CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 162 **Date: April 30, 2004**

CHANGE REQUEST 3180

I. SUMMARY OF CHANGES: Medicare carriers and Durable Medical Equipment Regional Carriers (DMERCs) use the National Standard Format (NSF) as the output format for paper claims received from key shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR). CMS will cease support of the NSF once the Health Insurance Portability and Accountability Act (HIPAA) contingency plan ends. At that time the X12N-based flat file will be the only output accepted by the shared systems for these claims. Item G is deleted from section 70.2.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

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/ Table of Contents -
N	24/30.7/ Claim Key Shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR) Mapping to X12N Based Flat File
R	24/70.2/ Carrier/DMERC Requirements

***III. FUNDING:** Contractors shall submit funding requests for any costs incurred in the implementation of this change request. They are to provide a detailed explanation for each task for which they are requesting additional funding. They shall submit any funding requests to Sumita Sen (SSEN@cms.hhs.gov) within 3 weeks after the release of this CR with an e-mail copy to their applicable Consortium Contractor Management Staff coordinator.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 162	Date: April 30, 2004	Change Request 3180

SUBJECT: Key Shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR) Output Mapping

I. GENERAL INFORMATION

A. Background: Medicare carriers and Durable Medical Equipment Regional Carriers (DMERCs) use the National Standard Format (NSF) as the output format for paper claims received from key shop and OCR/ICR operations.

NOTE: Carrier/DMERC preliminary work with their outsourced or internal key shop and OCR/ICR operations shall begin upon receipt of this Change Request (CR). This work involves communicating any of the requirements that apply to either their outsourced key shop and OCR/ICR operations or internal key shop and OCR/ICR operations. This may include providing mapping documentation, and any other information, as they deem appropriate.

B. Policy: CMS will cease support of the NSF once the Health Insurance Portability and Accountability Act (HIPAA) contingency plan ends. Therefore, the X12N-based flat file will be the only output format accepted by the shared systems for these claims.

C. Provider Education: None

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3180.1	Carriers and DMERCs shall communicate to their key shop and OCR/ICR operations, that do not use the HIPAA 837 or X12N-based flat file as output, one of the following: 1. They shall create the output from paper claims in the X12N-based flat file format or the HIPAA 837. When creating the X12N-based flat file, the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR". For key shop the REF02 shall contain a value of "K". For OCR/ICR the REF02 shall contain a value of "O". 2. They may continue to create output from	Carrier/DMERC

	paper claims in the NSF file format and you shall convert the format to the X12N-based flat file format prior to submission to your shared system.	
3180.2	Carriers and DMERCs who convert the output from their key shop and OCR/ICR operations shall populate the REF01 segment/element (found prior to the ST segment) with a value of "+PR". For key shop the REF02 shall contain a value of "K". For OCR/ICR the REF02 shall contain a value of "O".	Carriers/DMERC
3180.3	Carriers and DMERCs who support telephone claim submission shall convert the output to the X12N-based flat file format prior to submission to their shared system. The value in REF02 shall contain a "T".	Carrier/DMERC
3180.4	If the REF02 value is either "K", "O", or "T", the shared system shall apply implementation guide edits only to those requirements that are applicable to both the HIPAA 837 and the corresponding fields on the paper claim.	Shared System
3180.5	Contractors or their shared system shall by-pass implementation guide edits on the X12N-based flat file that are inappropriate for paper claims.	Carrier/DMERC or Shared System
3180.6	Shared systems shall continue to process these claims as "skinny" COBs and all necessary gap-fill measures shall be applied when the REF01 = "+PR" and REF02 = "K", "O" or "T" on the X12N-based flat file.	Shared System

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations: None

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Joy Glass **jglass@cms.hhs.gov** **Post-Implementation Contact(s):** Joy Glass **jglass@cms.hhs.gov**	**Funding is available through the regular budget process for costs required for implementation**

Medicare Claims Processing Manual

Chapter 24 - EDI Support Requirements

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(Rev. 162, 4-30-04)

30.7 - Key Shop and Optical Character Recognition (OCR)/Image Character Recognition(ICR) Output Mapping

30.7 Key Shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR) Output Mapping

(Rev.162, 4-30-04)

CMS will cease support of the NSF once the Health Insurance Portability and Accountability Act (HIPAA) contingency plan ends. Therefore, migration to the either the X12N-based flat file or the HIPAA 837 as the output format for key shop and OCR/ICR claims will need to occur.

Carrier and DMERC key shop operations, that do not use either the HIPAA 837 or X12N-based flat file as output, must create the output from paper claims in the X12N-based flat file format or the HIPAA 837. When the X12N-based flat file is the output the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR" and REF02 shall contain a value of "K" (key shop) or "O" (OCR/ICR).

Carriers and DMERCs who support telephone claim submission shall convert the output to the X12N-based flat file. The value in REF02 shall contain a "T" (teleclaim).

The carrier/DMERC shared system shall apply implementation guide edits only to those requirements that are applicable to both the HIPAA and the corresponding fields on the paper claim. Implementation guide edits that are inappropriate for paper claims shall be by-passed.

70.2 - Carrier/DMERC Requirements

(Rev.162, 4-30-04)

B-01-32, B-01-06, OCR/ICR definition created through outside IS text

A - Decimal Data Elements

Refer to the 837 IG download site (http://www.wpc-edi.com) for a more detailed explanation of control structure/loop references made in this section.
All decimal data elements are defined as "R" based on ANSI X12N protocol. The translator should write these data elements to the ANSI X12N-based flat file at their maximum field size, which will be initialized to spaces. The COBOL picture found under the ANSI X12N 837 element name will be used to limit the size of the amounts. These positions are right justified and zero-filled. Translators are to convert signed values using the conversion table shown below. This value is to be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the ANSI X12N-based flat file data element will be used as a placeholder to report an error code if an "R" defined data element exceeds the limitation that the Medicare system is authorized to process. The error code values are: "X" = value exceeds maximum amount based on the COBOL picture, "Y" = value exceeds maximum decimal places based on the COBOL picture, "Z" = value exceeds x-number of precision places, and "b" blank will represent no error. For example, a dollar amount with the implementation guide maximum of 18-digits would look like 12345678.90. The translator will map this amount to the ANSI X12N-based flat file using the COBOL picture of S9(7)V99. The flat file amount will look like 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0." The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

Positive Values	Negative Values
1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

B – Key *Shop* and Optical Character Recognition (OCR)/Image Character Recognition (ICR)

OCR/ICR are data input technologies based on the recognition of numbers or text through special input devices.

CMS will cease support of the NSF once the Health Insurance Portability and Accountability Act (HIPAA) contingency plan ends. Therefore, the X12N-based flat file will be the only output format accepted by the shared systems for these claims

For outbound coordination of benefits (COB), these claims shall continue to be processed as "skinny" COBs and all necessary gap-fill measures shall be applied when the REF01 = "+PR" and REF 02 = "K", "O", or "T" on the X12N-based flat file. The outbound ANSI X12N 837 COB shall be built as a "minimum" data set. It shall contain all "required" ANSI X12N 837 COB segments and post-adjudicated Medicare data.

C - Provider Direct Data Entry (DDE)

Since there is little provider use of DDE, it is not cost effective to redesign any existing DDE screens. Carriers are to eliminate support of DDE in conjunction with the elimination of the NSF for claim submission. Carriers may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA.

D - Implementation Guide Edits

The shared system will program edits per Medicare instructions and edits should be standard between all shared systems.

E - Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to reassociate all data required to map to the outbound ANSI X12N 837 (HIPAA version). The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

F - Transmission Mode

The CMS recommends that carriers send the outbound ANSI X12N 837 COB transaction over a wire connection. However, they may send tape or diskettes to those trading partners that do not wish to receive transmissions via wire. COB trading partners will need to reach agreement on telecommunication protocols. It is the carrier choice as to whether it wishes to process the ANSI X12N 997 Functional Acknowledgment from COB trading partners.

G **- Summary of Process**

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;
- Shared system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;
  NOTE: No changes are being made to core system data fields or field sizes.
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and
- Adjudicated data is combined with repository data to create the outbound COB.

H **- Additional DMERC Requirements**

If the DMERC or the shared system maintainer encounters an error when editing non-Medicare data, DMERCS must include language on reports that not only is the data in error, but the data is not required by Medicare.