Program Memorandum Intermediaries

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

Transmittal A-01-63 **Date: MAY 14, 2001**

CHANGE REQUEST 1611

SUBJECT: Further Guidance Regarding 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 further guidance 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) (Transmittal A-01-20 dated February 5, 2001). This further guidance is 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.

Translators

As stated in A-01-20, 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. Use only the 997 for syntax edit reporting. Use the X12 997 listed in the IG beginning on page B.2. The X12 997 GS08 data element will contain the X12N 837 GS08 data (currently 004010X096).

Attachment Data Processing

The HIPAA 837 version 4010 does not contain all of the attachment data contained in existing formats. Some Intermediaries receive attachment data via EDI and some don't. The decision to continue attachment processing via the Uniform Billing (UB) 92 Version 6.0 is to be made by each standard system user group, based on consensus reached. If the decision is to use the UB-92 Version 6.0, follow the UB-92 Version 6.0 instructions below. Otherwise, use Direct Data Entry (DDE) or paper. You are not required to create a 997 to acknowledge attachment data. You may create and use your own proprietary report(s) for feedback purposes.

UB-92 Version 6.0

The HIPAA 837 version 4010 does not contain attachment data found in the UB-92 record types (RTs) 74 through 77, which are used primarily for medical review. This data can no longer be submitted with the 837. You will need to maintain the capability to process certain UB-92 RTs used to create an attachment to an existing claim. These include RT01 (envelope record - shows where the records are coming from), RT10, RT74, RT75 series, RT76 series, RT77 series, RT90, RT95, and RT99 only (RT71, RT72, and RT73 are not included because the home health agency data in those records are adequately included in the HIPAA 837 version 4010). These records will be processed and their data merged with claims previously accepted into your adjudication system. You must request the attachment providing the internal control/document control number (ICN/DCN) of the previously accepted claim (as you currently do today) to the provider who will include it on RT74. Intermediaries having providers that currently send UB-92 claims that include

attachment RTs will need to notify those providers of the required processing change. Your standard system will process attachment UB-92 records against previously accepted claims as they do today. Information concerning the layout sequencing and use of these UB-92 RTs can be found in Addendum A of the Medicare Intermediary Manual (MIM). Accept only these RTs after October 16, 2002.

You will need to factor in these processing issues into your testing and implementation schedule.

Provider Direct Data Entry (DDE)

Providers may continue to use existing DDE screens for the input of attachment data.

Paper

Another format for submitting attachment data is Form HCFA-1450. Paper attachment data can no longer be submitted with the 837. You must request the attachment providing the previously accepted claim ICN/DCN to the provider (as you currently do today) who will include it on Form HCFA-1450, Form Locator 37. Information concerning the layout and use of Form HCFA-1450 can be found in MIM Section 3604.

Editing

Edits Performed by the Intermediary

- Edits to check the X12 syntax and IG requirements are performed on all data (Medicare and non-Medicare). Claims failing these edits should be rejected. If a data element is used by Medicare (e.g., condition code) and Medicare uses a limited number of iterations, all iterations are edited the same.

- The "HIGH-VALUES" editing described in A-01-20 has been changed. Data fields containing data larger than the data size described within the Medicare Part A Claim/COB flat file document will be flagged in one of two ways. If the data is defined on the Medicare Part A/COB flat file as numeric, populate the field with all nines. If the data is defined on the Medicare Part A/COB flat file as alpha-numeric, populate the field with ampersands.

- The 450 service line editing described in A-01-20 has been changed. 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 returned to the provider (RTP'd) by your standard system with an appropriate error message). There is no longer a requirement that the error message be based on a missing 001 revenue line.

- The Medicare additional edits document described in A-01-20 is now available at **www.hcfa.gov/medicare/edi/hipaadoc.htm** (instedit.xls). This document contains the specifications of edits that Medicare Fiscal Intermediaries are to perform on an inbound claim transaction. The first page of the workbook provides an overview of the columns/fields on the second page and how to utilize this workbook with the separate flat-file layout document. If a row/data element is grey in color, then the element is not used. The columns are as follows:

    - Element Identifier - This is the ANSI X12 Element Reference Designator (also known as the Abbreviated Element Name) from the HIPAA Implementation Guide.

    - Description - This is the ANSI X12 Element Name from the HIPAA Implementation Guide.

    - ID - This is the ANSI X12 Data Type from the HIPAA Implementation Guide.

    - Min./Max. - This is the element's minimum and maximum size in bytes from the HIPAA Implementation Guide.

    - Usage Req. - This indicates the INDUSTRY usage of the segment or data element from the HIPAA Implementation Guide.

- Loop - If the segment is part of a loop of repeating segments, the ID of the loop will appear here. If the segment is not part of a loop, then this field is blank.

- Loop Repeat - If the segment is part of a loop of repeating segments, the INDUSTRY Loop Repeat value will appear here.

- Valid Values/Valid Format - This field specifies the valid values/format for this data element or if it is a date or time, it specifies the format of the date or time. The values listed here are all the valid values or formats that are defined in the Implementation Guide.

- Medicare Values - This field may specify a subset of values or formats from the "Values" field that are applicable to Medicare.

- X12 Page No. - The page of the HIPAA Implementation Guide that this segment begins.

- Imp Guide Edit - This field is a Yes/No indicator to indicate if this field will be edited before passing the field to the standard Medicare claims processing system.

- Edit Logic - If the "Imp Guide Edit" field is Y, then this field will describe the type of editing to be performed on the data element. If the "Imp Guide Edit" field is N, this field will be blank.

- Suggested Reject Level - If there is edit logic to be performed for this data element, this field indicates that should the edit logic fail, this type of reject will occur.

You have the authority to decide how your proprietary reports going back to your submitters are done. You have the authority to provide provider education in lieu of or in addition to your reports.

Edits Performed by the Standard Systems

The “HIGH-VALUES” editing described in A-01-20 has been changed. Claims with Medicare numeric data elements containing all nines or claims with Medicare alpha-numeric data elements containing ampersands, are to be RTP’d, via the intermediary, with an appropriate error message.

While there has been some concern about claims with non-Medicare numeric data elements containing all nines or claims with non-Medicare alpha-numeric data elements containing ampersands (e.g., taxonomy code), based on today’s processing, **we expect this to occur rarely, if at all.** Send this data to the repository. We will revisit this issue during your testing to see if appropriate changes are needed.

You have the authority to decide how your proprietary reports going back to your submitters (via the intermediary) are done.

Combining Service Lines

The 837 can handle combining service lines (e.g., bundling, combining tests for laboratory panels, etc.). Specific instructions are contained in the IG in section 1.4.3, beginning on page 22. We have found 2 errors in the IG.

1. On page 22, the IG says: a pointer to the new bundled procedure code (SVD06, data element 554 (Assigned Number) is the bundled service line number that refers to either the line item control number (REF01 = 6R) submitted by the provider in the 837 (one/line) or the LX assigned number of the service line into which this service line was bundled if no line item control number is assigned). The line item control number (REF01 = 6R) is not valid in the institutional 837 IG. Therefore, the LX (Service Line Number) must be used.

2. On page 24, the SV2 (Institutional Service Line) is missing a revenue code (SV201) which is a required data element.

A corrected bundling example (bundling.doc) is being developed and will be at www.hcfa.gov/medicare/edi/hipaadoc.htm by April 30, 2001.

Additional Notes

The Summary of Process bullet 1 described in A-01-20 has been changed. The Intermediary's translation/edit process performs syntax edits and IG edits as well as maps incoming claim data to the flat file.

Both the flat file and the Medicare additional edit file should be considered FINAL. Any issues you discover during implementation should be communicated to the contact for this PM.

The usage of the IG Health Care Information (Health Claim Information Codes) on page 227 will be changed (as a result of the Designated Standard Maintenance Organizations (DSMO) process) from required to situational. This change will allow you to process certain claims without a principal diagnosis (as is done today). The DSMO process is still under way, but you should assume the field is situational.

The taxonomy code so far is required by the IG for certain claims. The DSMO process is under way to change the usage of the taxonomy code from required to situational. Until this is resolved, do not change your DDE process. If further instructions are needed, we will process another PM.

Your standard systems are not required to access the repository for adjustments and appeals.

Under HIPAA, otherwise valid Medicare claims will be rejected if they contain non-compliant non-Medicare data. Intermediaries should ensure that their provider education informs providers of this process.

This is to clarify that no claims correction facility for non-Medicare data is needed. If for any reason non-Medicare data from the repository cannot be translated out into a valid COB, the data may be dropped.

Summary of Major Differences between Transmittal A-00-89, dated November 28, 2000, (CR1391), A-01-20 (CR1533), and this PM

1. A-00-89 stated: 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. A-01-20 modified that language to: There is no need to collect non-Medicare data.

2. A-00-89 stated: The software (free billing) must be able to accept the maximum HIPAA compliant data content. A-01-20 modified that language to: Your billing software must be able to produce an IG compliant 837 for Medicare Part A claims.

3. A-01-20 stated: Standard systems are not to return non-Medicare data to the provider. This PM modifies that language to: Edits to check the X12 standard and IG requirements are performed on all data (Medicare and non-Medicare). Claims failing these edits should be rejected. This corresponds with language in the Medicare Intermediary Manual §3605.1.

The effective date for this PM is May 14, 2001.

The implementation date for this PM is July 1, 2001.

This PM clarifies A-01-20. See the section of A-01-20 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.