PS102        | Purchased Service                       | Negative values submitted in the following fields will not be processed and will result in the claim being rejected: PS102                                                                                                       | 490      |
| 2410 | CTP04        | Professional Service                    | 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**

| Loop | Segment | Description | Language                                                                                                                                                                                           | Page |
|------|---------|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
|      |         |             | 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. | B.15 |
|      |         |             | Palmetto GBA will return the version of the 837 inbound transaction in GS08 (Version/Release/ Industry Identifier Code) of the 997.                                                                |      |