Program Memorandum Intermediaries

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

Transmittal A-02-014 **Date: FEBRUARY 12, 2002**

CHANGE REQUEST 2028

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

This Program Memorandum (PM) provides additional information for intermediaries and their standard systems. CMS has been receiving HIPAA 837 claim implementation questions and requests for clarification on an ongoing basis. The following information is being provided to you to ensure an accurate HIPAA implementation.

1. Q: Since the HIPAA 837 institutional implementation guide (IG) allows for only 1 Investigational Device Exemptions (IDEs) per claim, how should HIPAA test claims containing multiple IDEs received via direct data entry (DDE) be tested since DDE currently allows for multiple IDEs?

   A: Notify your providers/submitters via your next scheduled bulletin that the HIPAA 837 transaction allows for only 1 IDE per claim (your HIPAA free billing software should already only accept 1 IDE per claim) and they should NOT submit HIPAA test claims containing multiple IDEs via DDE.

2. Q: Since the HIPAA 837 Institutional IG allows for only 1 IDE per claim, how should HIPAA production claims containing multiple IDEs received via DDE be processed since DDE currently allows for multiple IDEs?

   A: Notify your providers/submitters via your next scheduled bulletin that any production claim containing multiple IDEs must NOT be submitted via DDE. This should not be a hardship since we determined that from January 2001 through June 2001 less than 5 claims with multiple IDEs were processed by Medicare. **An instruction will be forthcoming instructing you to modify your DDE to allow for only 1 IDE per claim.**

3. Q: How should the standard system maintainers process HIPAA test claims containing a non-numeric revenue code?

   A: Notify your providers/submitters via your next scheduled bulletin that any HIPAA test claim containing a non-numeric revenue code will be returned to the provider (RTPd) with an appropriate error message.

4. Q: How should the standard system maintainers process HIPAA production claims containing a non-numeric revenue code?

   A: Notify your providers/submitters via your next scheduled bulletin that any HIPAA production claim containing a non-numeric revenue code will be RTPd with an appropriate error message. **An instruction will be forthcoming instructing you to modify your standard system to allow for only numeric revenue codes.**

5. Q: Can providers/submitters use HCPCS codes to bill for drugs on HIPAA test inpatient claims?

   A: Yes. Continue to test these claims using HCPCS. CMS will determine at a later time when to accept National Drug Codes (NDCs).

6. Q: Can providers/submitters use HCPCS to bill for drugs on HIPAA production inpatient claims?

   A: Yes. CMS will determine at a later time when to accept NDCs.

7. Q: Realizing there is no employment status code, employer name, or employer address in the HIPAA 837 Institutional IG, how should the standard system maintainers process HIPAA test claims when currently the standard system maintainers' internal software requires this information for certain claims?

   A: CMS has determined that this information is no longer needed. Do not RTP HIPAA test claims that do not carry this information. Process the test claim. Notify your providers/submitters via your next scheduled bulletin that test claims containing this information are NOT to be submitted via DDE.

8. Q: Realizing there is no employment status code, employer name, or employer address in the HIPAA Institutional 837 IG, how should the standard system maintainers process HIPAA production claims when currently the standard system maintainers' internal software requires this information status code for certain claims?

   A: CMS has determined that this information is no longer needed. Do not RTP HIPAA production claims that do not carry this information. Process the production claim. Notify your providers/submitters via your next scheduled bulletin that production claims containing this information are NOT to be submitted via DDE. This resolves HPARs MA2344H4, MA2344H7, and MA2344H8. **An instruction will be forthcoming instructing you to modify your DDE to remove the employment status code, employer name, and employer address information.**

9. Q: How should Notices of Election (NOEs) be tested and processed under HIPAA?

   A: NOEs are not established under HIPAA. Notify providers/submitters via your next scheduled bulletin not to use the 837 for NOEs. This resolves HPAR MA2344H3.

10. Q: How should HIPAA test claims that require Subscriber Demographic Information (DMG) be processed since Medicare has never required this information?

    A: The DMG segment is for other insured. This is information on the gender and date of birth for the holder of a supplementary insurance policy, if not the beneficiary. These pieces of information have been mapped to the flat file and since they are not required for Medicare they should go to your repository file. For your free billing software, we have already approved the use of dummy (any data that meets the IG requirements) test data for testing purposes. Notify your providers/submitters via your next scheduled bulletin under which conditions this information is required for HIPAA test claims and to not submit claims requiring this segment via DDE.

11. Q: How should HIPAA production claims that require DMG be processed since Medicare has never required this information?

    A: Notify your providers/submitters via your next scheduled bulletin under which conditions this information is required for HIPAA production claims and to not submit claims requiring this segment via DDE. **An instruction will be forthcoming instructing you to modify your DDE to allow DMG information.**

12. Q: Where should the start of care date for hospice outpatient claims be reported?

    A: The HIPAA 837 Institutional IG does not have a place to report the start of care date for hospice outpatient test claims. Notify your submitters/providers via your next scheduled bulletin

that no outpatient HIPAA hospice claims will be tested while CMS awaits the results of CMS's request to the National Uniform Billing Committee to establish a new occurrence code to be used for the hospice start of care date. **CMS anticipates this code being approved. An instruction will be forthcoming instructing you to modify your standard system to process the new code. CMS will notify you as to when to notify your providers/submitters to begin testing with the new code.**

13. Q: Where should the start of care date for home health claims be reported?

    A: To use the CR6 (Home Health Care Information) segment in the HIPAA 837 Institutional IG to report the start of care date for home health claims, all required segments must be used. However, home health agencies do not have the other data elements, and Medicare does not use the other data elements in this segment. Notify your submitters/providers via your next scheduled bulletin that no HIPAA home health claims will be tested while CMS awaits the results of CMS's request to the National Uniform Billing Committee to establish a new occurrence code to be used for the home health start of care date. **CMS anticipates this code being approved. An instruction will be forthcoming instructing you to modify your standard system to process the new code. Do not update your standard system to process CR6 data. CMS will notify you as to when to notify your providers/submitters to begin testing with the new code. Once the new code is in place, CR6, under the proposed addenda, will no longer be required because the use of CR6 will no longer be applicable under note 1.**

14. Q: Is the Medicare requirement for providers/submitters to enter an 0001 revenue code line which contains the sum of charges billed being deleted?

    A: No. There is nothing in the HIPAA 837 Institutional IG to prohibit this information on the claim (even though the total charges will also be contained in CLM02). Notify your providers/submitters via your next scheduled bulletin to continue sending an 0001 revenue line on claims.

14. Q: How should HIPAA test claims that require Discharge Hour information be processed since Medicare has never required this information?

    A: Discharge Hour information is required on all final inpatient claims/encounters. For testing purposes, use '0001' for DTP03. Notify your providers/submitters via your next scheduled bulletin under which conditions this information is required for HIPAA test claims and to not submit test claims requiring this segment via DDE.

15. Q: How should HIPAA production claims that require Discharge Hour information be processed since Medicare has never required this information?

    A: Notify your providers/submitters via your next scheduled bulletin under which conditions this information is required for HIPAA production claims and to not submit claims requiring this segment via DDE. **An instruction will be forthcoming instructing you to modify your DDE to allow Discharge Hour information.**

16. Q: How should HIPAA test claims that require a unique physicians identifier number (UPIN) be processed in the 2310A (Attending Physician information) loop?

    A: For testing purposes, use code 24 in NM108 and enter a 'dummy' 10 digit numeric employer's identification number (EIN) in NM109. Enter the UPIN in 2310A REF02. Notify your providers/submitters via your next scheduled bulletin under which conditions this information is required for HIPAA test claims and to not submit test claims requiring this loop via DDE.

17. Q: How should HIPAA production claims that require a UPIN be processed in the 2310A loop?

    A: Notify your providers/submitters via your next scheduled bulletin under which conditions this information is required for HIPAA production claims and to not submit claims requiring this loop via DDE. **An instruction will be forthcoming instructing you to modify your DDE to allow correct 2310A loop information processing.**

18. Q: How should the date of receipt be established?

    A: The date-of-receipt will be translator generated and mapped to the Medicare Part A Claim/COB flat file. This resolves HPAR MA2344H.

19. The following are Medicare Edits Document (available by February 15, 2002 at www.hcfa.gov/medicare/edi/hipaadoc.htm) changes:

    - The REF02 (Transmission Type Code) edit logic is changed to 'REF02 must be a value listed in the Valid Values column'.
    - HL04 (Billing Provider HL) Medicare Values is changed to 1.
    - CLM02 Edit Logic is changed to 'CLM02 must be numeric'.
    - HSD03 Q! is changed to Q1 in Valid Values/Valid Format column.
    - REF01 (2310A Loop) Medicare Values is changed to '1G for UPIN'.
    - CUR01 (2000A loop) Imp Guide Edit is changed to 'Y' and the edit logic is changed to 'Must be a value listed in Valid Values column'.
    - REF01 (2310A Loop) Edit Logic is changed to 'REF01 must contain 1G (UPIN)'.
    - REF01 (2310C Loop) Medicare Values is changed to '1C or 1G'.
    - MIS09 is changed to MIA09.
    - REF01 (2420C Loop) edit logic is changed to 'REF01 must be a value listed in the Valid Values column'.
    - REF01 (2420D Loop) edit logic is changed to 'REF01 must be a value listed in the Valid Values column'.
    - PWK02 (2300 Loop) edit logic is changed to 'See the Imp Guide for logic'.

    These changes will be included as a 'Summary of Changes' sheet in the document.

The effective date for this PM is February 12, 2002.

The implementation date for this PM is February 12, 2002.

This PM may be discarded after October 31, 2004.

Medicare contractor questions concerning this PM may be directed to Matt Klischer, (410) 786-7488, or e-mail MKLISCHER@CMS.HHS.GOV.