CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 238 **Date: JULY 23, 2004**

CHANGE REQUEST 3321

I. SUMMARY OF CHANGES: This transmittal includes instructions for Intermediary shared systems maintainers to make necessary changes to implement the HIPAA X12N institutional 837 transaction.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005
***IMPLEMENTATION DATE: January 3, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	24/40/7.1 - X12N 837 Institutional Implementation Guide (IG) Edits

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Change Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 238	Date: July 23, 2004	Change Request 3321

SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Institutional Health Care Claim Implementation Guide (IG) Additional Updates

I. GENERAL INFORMATION

A. Background: This instruction contains additional claim edits that were not contained in Pub. 100-4, Transmittals 107 (CR 3031), 175 (CR 3264), or 199 (CR 3337).

B. Policy: The CMS is committed to implementing the institutional 837 per the HIPAA IG.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article's release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3321.1	Contractors shall edit outpatient (as defined in Pub. 100-4 Transmittal 107 – CR 3031) claims submitted via direct data entry (DDE) to ensure each outpatient claim contains a line item date of service (LIDOS) for each revenue code.	FI Shared systems maintainer
3321.2	Any claims in requirement 1 not containing a LIDOS for each revenue code shall be subject to an appropriate on-line error message.	FI Shared systems maintainer
3321.3	Contractors shall edit outpatient claims submitted via DDE to ensure all occurrences of the data element do not contain Covered Days.	FI Shared systems maintainer
3321.4	Any claims in requirement 3 containing covered days shall be subject to an appropriate on-line error message.	FI Shared systems maintainer
3321.5	Contractors shall edit all claims submitted via DDE to ensure each does not contain a NPP000 UPIN.	FI Shared systems maintainer
3321.6	Any claims in requirement 5 containing a NPP000 UPIN shall be subject to an appropriate on-line error message.	FI Shared systems maintainers
3321.7	Contractors shall edit all claims submitted via DDE to ensure all occurrences of the data	FI Shared systems maintainers

	element do not contain an invalid condition code (a condition code not listed in the external code source referenced by the HIPAA 837 institutional IG).	
3321.8	Any claims in requirement 7 containing an invalid condition code shall be subject to an appropriate on-line error message.	FI Shared systems maintainers
3321.9	Contractors shall edit all HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid condition code.	FI Shared systems maintainers
3321.10	Any claims in requirement 9 containing an invalid condition code shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.	FI Shared systems maintainers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov 410-786-7488 **Post-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov 410-786-7488	**These instructions should be implemented within your current operating budget.**

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 238, 07-23-04, Issued 07-23-04, Effective: January 1, 2005, Implementation: January 3, 2005)

The FI shared system *shall* edit (via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims, TOBs 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims to ensure each contains a line item date of service (LIDOS) for each revenue code. Outpatient claims not containing a LIDOS for each revenue code shall be rejected from the flat file with an appropriate error message.

The FI shared system shall edit outpatient claims submitted via direct data entry (DDE) to ensure each contains a LIDOS for each revenue code. Any outpatient claims found without a LIDOS for each revenue code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. These claims containing an ICD-9 procedure shall be rejected by the shared system with an appropriate error message before the flat file is received by the shared system.

The FI shared system *shall* edit all outpatient claims to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a “ZZ” qualifier are accepted (not just HIPPS skilled nursing facility rate codes).

The FI shared system *shall* edit all outpatient claims to ensure each does not contain Covered Days (QTY Segment). Outpatient claims containing Covered Days shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit outpatient claims submitted via DDE to ensure all occurrences of the data element do not contain Covered Days. Any outpatient claims submitted via DDE containing Covered Days shall be subject to an appropriate on-line error message.

The FI shared system *shall* edit all claims to ensure each does not contain a NPP000 UPIN. Claims containing a NPP000 UPIN shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure each does not contain a NPP000 UPIN. Any claims submitted via DDE containing a NPP000 UPIN shall be subject to an appropriate on-line error message.

For the outbound X12N 837 HIPAA COB transaction, the FI shared system *shall* edit all claims to ensure each containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system *shall* edit all claims to ensure each does not contain an invalid E-code. Claims containing an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any *claims* found *containing an invalid E-code* shall be subject *to an appropriate on-line error message.*

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), *an invalid condition code (a condition code not listed in the external code source referenced by the HIPAA 837 institutional IG),* an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid E-code, *condition code,* value code, diagnosis code, occurrence code, or occurrence span code shall be subject *to an appropriate on-line error message.*

The FI shared system shall edit outpatient claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any *outpatient claim* found *containing an ICD-9 procedure code* shall be subject *to an appropriate on-line error message.*

The FI shared system shall edit outpatient HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid E-code, *condition code,* value code, occurrence code, or occurrence span code. These shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs and FI shared system, as contractor-controlled table data, rather than hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. The HPTCs are scheduled for update 2 times per year (tentatively October and April).

That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Use the most cost effective means to obtain the list for validation programming and updating purposes.

The FIs and FI shared system *shall* edit all claims to ensure that HPTCs that have been submitted comply with both the data attributes for the data element as contained in the HIPAA 837 institutional IG, and are contained in the approved list of HPTCs. HPTCs are not required data elements. Claims received with invalid HPTCs shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system *shall* edit all outpatient claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code. Outpatient claims containing an invalid "Patient Reason for Visit" code (a "Patient Reason for Visit" code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound HIPAA X12N 837 COB transaction, the FI shared system shall ensure a "ZZ" qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present on an outpatient claim.

For bill types 12X and 22X, FIs and FI shared system *shall* be responsible for editing to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.

For bill types 12X and 22X, the FI shared system *shall* edit to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via DDE (these are already required for other inpatient bill types). Claims not containing this data shall be subject to an appropriate on-line error message.