Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-026 **Date: FEBRUARY 21, 2003**

CHANGE REQUEST 2385

SUBJECT: Implementation of the Modifications (4010A1) to Transactions and Code Set Standards for Electronic Transactions Adopted Under the Health Insurance Portability and Accountability Act (HIPAA)

This Program Memorandum (PM) provides carriers, durable medical equipment regional carriers (DMERCs), intermediaries, and their standard systems instructions regarding the implementation of the modifications to certain standards adopted in the regulations entitled "Health Insurance Reform: Standards for Electronic Transactions" published in the **Federal Register** on August 17, 2000 (65 FR 50312). Part 162 of title 45 of the Code of Federal Regulations adopted modifications to the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837 Health Care Claim (version 4010), X12N 835 Health Care Claim Payment/Advice (version 4010), X12N 270/271 Health Care Eligibility Benefit Inquiry and Response (version 4010), X12N 276/277 Health Care Claim Status Request and Response (version 4010) and the National Council for Prescription Drug Program (NCPDP) format. These modifications are effective 180 days after the effective date of the final rule. Instructions for DMERCs, regarding the X12N 278 Health Care Services Review-Request for Review and Response (version 4010) will be provided in a separate PM.

X12N Addenda Documentation

The Designated Standards Maintenance Organizations (DSMOs) developed a "fast track" process to address the changes to the X12N 4010 implementation guides that are required within the first year for compliance reasons. The DSMOs only considered changes that were necessary for compliance in the strictest sense of the word. All other change requests will be addressed as part of the regular DSMO process. The DSMOs categorized the change requests into three categories:

Changes necessary for industry compliance during the first 12 months;
Changes that are not necessary for compliance during the first 12 months; and
Changes that are maintenance to the implementation guides.

As part of the "fast track" process, the DSMOs reviewed all change requests received as of March 1, 2001, and categorized the requests within one month. The DSMOs came to agreement on what will be included in the addenda and what will be modifications for the regular DSMO process. The addenda were posted to the Washington Publishing Company (WPC) Web site (see below). The DSMOs presented the consolidated list of approved changes to the National Committee on Vital and Health Statistics (NCVHS). The NCVHS approved the DSMO recommendations in June.

A Notice of Proposed Rule Making (NPRM) was published on May 31, 2002. The DSMOs reviewed the technical comments received and made recommendations to X12N, who in turn, through their due process, reviewed the recommendations and incorporated changes into a revised addendum. X12N posted the revised draft versions of the addenda on the WPC Web site for public comment in August 2002.

The changes that you are to implement are described in the attachment to this PM. The changes apply to the following transactions:

X12N 837 Professional and Institutional
X12N 835 Remittance Advice
X12N 270/271 Eligibility Inquiry/Response
X12N 276/277 Claim Status Inquiry/Response
NCPDP

The final updated Designated Standards Maintenance Organizations (DSMO) addenda pages may be found at http://hipaa.wpc-edi.com/HIPAAAddenda_40.asp

Programming

Your standard system maintainers must make the necessary programming changes and install the changes for the transactions mentioned above, by April 1, 2003. The carrier and DMERC standard system maintainer will be responsible for applying the appropriate implementation guide (IG) edits based on the version of the transaction. The Fiscal Intermediaries (FIs) are responsible for the 837 IG edits and their standard systems are responsible for the 276 IG edits. Your translators will need to be modified accordingly.

- X12N 837

  The X12N-based professional claim flat file, available at http://cms.hhs.gov/providers/edi/hipaadoc.asp will be updated to reflect the IG changes no later than November 29, 2002. The updated flat file will be used for both 4010 and 4010A1 transactions. All loops/segments/elements that are being deleted by the addenda (4010A1) will remain in the flat file. All loops/segments/elements that were added by the addenda will be added to the same flat file. The name of the flat file will be P4010A1-1.zip.

  The institutional claim flat file is being redesigned by the Part A standard systems to include the addenda, and to improve the efficiency of the format in terms of space utilization, speed, and overall usability. The redesigned claim flat file will be available on or about December 20, 2002. The current 4010 flat file will continue to be used for 837 4010 transactions until October 16, 2003. The 4010A1 flat file will be used for 4010A1 837 transactions. The name of the redesigned flat file will be I4010A1-1.zip.

- X12N 835

  The X12N-based remittance flat file, is available at http://cms.hhs.gov/providers/edi/hipaadoc.asp. The Part A file name is A835v4010&4010A1-1.zip. The Part B file name is B835v4010&4010A1-1.zip. The updated flat files will be used for both 4010 and 4010A1 transactions.

- X12N 270/271

  The only changes to the 270/271 are the addition of a few codes values and deletion of one code value. The CWF maintainer (CWFM) will upgrade the software, effective with their April 1, 2003 release, that will translate the 270 into the HUQA inquiry, and the HUQA response into the 271 to accept/send the new codes values in version 4010A1. The initial release of the software will support version 4010. Changes are not required by you or your standard system maintainer.

- X12N 276/277

  Your standard system has made changes to the CMS suggested flat files to accommodate your systems capabilities and user preferences (within the overriding design parameter of HIPAA compliance). The 276/277 claim status/response flat file will be available at http://cms.hhs.gov/providers/edi/hipaadoc.asp no later than November 29, 2002. The updated flat files will be used for 4010A1 transactions. The names of the flat files and changes are as follows (the addenda changes are listed in the attachment):

  1) 276277A-A1.zip – This is the flat file agreed to by Part A standard systems and their users for claim status on institutional claims. The inquiry and response are combined. The major changes to the original flat file include a reduction from 42 record types per file to 12 record types per file, the orientation of the document from picture to landscape, this was done to include some additional information i.e. 277 IG Edits, 277 Valid Values columns. The key on the original combined file was 18 bytes and unknown as to what it was to include, thus changed to assisted in processing to be 56 bytes, the record identifier was the segment identifier, this was changed to be a record number, the length was changed from variable to fixed of 350 bytes. The original combined file included all data elements within a segment even if they were identified as 'not used', the new file excluded any 'not used' data elements. In previous HIPAA 837 and 835 flat file development some of the data elements size were limited by the size of the valid values available for the data element. Other fields that were limited were the communication numbers from 80 to 40 or 20, qualifiers, identification numbers based on the qualifiers. A lot of the same criteria that was applied to the 837 flat file was applied to the 276 277 flat file. This file also includes the addenda changes.

  2) 276277B-A1.zip - This is the flat file agreed to by Part B standard systems and their users for claim status on professional claims. Inquiry and response are separated. This file also includes the addenda changes.

- NCPDP

  Details on any NCPDP revisions will be included in a future PM.

Testing and Version Support

- 837 Claim Transaction

  You must begin to set up test schedules to test your EDI claim submitters on the inbound 837 version 4010A1 beginning April 1, 2003. In order that all tests are completed by October 16, 2003, you are to encourage your EDI submitters to begin testing as early as possible. If a health care provider, billing service, or clearinghouse submits transactions directly to several contractors, they are still required to perform, at a minimum, compatibility testing with each contractor on each standard system with whom they exchange electronic transactions to ensure communication protocols and volume considerations unique to each contractor are tested. They must notify you of the contractor with whom they have successfully tested.

  As previously stated in CR1704, those EDI submitters that tested the inbound (version 4010A1) X12N 837 with a certification system are to provide you with either a certificate of compliance that specifies the different levels of testing passed or provide you with a certification Web site that indicates they have successfully passed certification testing. If you believe the testing with the certification system is adequate, those EDI submitters that have been certified at levels 1 through 2, do not need to test with you.

EDI submitters that have successfully tested with the 837 version 4010 do not need to be retested on 4010A1 unless they request retesting. However, it is your option if you want to retest each EDI submitter on 4010A1.

Until further notice, all CMS contractors should continue to accept claims sent on non-4010 formats regardless of whether a provider has submitted an ASCA extension form to CMS on or before October 16, 2002. If a contractor is aware that it is currently accepting claims produced by a particular vender's pre-4010 software, then it should continue to accept such pre-4010 claims from new submitters using that software.

New submitters not using a current, Medicare approved billing service (approved by the contractor with which the submitter does business), clearinghouse, or software, who request to begin sending inbound EDI claim transactions should be encouraged to use the 4010 formats. However, you may allow them to send pre-4010 transactions if you believe the Medicare program's best interest is served by allowing them to begin electronically using these formats. If you are not able to produce a 4010/4010A1 COB file or 835, then you have the discretion to allow a new submitter to use a pre-4010 format.

- 835, 837 COB, and 276/277 Transactions

  You do not need to retest receivers that have successfully passed testing on the 4010 version of the 835 and 837 coordination of benefits (COB) unless they request retesting. Depending on your business situation with your COB trading partner, you may hold them in test instead of placing them in production until you are ready to place them in production on version 4010A1, but no later than October 16, 2003.

  You must set up test schedules for requesting EDI submitters/receivers and begin to test them on the 276/277 using version 4010A1 beginning April 1, 2003. You do not need to test and implement the 276/277, version 4010, as previously instructed.

The CMS assumes that all contractors will have some trading partners in production with version 4010 of the 837, 835 and 837 COB by April 1, 2003. Therefore, you will need to support versions 4010 and 4010A1 for those transactions during the transition period which ends October 16, 2003. Support of version 4010 may end earlier if you have transitioned all of your trading partners that are in production with 4010 over to 4010A1. You must schedule the transitioning of your trading partners who are in production with version 4010 to version 4010A1 beginning April 1, 2003. If you do not have trading partners in production using 4010, you have the option to only support version 4010A1.

Free Billing Software

You are to upgrade your free billing software to support all changes that are required for X12N 837 4010A1. You must have the software available to requesting providers no later than April 1, 2003. You do not need to support both versions (4010 and 4010A) of the software. Those providers using the version 4010 software must switch over to version 4010A1 beginning April 1, 2003. If you mass distribute your software, it is your option to continue to distribute your version 4010 software until April 1, 2003 or to wait and upgrade the version 4010 to 4010A1 and distribute the revised version (4010A1) by April 1, 2003. If you supply the 4010 software you must notify your submitters that they must update to 4010A1.

Outreach

You must notify your EDI trading partners of all of the factors discussed in this PM on your next scheduled bulletin, as well as the following:

- Medicare will be ready to begin to schedule testing and transitioning of EDI trading partners on version 4010A1 by April 1, 2003;

- Medicare plans to switch to exclusive use of the version 4010A1 by October 16, 2003;
- Each provider must submit all of their electronic claims, claim status inquiry, and eligibility inquiry in compliance with the requirements in the X12N 837 version 4010A1, by October 16, 2003;
- Each trading partner that has elected to exchange COB, remittance, claim status response, and eligibility response electronically must accept version 4010A1 by October 16, 2003;
- The addenda pages may be found at http://hipaa.wpc-edi.com/HIPAAAddenda_40.asp

Cost Issues

The FY 2003 Budget and Performance Requirements specify that you include one transaction version upgrade per year in your line one maintenance costs for the claim, COB, 835 and intermediary 270/271 formats. However, you are entitled to non-routine cost reimbursement related to HIPAA for supplemental costs for translator mapping to the revised X12N-based flat files that support version 4010A1, upgrading your free billing software, provider notification on the changes in versions and transition to 4010A1, retesting by providers, their agents, clearinghouses, and trading partners for these HIPAA transactions, and costs related to a 276/277 and intermediary 270/271 upgrade in FY 2003. You should submit Supplemental Budget Requests (SBRs) for incremental permitted costs as soon as possible, but no later than December 13, 2002.

Your SBR must itemize your incremental costs for the addenda changes ***by transaction*** according to the following categories:

- Any necessary hardware costs;
- Any necessary software costs;
- Release testing costs;
- Submitter testing costs (that were not included in a prior request for FY 2003 submitter testing funds);
- Anticipated number of submitters;
- Share of data center costs;
- Staff training costs;
- Any subcontracting costs; identify the activity being subcontracted;
- Other costs not included in one of the above categories. Itemize to identify the reason for expenses in this other category and the amount for each type of other expense; and
- Total funding requested.

Do not include provider outreach costs in these estimates. Limit these costs to incremental direct costs of implementation of the requirements contained in this PM.

HBPSS Standard System

The HPBSS standard system and associated carriers are waived from implementing this PM due to their upcoming transition to the MCS system.

The *effective date and implementation date* for this PM is April 1, 2003.

This PM may be discarded after October 16, 2004.

If you have any questions, contact Joy Glass on 410-786-6125 or jglass@cms.hhs.gov.

ATTACHMENT

X12N 837 (Inbound/Outbound) Professional IG Addenda Items

Original IG Page	Description of Change	Shared System Action
66	The value of REF02 is changed to "004010X098DA1" for pilot mode and "004010X098A1" for production mode.	Translator and IG edits must be modified to accept the new values for 4010A1 claims. Flat File Update.
70, 76, 87, 102, 120, 133, 142, 149, 160, 287, 295, 306, 315, 353, 362, 506, 517, 526, 532 & 546	All N2 segments used to report additional name data were removed.	IG edits are to be modified to reject if N2 is present on 4010A1 claims.
79	The provider specialty segment requirement has been modified to include two requirements that must be met if the information is sent.	Do not need to send on COB, if not present on 4010A1 claims.
115 & 155	Data element PAT05 requirement has been modified to state if data is available to the provider.	No action required.
115 & 156	Data element PAT06 requirement has been modified to include two requirements that must be met if the information is sent. PAT08 note changed. The "GR" (grams) qualifier in the PAT07 data element is replaced by qualifier "01" (pounds).	IG edits must be modified to accept only the new qualifier for 4010A1 claims. Flat file update.
116 & 156	Data element PAT09 note modified.	No action required.
119	Data element NM109 subscriber identifier requirement has been modified to be required if patient is the subscriber, or if not, only send if identifier is know.	No action required.
128 & 168	Property and Casualty Claim Number requirement revised to state not required for HIPAA.	No action required.
173	CLM05-3 data element note and codes were removed.	IG edits must be modified to accept codes from the code source for 4010A1 claims. Flat file update.
176	Data element CLM11-1, 2 and 3: code "AB" (abuse) was removed.	IG edits must be modified to reject if "AB" is present on 4010A1 claims. Flat file update

178	Note added to data element CLM12 code values to require certain codes for Medicaid.	No action required.
180, 184 & 199	Segments for order date, referral date and estimated birth date were removed.	IG edits are to be modified to reject if these dates are present on 4010A1 claims.
182	Replaced note 2.	No action required.
186	Note changed.	No action required.
201 & 203	Disability begin and end dates revised to state not required for HIPAA.	No action required.
220	Clarified Note 1, removed Note 3.	No action required.
221	Expanded requirement to for reporting the amount for vision claims.	No action required.
226	Changed requirement to eliminate Medicare specific requirement and to indicate that the segment is required when a certified mammography provider renders the service.	No action required.
251 & 252	Changed note to state required for chiropractic claims and known to impact payer's adjudication system. CR201 through 207 and 209 are changed to not used.	Translators will not map these to the flat file for 4010A1. Flat file update.
	New segmented added CRC - EPSDT	IG edits are to be developed to accept the segment on 4010A1 claims and place on store and forward, if present on inbound 4010A1 claim. IG edits modified to reject is present on 4010 claims. Flat file update.
256	CR212 changed to situational. Note changed.	IG edits need to be modified for 4010A1 claims. Flat file update.
260	Note Changed.	No action required.
285	Referring provider specialty note changed to state it is required if adjudication is known to be impacted.	Do not need to send on COB, if not present on 4010A1 claims.
293	Rendering provider specialty requirement changed from "required" to situational" and a note added to state it is required if adjudication is known to be impacted	IG edits are to be modified to not reject if data is not present on 4010A1 claims. Flat file update.
299	Purchased service provider name data element NM103 usage changed from "not used" to "required". NM104 and NM105 usage changed from "not used' to "situational" . Note added to state required if NM102 is a person.	IG edits are to be modified to reject if name is not present on 4010A1 claims when NM102 = 1. IG edits need to be developed to edit NM104 and NM105 for 4010A1 claims. Flat file update.
375, 379, 383, 387, 391, & 395	NM103 (other payer) usage changed to "not used".	IG edits are to be modified to reject if NM103 is present on 4010A1 claims.

401	Note added to the data element SV101-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, N3, N4 were removed.	IG edits are modified to reject if N1, N2, N3 & N4 are on 4010A1 claims. Flat file update.
406	Data element SV109 usage changed from "required" to "situational". Note added that element is required if the service is known to be an emergency by the provider. Definition of emergency added. Code value 'N' (no) was removed.	IG edits are to be modified to not reject if data is not present on 4010A1 claims. IG edits to be modified to reject if "N" is present in SV109 for 4010A1 claims. Flat file update.
408	Segment SV4 was removed.	IG edits are to be developed to reject if SV4 is present on 4010A1 claims. Flat file update.
	Segment SV5 added.	IG edits are to be developed to reject if SV5 is present on 4010 claims and to accept the SV5 segment and related data elements for 4010A1 claims. Flat file update.
415	Replaced note to state required on chiro and known to impact payer's adjudication system.	No action required.
416, 417, 418 & 419	Usage for the following elements is changed from "required to "not used": CR201, CR202, CR203, CR204, CR205, CR206, CR207, and CR209.	Translators will not map these to the flat file for 4010A1. Flat file update.
420	CR212 usage changed from "required" to "situational". Note added "Required for service dates prior to January 1, 2000".	IG edits are to be modified to not reject if data is not present for services after 1/1/2000 for 4010A1 claims. Flat file update.
439 & 444	Referral and Order Date segments were deleted.	IG edits to be modified to reject if these dates are present on 4010A1 claims.
445	Date last seen note changed.	No action required.
447	Date of Test note changed.	No action required.
458	Date Initial Treatment note 1 changed.	No action required.
462	Segment QTY was removed.	IG edits are to be developed to reject if the QTY segment is on 4010A1 claims.
464	Replaced note #1 on MEA segment to clarify the proper usage for dialysis claims and what qualifiers are valid. Added notes #2 and 3, which clarify the proper usage for oxygen therapy and what qualifiers are valid. Added note #4, which clarifies the proper usage for DMERC claims and what qualifiers are valid.	No action required.
465	Deleted qualifier "CON" in MEA02. Note changed for MEA03.	IG edits are to be modified to reject if qualifier "CON" is present on 4010A1 claims. Flat file update.

474	Note replaced to eliminate specific Medicare requirement and to indicate that segment is required when a certified mammography provider renders the service.	No action required.
489	Replaced note #2, which specifies that the segment is required when purchased service charge amounts are necessary for processing. Added note #3 that clarifies segment is used on vision claims.	No action required.
	New loop added, 2410 (Drug Identification). New segments added to loop are LIN (Drug Identification), CTP (Drug Pricing), and REF (Prescription Number).	IG edits to be developed to edit segments and data elements if the loop is present on 4010A1 claims and move to store and forward repository for COB. IG edits modified to reject if loop is presents on 4010 claims. Flat file update.
504	Rendering provider specialist usage changed from "required" to "situational" and note added to provide the specialty information if adjudication is known to be impacted.	Do not need to send on COB, if not present on 4010A1 claims.
555 & 556	Note added to the data element SVD03-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, N3, N4 were removed.	IG edits are modified to reject if N1, N2, N3 & N4 are on 4010A1 claims. Flat file update.
557	Industry name and Alias replaced for SVD06 to read "Bundled Line Number" for both. Note replaced to reflect new Industry Name and Alias.	No action required.
A.6	Added new note in A.1.3.1.2 to limit decimal data elements in DE 782 (monetary) to 10 characters.	No action required.
B.8	Replaced example for GS segment.	No action required.
B.9	Code value in GS08 was changed to "004010X098A1" to reflect new addendum version.	Translator and IG edits must be modified to accept and send the new value for 4010A1 claims. Flat file update.

X12N 837 Institutional IG Addenda Items

Original IG Page	Description of Change	Shared System/FI Action
60	The value of REF02 is changed to "004010X096DA1" for pilot mode and "004010X096A1" for production mode.	Translator and IG edits must be modified to accept the new values. Flat file update.
71	The provider specialty segment requirement has been modified to include two requirements that must be met if the information is sent.	No action required. Medicare does not use this information for claims processing.
106	2000B PAT segment was removed.	IG edits are to be removed. Flat file update.
144	The usage of data elements PAT07, PAT08, and PAT09 was changed from SITUATIONAL to NOT USED.	IG edits are to be removed. Flat file update.
119 & 155	Property and Casualty Number requirement revised to state not required for HIPAA.	ID edits may be removed. Data does not need to be stored and forwarded for COB. Flat file update.
161	The usage of data composite CLM11 was changed from SITUATIONAL to NOT USED.	IG edits are to be removed. Flat file update.
163	The usage of data element CLM12 was changed from SITUATIONAL to NOT USED.	IG edits are to be removed. Flat file must be updated.
189	Documentation Identification Code repeat was changed from 1 to 2. Note added for REF02.	IG edits are to be updated. Flat file update.
210	Home Health note changed to require when applicable.	No action required.
227	Principal, admitting, e-code and patient reason for visit diagnosis information requirement changed from "required" to "situational" and note added to clarify when required.	IG edits are to be modified to not reject if data is not present. IG edits are also to be modified to meet 'when required' criteria.
321	2310A Attending physician NM1 note changed.	No action required (note corrects a typo).
324	2310A Attending physician specialty note added to state it is required if adjudication is known to be impacted.	No action required.
328	2310B Operating physician NM1 note changed.	No action required (note corrects a typo).
331	2310B Operating physician specialty information (PRV) was removed.	IG edits are to be updated. Flat file update.
335	2310C Other provider NM1 notes changed.	Note 1 corrects a typo (No action required). Note 3 provides clarification (IG edits are to be updated). Note 4 is removed (IG edits are to be updated).
338	2310C Other provider specialty information (PRV) was removed.	IG edits are to be updated. Flat file update.
342 - 348	Data segments for referring provider information were removed.	IG edits are to be removed. Flat file update.
352	Service facility specialty information (PRV) was removed.	IG edits are to be removed. Flat file update.
436 - 439	Data segments for other payer referring provider information were removed.	IG edits are to be removed. Flat file update.
446 - 447	Note added to the data element SV202-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, N3, and N4. were removed. NDC information was moved to the	IG edits are to be removed/modified. Flat file update.

	LIN segment. New note added to state HCPCS are required for outpatient claims and reported only when an appropriate code exists for that service.	
450	Segment SV4 was removed.	IG edits are to be removed. Flat file update.
456	Service line date note added to state that it is not used if Assessment date is used.	IG edits are to be modified to reflect note requirement.
458	Assessment date note added to state that it is not used if Service line date is used.	IG edits are to be modified to reflect note requirement.
	New loop added, 2410 (Drug Identification). New segments added to loop are LIN (Drug Identification), CTP (Drug Pricing), and REF (Prescription Number). The LIN segment will house the NDC.	IG edits to be developed to edit segments and data elements if the loop is present and move to store and forward repository for COB. Flat file update.
462	Attending physician name note added to state that it is required if adjudication is known to be impacted.	No action required.
465	2420A Attending physician specialty information (PRV) was removed.	IG edits are to be removed. Flat file update.
469	Operating physician name note changed to state it is required if adjudication is known to be impacted.	No action required.
472	2420B Operating physician specialty information (PRV) was removed.	IG edits are to be removed. Flat file update.
476	Other provider name note changed to state that it is required if adjudication is known to be impacted.	No action required.
479	2420C Other provider specialty information (PRV) was removed.	IG edits are to be removed. Flat file update.
483 - 489	Data segments for referring provider information were removed.	IG edits are to be removed. Flat file update.
491	Note added to the data element SVD03-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, N3, and N4 were removed. NDC information was moved to the LIN segment.	IG edits are to be removed. Flat file update.
	New segment HCP (Line Pricing/Repricing Information).	IG edits to be developed to edit segments and data elements if the segment is present and move to store and forward repository for COB. Flat file update.

A.6	Added new note in A.1.3.1.2 to limit decimal data elements in DE 782 (monetary) to 10 characters.	No action required.
B.8	Replaced example for GS segment.	No action required.
B.9	Code value in GS08 was changed to "004010X096A1" to reflect new addendum version.	Translator and IG edits must be modified to accept and send the new value. Flat file update.

X12N 276 IG DSMO Addenda Items

Original IG Page	Description of Change	Shared System/FI Action
74	Loop repeat changed to "1"	IG edits must be modified to accept 1 repeat.
77	Claim submitter trace number usage change to "situational"	IG edits to be modified to not reject if data is not present.
78, 80, & 82	Note 3 & 4 added. The REF in 2200 cannot exceed 3.	IG edits are to be modified to reject if more than 3 REF occurs in loop 2200.
103	Note 1 changed to state use only if patient is other than the subscriber. Note 4 added to state the REF in 2200 cannot exceed 3.	IG edits modified to reject if more than 3 REFs occur in loop 2200.
	New REF segment added to report the group number	IG edits are to be added to accept and edit the new segment.
98	Loop repeat changed to "1"	IG edits must be modified to accept 1 repeat.
103	Note changed	No action required.

X12N 277 IG DSMO Addenda Items

Original IG Page	Description of Change	Shared System/FI Action
148	Subscriber demographic information changed from required to situational. New note added.	No action required.
150	Loop repeat changed to "1".	No action required.
153	Claim submitter trace number usage changed to situational.	No action required.
165, 167 &169	Note 3 added. The REF in 2200 cannot exceed 3.	IG edits are to be modified to send up to 3 REF in loop 2200.
194	Dependent Name loop repeat changed to "1".	No action required.
103	Note changed	No action required.
A.6	Added new note in A.1.3.1.2 to limit decimal data elements in DE 782 (monetary) to 10 characters.	No action required.
B.8	Replaced example for GS segment.	No action required.

B.9	Code value in GS08 was changed to "004010X093A1" to reflect new addendum version.	Translator and standard system edits must be modified to send the new value.

X12N 270 IG DSMO Addenda Items

Original IG Page	Description of Change	Shared System/FI Action
52	Added new code value "XV" for Plan ID (NM108)	IG edits must be modified to accept code value.
96 & 138	Added new code value and N4 (NDC). Deleted code value ND.	IG edits to be modified to accept new code value and reject "ND" if present.

X12N 271 IG DSMO Addenda Items

197	Added new code value "CT" to REF01.	No action required.
231 & 308	Added new code value IV and N4 (NDC). Deleted code value ND.	No action required.
262 & 338	Added two new code values to PRV01.	No action required.
275	Added two new code values to REF01.	No action required.
A.6	Added new note in A.1.3.1.2 to limit decimal data elements in DE 782 (monetary) to 10 characters.	No action required.
B.8	Replaced example for GS segment.	No action required.
B.9	Code value in GS08 was changed to "004010X092A1" to reflect new addendum version.	Edits must be changed to send the new value.

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63	Changed note in N103 to state required if the NPI is transmitted in N104 and required if it is mandated.	No action required.
140 & 143	Added new code value IV. Deleted code values N1, N2, N3 an ND.	No action required.
166	Added new code value "AH" to PLB03-1.	No action required.
A.6	Added new note in A.1.3.1.2 to limit decimal data elements in DE 782 (monetary) to 10 characters.	No action required.
B.8	Replaced example for GS segment.	No action required.
B.9	Code value in GS08 was changed to "004010X091A1" to reflect new addendum version.	Translator and standard system edits must be modified to send the new value.