Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1391

SUBJECT: Implementation of HIPAA Transaction Standards – Overview and Specific Instructions for Implementing the Inbound Claim

Overview

The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification provisions direct the Secretary of Health and Human Services to adopt standards for administrative transactions, code sets, and identifiers, as well as standards for protecting the security and privacy of health data. On October 16 a final rule designating standards for eight administrative transactions and for medical code sets used in these transactions became effective.

This begins a 2-year implementation period, after which all other formats and code sets may not be used. Intermediaries will be required to implement five of these transaction standards: health care claim and equivalent encounter; remittance advice; coordination of benefits; eligibility query and response; claim status query and response. They will also be required to implement the National Drug Code (NDC) in place of HCPCS "J" codes for drugs, and to eliminate the use of HCPCS local codes. During the 2-year implementation period, intermediaries and standard system maintainers will be required to conduct analysis, programming and extensive testing to implement these changes.

This initiative is large and complex. This instruction requires the intermediaries to begin work that will lay the foundation for future work. We plan to accomplish HIPAA requirements over the 2-year period, spreading the work over multiple quarterly standard system releases in order to reduce risk. Each step will require successful completion of the prior step. Intermediaries will need to be diligent in maintaining the momentum needed to accomplish this complex project. To assure Medicare contractors are on track, HCFA staff will monitor progress throughout the implementation period.

After discussions with industry, and considering the logical fit of each transaction, we determined to stagger implementation of these transactions beginning with the claim, Coordination of Benefits (COB) and remittance advice. These transactions are closely interrelated, since the outbound COB and remittance advice data content relies on the incoming claim, and they are grouped together to facilitate provider and trading partner testing. The remaining transactions will be implemented with quarterly releases leading up to the October 2002 final implementation deadline required under HIPAA.

This is the first in a series of instructions concerning HIPAA implementation. Future instructions will address implementation for these subsequent transactions as well as instructions for testing and monitoring. This Program Memorandum (PM) instructs intermediaries and their standard systems to begin systems analysis and planning in order to program and test the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) inbound X12N 837 Health Care Claim transaction, version 4010; the outbound X12N 837 COB, and the X12N 835 Health Care Claim Payment/Advice.

Note that this instruction includes analysis of the remittance advice and COB transactions as well as the incoming claim, because these rely on data flowing from the inbound claim transaction. Due to the complexity of the requirements, this initial analysis phase needs to begin during the work period for the April 2001 release, but the programming will be put into production with the July 2001 release.

Requirements

X12N developed HIPAA implementation guides that provide details on how each transaction is to be implemented, including field sizes, data definitions, and conditions (whether specific fields are mandatory or situational). Those guides were incorporated by reference in the final rule, and they must be complied with in order to create a compliant transaction. Intermediaries should reference the 837 (version 4010) and 835 (version 4010) guides. Intermediaries and standard system maintainers may use an alternate format for **internal** systems programming, as long as incoming and outgoing transactions are translated to fully comply with the HIPAA requirements.

Intermediaries must use this flat file to map the incoming X12N 837 transaction to the appropriate flat file data elements. It will allow a one to one correlation between the flat file and the data received. Intermediaries will pass the flat file to the standard system. The standard system maintainers will use this flat file to process the claims and later to supply data needed for a compliant outbound X12N 837 COB transaction and X12N 835 remittance when implemented. We have developed a flat file that contains all (Medicare and non-Medicare) 837 data elements as a starting point for analysis.

Electronic Data Interchange (EDI) submitters may send an inbound X12N 837 compliant transaction containing data that exceeds Medicare's needs. Intermediaries must be able to accept a HIPAA compliant X12N 837 transaction into their front-end system. Contractors may not reject transactions that comply with the 837 version 4010 implementation guide. However, the contractor's front-end system and the standard system do not have to process non-Medicare information. The standard system must retain all data from the original inbound X12N 837 in order to create a HIPAA-compliant outbound X12N 837 COB and X12N 835 remittance for the intermediary's trading partners. The data in excess of that required for Medicare will be stored in a standard system repository file prior to entering the standard system's main processing system and retrieved at the back end, along with data required for Medicare, to build an outbound X12N 837 COB and 835 remittance transaction.

Intermediaries are to continue their current practice for obtaining translation software. Intermediary translators will create the 837-based flat file, which will be transmitted to the appropriate standard system. Intermediary translators will also validate the syntax compliance for the X12N 837 such as alpha numeric, field length, valid qualifiers, mandatory loops and segments, appropriate segments within a given loop, and handling multiple ISA/IEA envelopes within one transmission.

Intermediary translators must also be able to validate for syntax compliance specific to the X12N 837 version 4010 implementation guide in addition to the basic standard verification. While translators can perform additional claim level editing, it will be the responsibility of the intermediaries and their standard systems to determine where it is most efficient to perform those edits, such as within the front-end system or within the standard system.

Documentation

The HIPAA implementation guide for the ANSI ASC X12N 837 (4010) and 835 (4010) may be found at www.wpc-edi.com. The flat file is in an Excel spread sheet format available for download from www.hcfa.gov/medicare/edi/hipaadoc.htm. The file name is 4010837i.xls. You will be separately notified if any further modifications are required to this flat file to resolve issues identified during the analysis phase, programming or testing.

A file (305104010.pdf) listing major differences between the 837 version 3051 (Medicare's implementation) and the 837 version 4010 is located at www.hcfa.gov/medicare/edi/hipaadoc.htm. Also on the same web site are 837toUB.pdf and map60.pdf. These files may be used to aid your mapping efforts.

Analysis, Planning, and Issues to be Resolved

Intermediaries and standard system maintainers are to perform the necessary systems analysis and planning for the implementation of the inbound X12N 837, X12N 835, and outbound X12N 837 COB. This does not include changes to accommodate the NDC, National Provider Identifier (NPI), Payer Identifier (PlanID), or the elimination of local procedure codes. Those changes are not being implemented at this time. Subsequent instructions will be provided at a later date for the NDC and the elimination of local procedure codes, as these will be implemented no later than October 2002. The NPI and PlanID instructions will be issued after the publication of final rules for those standards. This may or may not occur prior to October 2002.

We realize that certain issues have not been resolved. These include, but are not limited to, the impact on existing direct data entry (DDE) systems, specifications for the repository, and COB procedures. If DDE is used to create claims by directly keying data into a contractor's computer (database), the DDE system must be able to accept the maximum HIPAA compliant data content. If DDE is used to create claims to be entered into a computer (database) to be transmitted at a later time, the DDE system must be able to accept the maximum HIPAA compliant data content as well as comply with the HIPAA implementation guide format.

We expect to address these and other issues working with a team of representatives from standard system maintainers, intermediaries, and data centers. This group will attend a 4-day conference in mid-November and twice-weekly conference calls throughout the analysis and programming period. Group members have already been notified of these events. We expect to issue the next instruction in the series of PMs that will implement HIPAA in December. By February 2001 we will also publish a PM detailing the requirements for the implementation of the X12N 835 and outbound X12N 837 COB, for inclusion in the July 2001 release.

Subsequent instructions will address requirements for testing and for monitoring all of the HIPAA transactions. These instructions will include detailed testing schedules, information collection requirements, and reporting requirements. We will also address how staff in both the central and regional offices will oversee the contractor efforts.

Programming

Subject to the resolution of issues identified above, the standard system maintainers must complete the necessary programming changes for the inbound X12N 837, the X12N 835 and the outbound X12N 837 COB for inclusion in the July 2001 release. File any problem reports with the standard systems maintainers so corrections may be issued in a subsequent release. Intermediaries are to begin limited testing of the inbound and outbound X12N 837 and the X12N 835 with selected providers/trading partners on or about August 1, 2001. Testing with all EDI submitters should begin on or about October 1, 2001. As the submitters successfully test, they may be migrated into production.

Individual contractors are to continue to offer free electronic billing software. You must upgrade your free billing software to support the submission of claims in the X12N 837 (4010) format by August 2001. In conjunction with programming for the 837 version 4010 incoming claim, and to enable issuance of compliant 837 transactions to COB trading partners, you must also modify free/at cost billing software furnished to providers so it also collects all claim data permitted by the 837 version 4010. That is, the software must be able to accept the maximum HIPAA compliant data content.

We intend to phase out the support of free billing software approximately 1 year after all of the HIPAA standards are implemented, since this standardization will preclude the need for specific proprietary EDI products.

Contractor Funding

The update to the X12N 837 incoming claim transaction is included in normal operating costs. Supplemental Budget Requests should be submitted for any work that involves the processing of information outside the Medicare requirements for the incoming claims (for example, translator procurement and mapping, local system front end and back end programming to support additional data requirements in version 4010, upgrading of the free billing software to accommodate X12N 837 version 4010 data requirements in excess of Medicare's routine data needs, and Beta testing of the X12N 837 and the free billing software with a select number of providers during the 4th quarter of FY 2001).

HIPAA established requirements binding on all health care payers, not only on Medicare. HIPAA did not fund national implementation of its administrative simplification standards requirements by all health payers. As with other system and program changes that impact a Medicare contractor's parent company's private/commercial lines of business as well as their Medicare processing activities, direct and indirect costs related to such changes must be proportionately shared by the impacted lines and cost centers, and not charged to Medicare in total. Programming, transition, and operational costs related to a corporate clearinghouse operated by a Medicare contractor's parent company, or any other profit or non-profit line of business of the parent company not required to support Medicare processing under the terms of their Medicare contract may not be charged in total or in part to the Medicare program.

This *effective date* of this PM is November 28, 2000.

The *implementation date* for this PM is July 1, 2001. (Exception: the free billing software *implementation date* is August 1, 2001.)

See the funding issues section above for funding requirements.

This PM may be discarded after October 1, 2001.

Contact person is Matt Klischer, 410-786-7488 or e-mail mklischer@hcfa.gov.