Program Memorandum Intermediaries

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

Transmittal A-01-20 **Date: FEBRUARY 5, 2001**

CHANGE REQUEST 1533

SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) Health Care Claim and Coordination of Benefits (COB)

The 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, 2000, a final rule designating standards for eight administrative transactions and for medical code sets used in these transactions became effective.

This Program Memorandum (PM) provides intermediaries and their standard systems final instructions regarding HIPAA implementation of version 4010 of the inbound X12N 837 Health Care Claim and the outbound X12N 837 COB transactions established with the 004010X096 Implementation Guide (IG). These instructions are based on recommendations from the electronic data interchange (EDI) Intermediary Workgroup. The workgroup consists of members from HCFA, Part A contractors, and standard system maintainers. These instructions supplement Transmittal A-00-89 dated November 28, 2000, which instructed you to perform the necessary systems analysis and planning in order to program and test the inbound X12N-837, outbound X12N-837, and X12N-835 transactions. The instructions in Transmittal A-00-89 dated November 28, 2000, remain in effect unless specified in this PM. The Medicare Intermediary Manual sections that address electronic transaction requirements will be updated to include changes detailed in this PM.

Health Care Claim

Translators

As directed in Transmittal A-00-89 dated November 28, 2000, intermediaries must be able to accept a HIPAA compliant X12N 837 transaction into their front-end system and write the Medicare Part A Claim/COB flat file to your standard system. A HIPAA compliant X12N 837 transaction may include Medicare data (data sent to the core of your standard system) and non-Medicare data (data not sent to the core of your standard system). Intermediary translators will validate syntax compliance of the inbound X12N 837 standard such as alpha-numeric or numeric data formats, field lengths, valid qualifiers, mandatory loops and segments, appropriate segments within a given loop, and handling multiple ISA/IEA envelopes within one transmission. Intermediary systems must also be able to validate for syntax compliance specific to the IG. 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. As a result of workgroup analysis, the X12N 837-based flat file proposed in Transmittal A-00-89 dated November 28, 2000, will now be a flat file based on the electronic Uniform Billing (UB)-92 naming structure. This Medicare Part A Claim/COB flat file layout (4010837i.xls) is available at www.hcfa.gov/medicare/edi/hipaadoc.htm Attachment 2 gives a description of this file. Any updates to this file will also be posted to the web site. Intermediaries are to create the X12 997 Functional Acknowledgment as detailed in the IG and transmit it to all EDI submitters who submit claims in the IG format. The X12 997 is to be used for X12N 837 standard syntax editing only. You must return a X12 997 within 1 business day. Intermediaries are required to use X12 997 loops AK2, AK3, and AK4. Intermediaries may purge the X12 997 after 5 business days in the event the X12 997 transaction is not received by the submitting entity.

You are not required to accept multiple functional groups (GS/GE) within one transmission. Your translator's acceptance of multiple interchange envelopes within a single transmission may be determined within your trading partner agreements.

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

If a syntax error occurs at the standard level, return the entire transmission (ISA to IEA) to the submitter via the X12 997.

Transmission Mode

The X12N 837 standard claim transaction is a variable-length record designed for wire transmission. HCFA recommends you accept the X12N 837 over a wire connection. However, you may support tape or diskettes for those trading partners that do not want to send/receive transmissions via wire. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

Compression

You need not support file compression for X12N transactions. Compression is permitted between you and your data center, if applicable. However, the Medicare Part A Claim/COB flat file must not be compressed when presented to your standard system.

Free Billing Software

As directed in Transmittal A-00-89 dated November 28, 2000, your shared system maintainer must upgrade your free billing software to support the submission of claims in the IG format and make it available to requesting providers no later than October 1, 2001. This date is being revised from the date on the draft CR 1533 since you will not be required to upgrade your software to create an HIPAA-compliant claim transaction as previously instructed. Your billing software must be able to produce an IG compliant 837 for Medicare Part A claims. If you do not believe you will be able to have your billing software ready by October 1, 2001, you may request a waiver by April 30, 2001, for consideration. Direct waivers to mklischer@hcfa.gov. You are to coordinate test data issues with your Beta testing partners. HCFA will not provide test data. A PM detailing the phasing out of HCFA's support of free billing software will be forthcoming.

External Keyshop or Imaging Processing

Per CR 1478, after March 31, 2001, only support the UB-92 version 6.0 as the output format for paper claims received from your external keyshop or imaging processes. However, since HCFA will cease to support the UB-92 version 6.0, eventual migration to the Medicare Part A Claim/COB flat file as the output format for these claims will need to occur by October 1, 2002. If you decide to use the Medicare Part A Claim/COB flat file as output for these claims, you may bypass the IG edits since these claims will not contain all of the data on the inbound X12N 837 transaction.

Provider Direct Data Entry (DDE)

DDE systems are not subject to the syntax (format) requirements of the standards, but must contain "applicable data content" for the claim. You may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA. DDE systems are proprietary by definition. They are a direct link between a particular health plan (Medicare) and its providers, and the software (and sometimes hardware) is unique to and maintained by the plan. HCFA recognizes that DDE is currently the only viable means of EDI available to some providers, particularly small providers. The widespread use of the standard HIPAA transactions will make it economically feasible for more providers to procure or develop their own EDI products that can be used with all plans. The use of DDE should decrease over time as a result. The requirement for "applicable data content" is meant to facilitate that eventual conversion. Implementing the data content portion of the standards now means that a provider's change from DDE to their own EDI software (or to use of a clearinghouse) would be simplified, and plans would be able to accommodate DDE-generated data and HIPAA standard transaction-generated data in the same databases.

In this context, "applicable data content" means your standard system's DDE systems must:

- Collect all fields that are ***required*** in the IG as well as those ***situational*** elements that are needed for Medicare processing (unless the data is already available to the payer's system);

- Use ***only*** the internal and external code sets designated in the IG with no additions or substitutions;

- Provide for ***at least*** the field size minimums noted in the IG, but no more than the maximum sizes (Do not expand your standard systems internal claim records); and

- Permit ***at least*** the minimum number of field repeats noted in the IG, but no more than the maximum number.

Based upon the most recent workgroup analysis, there are no IG requirements that necessitate a change to your current DDE systems. There is no need to collect non-Medicare data. Claims correction via DDE should be limited to Medicare data (non-Medicare data in error should be purged with an appropriate error message to the DDE user). With Medicare data plus some information from your standard system files, an IG compliant COB transaction can be written. Note that additional edits may be needed based on further analysis and issues that may be encountered during implementation.

Edits Performed by the Intermediary

You are to perform standard and IG edits as explained in the IG. IG edits should be standard among all intermediaries. If a syntax error occurs at the IG level, you may reject the entire transmission, the functional group, batch, or claim. At a minimum, you must return the claim to the provider (RTP) if it is not HIPAA compliant. Amounts, percentages, integers, and other fields designated in the IG as numeric will be right-justified and zero-filled if the incoming data is smaller than the Medicare Part A Claim/COB flat file field size. Fields designated in the IG as alpha-numeric will be left-justified and space filled if the incoming data is smaller than the Medicare Part A Claim/COB flat file field size. All non-Medicare data field lengths will correspond to the maximum IG length. Incoming alpha-numeric non-Medicare data will be left-justified and space filled if the data is smaller than the Medicare Part A Claim/COB flat file field size. Incoming numeric non-Medicare data will be right-justified and zero-filled if the data is smaller than the Medicare Part A Claim/COB flat file field size. Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) will be mapped to the Medicare Part A Claim/COB flat file (and later written to the SFR by your standard system). Based on the intermediary workgroup analysis, the following programmatic edits override the IG:

- Claims where the zip code exceeds 9 positions will be left adjusted and the claim will be processed.

- Data where there is an IG note, internal code list, external code list, or qualifier will be limited by the reference. Claims where data exceeds referenced sizes are to be flagged so the standard system can RTP with an appropriate error message.

- The submitter Employer Identification Number (EIN) will not exceed 10 positions. Claims where the EIN exceeds 10 positions are to be rejected with an appropriate error message.

- Incoming data mapping to data elements marked "NOT USED" in the IG will be disregarded.

- All date data will not exceed 8 digits (CCYYMMDD), except for date ranges. Claims where the date data exceeds 8 positions (and not a valid date range) are to be rejected with an appropriate error message.

- Claims where the attending, referring, or operating physician numbers exceed 16 positions are to be flagged so the standard systems can RTP with an appropriate error message.

- Units of service will not exceed 7 positions. Claims where the Units of service exceeds 7 positions are to be flagged so the standard system can RTP with an appropriate error message.

- Number of days (covered, lifetime reserve, etc.) will not exceed 4 positions. Claims where the number of days exceeds 4 positions are to be flagged so the standard systems can RTP with an appropriate error message.

- Credit card and foreign currency data will be disregarded per note in the IG stating that this information must never be sent to the payer and therefore would not be included on the COB transaction.

- Your IG edit process will map amounts to the Medicare Part A Claim/COB flat file using the COBOL picture of S9(8)V99 (10 positions). Other numeric data elements will be mapped to the data size described within the Medicare Part A Claim/COB flat file document. Numeric data fields larger than the data size described within the Medicare Part A Claim/COB flat file document will be populated with "HIGH-VALUES". HIGH-VALUES has the hexadecimal value X"FF" (a character code of all binary ones).

- While HCFA is negotiating to have the X12N 837 number of service lines limited to 450 in the IG, intermediaries are directed to implement a 450 service line number limit for the X12N 837. For claims exceeding 450 service lines, write the first 450 lines to the Medicare Part A Claim/COB flat file (the claim will later be RTP'd by your standard system with an appropriate error message based on the missing 0001 line).

Pass all spaces to the Medicare Part A Claim/COB flat file for fields that are not present in the inbound X12N 837 version 4010. Additional edits currently in development by the intermediary workgroup will be available at www.hcfa.gov/medicare/edi/hipaadoc.htm by February 28, 2001. These additional edits should be standard between all intermediaries. Note that additional edits may be needed based on further analysis and issues that may be encountered during implementation. You and your standard system have the authority to decide how your reports back to your submitters are done.

Edits Performed by the Standard systems

- Claims with numeric data elements containing HIGH-VALUES are to be returned by the standard system to the provider via the intermediary with an appropriate error message.

- Claims with S9(8)V99 numeric data elements containing an amount greater than corresponding fields set in your core system at 9 digits (S9(7)V99) are to be returned by the standard system to the provider via the intermediary with an appropriate error message.

- Data residing on the Medicare Part A Claim/COB flat file as a result of data received in loop 2010BD RESPONSIBLE PARTY NAME of the X12N 837 will be RTP'd with an appropriate error message because Medicare policy requires a signature on file for payment.

- Standard systems are not to return non-Medicare data to the provider.

NOTE: Additional edits may be needed based on further analysis and issues that may be encountered during implementation and standard system core fields are not to be expanded.

Medical Review/Attachment Data

Some medical review/attachment data currently defined in many of the electronic UB-92 70-series records are not included in the IG. We are looking at alternative ways of processing this data electronically.

COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. As directed in Transmittal A-00-89 dated November 28, 2000, you are required to receive all possible data on the incoming 837 although you do not have to process non-Medicare data. However, your standard system must store that data in a store-and-forward repository (SFR). This repository file will be designed and maintained by your standard system. This data must be reassociated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. Your standard system 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. Your standard system must retain the data in the SFR for a minimum of 6 months.

The Medicare Part A Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. Your translator will build your outbound COB transaction from the Medicare Part A Claim/COB flat file.

You are not required to process an incoming X12 997. You may create and use your own proprietary report(s) for feedback purposes.

Your standard system maintainer must make the necessary programming changes for the COB transaction as part of the July 2001 release. Begin internal testing of the COB transaction on or about July 1, 2001. Begin testing with your EDI COB trading partners on or about October 1, 2001.

Transmission Mode

HCFA recommends you send the outbound COB transaction over a wire connection. However, you may send tape or diskettes to those trading partners that do not wish to receive transmissions via wire. You and your COB trading partners will need to reach agreement on telecommunication protocols. It is your choice as to whether you wish to process the X12 997 Functional Acknowledgment from your COB trading partners.

External Keyshop or Imaging Processing

Data on claims that your receive from your keyshop or image processing systems may not be included on your SFR, depending on your standard system design. Create your Medicare Part A Claim/COB flat file using data available from claim history and reference files. Since some data will not be available on these "paper" claims, the outbound COB transaction will be built as a "minimum" data set. It will contain all "required" COB transaction segments and post-adjudicated Medicare data.

Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB (see Attachment 1):

- Intermediary's translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;
- Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by your standard 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 SFR by your standard system; and

- Adjudicated data is combined with SFR data to create the outbound COB transaction.

Outreach

By September 30, 2001, intermediaries must notify their providers, third party provider billing agents, provider clearinghouses, and the COB trading partners with whom they interact electronically for Medicare that:

- Medicare will switch to exclusive use of the outbound COB by October 16, 2002;

- Medicare will cease issuance of non-version 4010 COB transactions and acceptance of non-837 version 4010 electronic claims by October 2002;

- Each provider that has elected to submit claims electronically must submit all of their claims in compliance with the IG requirements. Vendors that submit electronic claims for Medicare providers must also comply with the IG requirements;

- Each trading partner that has elected to exchange COB electronically must accept the IG claim format, or contract with a clearinghouse to translate their claim data into the IG format, they must furnish that clearinghouse all data required by the IG;

- A provider, provider agent, trading partner, or clearinghouse that elects to use a clearinghouse for translation services is liable for those costs;

- The IG and X12N data dictionary can be downloaded without charge from www.wpc-edi.com/HIPAA;

- If an EDI submitter is using a vendor, clearinghouse, or billing service to generate a certain transaction and that entity has passed testing requirements for a specific transaction and is using the same program to generate the transaction for all of their clients, then all clients of the vendor/clearinghouse/billing service will not be required to test prior to intermediary acceptance of production data. EDI submitters should request a testing appointment as soon as possible to be assured they could complete testing and correct any detected system problems prior to October 2002. Appointment slots will be assigned on a first come basis. Intermediaries will not be able to guarantee testing by the end of September 2002 for any entities that delay scheduling testing until late in the transition period;

- COB trading partners must either request system compatibility testing for use of the COB transaction prior to October 2002, or be confident that they have completed system changes as required to accept production COB transactions by October 2002. Any trading partner that prefers to have COB testing conducted prior to transmission of production data must schedule testing with you as soon as possible to assure testing will be completed before October 2002. Current trading partners will automatically be sent production X12N 837 transactions in October 2002 unless they notify you that they want to terminate their COB agreement;

- As result of the large number of providers, agents, clearinghouses, and trading partners to be tested and the number of HIPAA standard transactions, it will not be feasible to test each entity during the last quarter of the transition process; and

- There is no Medicare charge for this system testing.

You will be notified of detailed data testing, data migration, and data monitoring requirements in a forthcoming PM.

Intermediaries must be pro-active to assure that providers, agents, clearinghouses, and trading partners are furnished adequate information for them to understand the impact of the HIPAA Administrative Simplification requirements, as implemented by Medicare, on their operations. Intermediaries are not expected to furnish providers or others with in-depth training on use and interpretation of the X12N 837 for incoming claims and COB. However, they must furnish appropriate information in regularly scheduled provider bulletins/newsletters, in other provider educational publications, during their regularly scheduled provider educational seminars, and in correspondence with COB trading partners to enable those individuals and entities to make educated and timely decisions to plan their reaction to the HIPAA standards as implemented by Medicare. A reasonable number of tests are to be conducted monthly throughout the transition period to enable Medicare providers, agents, clearinghouses, and trading partners who request testing by June 30, 2002, to complete testing by October 2002.

Cost Issues

The FY 2001 budget and performance requirements specify that intermediaries include one X12N 837 version upgrade per year in their line one maintenance costs. However, intermediaries are entitled to non-routine cost reimbursement related to HIPAA for supplemental costs for translator upgrades, translator mapping to the new Medicare Part A Claim/COB flat file, provider education on HIPAA transaction requirements, beta testing of X12N 837 with selected partners, and testing requested by providers, their agents, clearinghouses, and trading partners for these HIPAA transactions. Intermediaries should submit supplemental budget requests (SBRs) for reasonable supplemental costs incurred to comply with these non-routine X12N 837 requirements in FY 2001. SBRs should also be submitted for FY 2002 testing of your trading partners.

Attachments

The effective date for this PM is February 1, 2001.

The implementation date for the X12N 837 COB and X12 997 changes is July 1, 2001.

The implementation date for DDE changes is October 1, 2001.

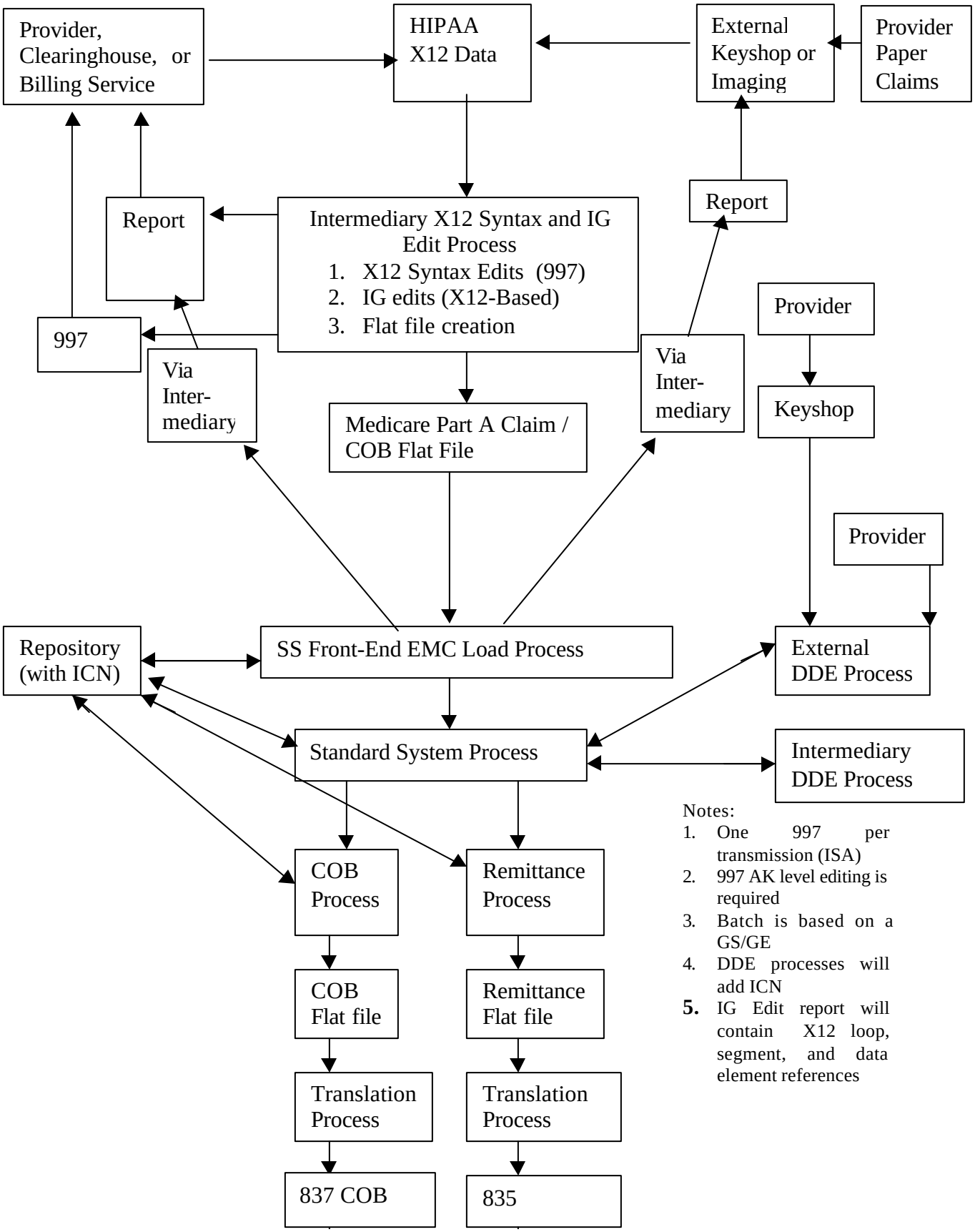
See the section of the instruction labeled "Cost Issues" for implementation cost information.

This PM may be discarded after October 1, 2002.

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

Attachment 1

Institutional High-Level Work Flow



Notes:

1. One 997 per transmission (ISA)
2. 997 AK level editing is required
3. Batch is based on a GS/GE
4. DDE processes will add ICN
5. IG Edit report will contain X12 loop, segment, and data element references

Attachment 2

This information supplements the Medicare Part A Claim/COB Flat File Spreadsheet:

Column	Description
Record	Record number
Title	Title of the Record
Field No.	The number of the filed within the record
Field Name	The name of the field (corresponds with the X12N 837 version 4010 name)
X12 PIC	The format of the Medicare Part A Claim/COB Flat File field data (x = alphanumeric, 9 = numeric), along with the number of data positions in the field
UB-92 PIC	The format of the UB-92 6.0 field data (x = alphanumeric, 9 = numeric), along with the number of data positions in the field
L/R	Whether the data is Left justified (alphanumeric) or Right justified (numeric)
Loop ID	The X12N 837 version 4010 loop identification
Segment	The X12N 837 version 4010 segment identification
Element	The X12N 837 version 4010 element identification
RQMT	Data requirement status – R = required, S = situational
Comments	IG page number or other comments pertinent to the data