Program Memorandum Intermediaries

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

Transmittal A-03-064 **Date: JULY 25, 2003**

CHANGE REQUEST 2505

SUBJECT: X12N 837 Institutional Health Care Claim Companion Document

This Program Memorandum (PM) is to provide contractors with language to include in a companion document. A companion document is defined as a set of statements, which supplements the X12N 837 Institutional Implementation Guide (IG) version 4010A1 and clarifies the contractor expectations regarding data submission, processing, and adjudication. A companion document is to be shared with each entity (either provider, billing agent, or clearinghouse) that will submit claims to Medicare electronically. The specific language provided in this companion document is based on recommendations/decisions made by a workgroup consisting of members from CMS, Part A contractors, and shared system maintainers. Contractors have the option to add specific items not contained in this PM. However, these items must not contradict any items in this PM or in the IG except as addressed in this PM. Contractors are to communicate this companion document information to their electronic data interchange (EDI) claim submitters via regular newsletter, and/or posting to their Web site (or an alternate method, if deemed cost effective).

X12N 837 Institutional Companion Document

The table provided below indicates whether the usage is:

(R) Required-	You must include this language in your companion document.
(S) Situational –	RHHIs must include this language in your companion document.
(O) Optional-	You can choose to include this language in your companion document, if applicable.
(R/O) Selection required-	You must choose one statement from the list of the statements provided. The choices will be labeled either (a) or (b) to identify each option. You should select the language that is applicable to your business situation.

For those statements that include the choice between [***will/may***], you must use either "will" (to mean must) or "may" (to mean could, but not always), depending on your business situation, in the finalized companion document you issue.

You must include the following language in your X12N 837 Institutional Companion Document:

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health benefit payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 IGs have been established as the standards of compliance for claim transactions. The IGs for each transaction are available electronically at http://www.wpc-edi.com/hipaa.

The following information is intended to serve only as a companion document to the X12N 837 IGs adopted for national use under HIPAA. The use of this document is solely for the purpose of Medicare clarification.

The information describes specific requirements to be used for processing data in the [***contractor system name***] system of [***contractor name***] Medicare contractor number [***contractor number***]. The information in this document is subject to change. Changes will be communicated in the standard [***contractor newsletter name***] periodic news bulletin and on the [***title***] web site: [***URL***]. Separate companion documents have been or will be issued for use with other HIPAA transaction standard IGs.

USAGE	LANGUAGE
R	For Medicare, submit using the basic or extended character set or the Base or Extended control set as defined in Appendix A, you may choose to submit lower case characters but the following can not be used as delimiters: A..Z a..z '.' 0..9 '-' ' ' (space). Doing so will cause the interchange (transmission) to not be processed.
R	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). Claims containing data in the Patient Hierarchical Level (2000C loop) will not be processed.
R	The maximum size for the fields containing number of days information (covered, lifetime reserve, etc.) in the Medicare system is four characters. Claims submitted with data that exceed will be returned to the provider (RTP'd) or will be errored back to the submitter by **[*contractor name*].**
R	The maximum size for dollar amount fields in the Medicare system is 10 characters. Claims submitted with dollar amounts in excess of 99,999,999.99 will be RTP'd or will be errored back to the submitter by **[*contractor name*]**.
R	Claims submitted with attending, other, or operating physician UPIN data exceeding 6 positions will be RTP'd or will be errored back to the submitter by **[*contractor name*]**.
R	Claims with external code set data that does not conform to the format requirements of the external code set maintainer will be RTP'd or will be errored back to the submitter by **[*contractor name*]**. Data elements referencing external code sets are limited to the size of the data as defined by the code set maintainer. For example, the element in the Implementation Guide designated for HCPCS information may contain up to 30 positions but the HCPCS external code list allows only 5 positions (claims with more than 5 positions of HCPCS data in this element would be RTP'd or will be errored back to the submitter by **[*contractor name*]**.
R	The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will be RTP'd or will be errored back to the submitter by **[*contractor name*].** Claims submitted with decimal data will be rounded to the closest whole number before being processed.
R	Data submitted in CLM20 (Delay Reason Code) will be ignored.
R	The Medicare system does not process decimal points in diagnosis codes or ICD9-CM procedure codes. Medicare will strip out decimal points submitted in valid diagnosis before processing. Medicare will strip out decimal points submitted in valid procedure codes before processing.
R	You may send as many diagnosis codes as allowed in the implementation guide. However, only the primary/principal and first 8 other diagnosis codes will be considered for adjudication and payment determination.
R	Hospital other (14X) claims that lack diagnosis information when required for CMS adjudication (2300 HI Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) will be RTP'd or will be errored back to the submitter by **[*contractor name*].**
R	Credit/Debit card information (Loop 2010AA REF or 2010BB Loop) will be ignored.

R	Claims that lack a patient status code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by **[*contractor name*].**
R	Claims that lack an admission source code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by **[*contractor name*].**
R	Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by **[*contractor name*].**
R	Medicare will process only HL structures as described in the implementation guide front matter (Billing Provider HL (parent) followed by the appropriate Subscriber HL (child)).
S	Since the date care starts is considered for billing purposes to be the date the beneficiary is admitted to Home Health Agency (HHA) care, HHAs must enter the Home Health Start of Care Date as Admission Date (2300 DTP Admission Date/Hour) for Medicare processing purposes. Any compliant time is acceptable in this field.
O	[***Contractor name***] will reject an interchange (transmission) that uses the following character as a delimiter: ' '.
O	[***Contractor name***] will reject an interchange (transmission) that uses the following character as a delimiter: '\'.
O	[***Contractor name***] will only process one transaction type (records group) per interchange (transmission). A submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange) when submitting claims to **[*contractor name*].**
O	[***Contractor name***] will validate individual identifiers submitted within the ISA and GS envelope segments in addition to the verifying the format requirements defined in the IG. Claims submitted with invalid Medicare identifiers will be RTP'd or will be errored back to the submitter by **[*contractor name*].**
O	[***Contractor name***] will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements within the same GS to GE envelope.
O	[***Contractor name***] will not process an interchange (transmission) that is not submitted with a valid receiver/submitter code (each individual Contractor determines this code).
O	[***Contractor name***] will accept claims for only one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to not be processed.
O	[***Contractor name***] will process only one transaction per functional group; a submitter must submit only one ST-SE (Transaction Set) within a GS-GE (Functional Group).
O	[***Contractor name***] will accept and process transmissions with a Claim or Encounter Indicator (BHT06) of 'CH' (Chargeable). [***Contractor name***] will accept but will ignore a Claim or Encounter Indicator (BHT06) if 'RP' (Reporting) during adjudication.
O	[Contractor name] will generate a 997 Functional Acknowledgment transaction in reply to an 837 transaction. [Contractor name] will issue specific instructions about accessing the 997 transactions. For 997 acknowledgements, [***Contractor name***] will return the version of the standard used to create the 997 transaction in GS08 (Version/Release/Industry Identifier Code).

R/O (a)	Compression of files is not supported for transmissions between the submitter and [***Contractor name***].
R/O (b)	Compression of files using [*name of software*] is supported for transmissions between the submitter and [***Contractor name***].

The *effective date* and *implementation date* for this PM is July 25, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2004.

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