Program Memorandum Carriers

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

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CHANGE REQUEST 1534

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

This Program Memorandum (PM) provides carriers, Durable Medicare Equipment Regional Carriers (DMERCs), and their standard systems final instructions regarding implementation of version 4010 of the inbound X12N-837 Health Care Claim, and the outbound X12N-837 coordination of benefit transactions established with the 004010X098 Implementation Guide (IG). These instructions are based on recommendations from the Electronic Data Interchange Functional Workgroup (EDI FWG). The EDI FWG consists of members from HCFA, Part B contractors, and standard system maintainers. These instructions supplement PM B-00-49, dated September 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. These instructions also eliminate the requirement in PM B-00-68, dated November 28, 2000, regarding support of direct data entry (DDE) for incoming claims. The Medicare Carriers Manual sections that address electronic transaction requirements will be updated to include changes detailed in this PM.

Health Care Claim

Translators

As directed in PM B-00-68, dated November 30, 2000, carriers and DMERCs must be able to accept a HIPAA compliant X12N 837 transaction into their front-end system and write the X12N-based flat file to the 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). Carrier/DMERC translators will validate the syntax compliance of the inbound X12N 837 standard. Use the X12 997 Functional Acknowledgment to report standard level errors detected by your translators. Create the X12 997 Functional Acknowledgment, as detailed in the X12N 837 4010 implementation guide, to all EDI submitters who submit claims in the X12N 837 version 4010 format. You must return a X12 997 within 1 business day.

You must accept at least the basic character set on an inbound X12N 837, plus lower case and the @ sign which are part of the extended character set. Refer to appendix A, page A2 of the implementation guide for a description of the basic character set. All other character sets will be rejected at the translation level. If you can not accept more than 9,999 loops or segments due to the limitations of your translator, you may reject the transaction at the translator level and use the X12 997, AK3 segment with a value of “4” in data element “04”.

Your translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) and may include the BHT, in order that the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure which could cause software failure when mapping to the X12N-based flat file. The BHT is included as part of the envelope because data element BHT01, which indicates the hierarchical structure for the transaction set, may contain a code value other than indicated in the implementation guide and this could cause programming logic to process erroneously. It is your choice to edit the BHT at the translator level. You are not required to accept multiple functional groups (GS/GE) within one transmission. Your translators must also:

- Convert lower case to upper case;
- Pass all spaces to the X12N-based flat file for fields that are not present in the inbound X12N 837 version 4010;
- Map "Not Used" data elements based upon that segment's definition, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped;
- Remove the hyphen from all range of dates with a qualifier of "RD8" when mapping to the X12N-based flat file; and
- Accept multiple interchange envelopes within a single transmission.

Decimal Data Elements

All decimal data elements are defined as "R". Your translator should write these data elements to the X12N-based flat file at their maximum field size, which will be initialized to spaces. The COBOL picture found under the X12N 837 element name will be used to limit the size of the amounts. These positions are right justified and zero-filled. Your translators are to convert signed values using the conversion table shown below. This value is to be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the X12N-based flat file data element will be used as a placeholder to report an error code if an "R" defined data element exceeds the limitation that the Medicare system is authorized to process. The error code values are: "X" = value exceeds maximum amount based on the COBOL picture, "Y" = value exceeds maximum decimal places based on the COBOL picture, "Z" = value exceeds x-number of precision places, and "b" blank will represent no error. For example, a dollar amount with the implementation guide maximum of 18-digits would look like 12345678.90. Your translator will map this amount to the X12N-based flat file using the COBOL picture of S9(7)V99. The flat file amount will look like 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0". The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

Positive Values	Negative Values
1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

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.

PKZIP

You do not need to support PKZIP for X12N transactions. Compression is permitted between you and your data center. However, the X12N-based flat file must not be compressed when presented to your standard system.

Free Billing Software

As directed in PM B-00-49, dated September 28, 2000, you are to upgrade your free billing software to support the submission of claims in the X12N 837 (4010) format. You are to make it available to requesting providers no later than April 1, 2002. Your billing software must be able to create an IG compliant Medicare Part B claim. Medicare will stop supporting free billing software after October 2003.

Keyshop and Optical Character Recognition (OCR)/Image Character Recognition (ICR)

You may continue to use the National Standard Format (NSF) as the output format for paper claims received from keyshop and OCR/ICR. However, since HCFA will cease to support the NSF, eventual migration to the X12N-based flat file as the output format for these claims will need to occur. If you decide to use the X12N-based flat file as output for these claims, you may bypass the implementation guide edits since these claims will not contain all of the data on the inbound X12N 837 transaction.

Provider Direct Data Entry (DDE)

Since there is little provider use of DDE, it is not cost effective for you to redesign any existing DDE screens. You are to eliminate support of DDE in conjunction with the elimination of the NSF for claim submission. You may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA.

Implementation Guide Edits

Your standard system will program edits per the EDI FWG and edits should be standard between all shared systems.

Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. As directed in PM B-00-49, dated September 28, 2000, you are required to receive all possible data on the incoming X12N 837 although you do not have to process non-Medicare data. However, you must store that data in a store-and-forward repository (SFR). This repository will be designed by your standard system. This data must be reassociated with Medicare claim and payment data in order to create an outbound X12N 837 COB transaction. Your standard systems maintainer 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. You must retain the data in the SFR for a minimum of 6 months.

The X12N-based flat file is the format to be used to reassociate all data required to map to the outbound X12N 837 (4010). Your translator will build your outbound X12N 837 COB from the X12N-based flat file.

Your standard system maintainer must make the necessary programming changes for the outbound X12N 837 transaction as part of the July 2001 release. Begin internal testing of the outbound X12N 837 on or about July 1, 2001. You are to begin testing with your EDI COB trading partners on or about October 1, 2001.

Transmission Mode

HCFA recommends you send the outbound X12N 837 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.

Transmission Mode

HCFA recommends you send the outbound X12N 837 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.

Keyshop and OCR/ICR

Data on claims that your receive from your keyshop or OCR/ICR may not be included on your SFR, depending on your standard system design. Create your X12N-based flat file using data available from claim history and reference files. Since some data will not be available on these "paper" claims, the outbound X12N 837 COB will be built as a "minimum" data set. It will contain all "required" X12N 837 COB 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:

- Carrier's translator performs syntax edits and maps incoming claim data to the X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on X12N flat file is mapped to the core 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 store-and-forward repository; and
- Adjudicated data is combined with repository data to create the outbound COB.

Outreach

By September 30, 2001, carriers and DMERCs 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 X12N 837 for 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;
- Medicare will cease support of DDE for Part B claim submission.
- Each provider that has elected to submit claims electronically must submit all of their claims in compliance with the requirements in the X12N 837 version 4010, or if they contract with a clearinghouse to translate their claim data into the X12N 837 (4010) format, they must furnish that clearinghouse all data required by X12N 837 version 4010;
- Each trading partner that has elected to exchange COB electronically must accept version 4010 of the X12N 837, or contract with a clearinghouse to translate data from the X12N 837 version 4010 standard on their behalf;
- A provider, provider agent, trading partner, or clearinghouse that elects to use a clearinghouse for translation services is liable for those costs;

- The version 4010 X12N 837 implementation guide 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 carrier/DMERC acceptance of production data. EDI submitters should request a testing appointment as soon as possible to be assured they can complete testing and correct any detected system problems prior to October 2002. Appointment slots will be assigned on a first come basis. Carriers/DMERCs 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 X2N 837 COB prior to October 2002 or be confident that they have completed system changes as required to accept production X12N 837 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 COB transactions in October 2002 unless they notify you that they want to terminate their COB agreement;

- As a result of the large number of providers, agents, clearinghouses, and trading partners to be tested and the number of standard transactions that are to be implemented, 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 in a forthcoming program memorandum of detailed testing requirements and monitoring instructions.

Carriers/DMERCs 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. Carriers/DMERCs 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 carriers include one X12N 837 version upgrade per year in their line one maintenance costs. However, carriers are entitled to non-routine cost reimbursement related to HIPAA for supplemental costs for translator mapping to the new X12N-based flat files, 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. Carriers 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 EDI trading partners.

DMERCs were not previously required to implement any ASC X12N standards. DMERCs are entitled to reasonable costs for implementation, testing, and transition to these ASC X12N standards, and should submit SBRs in FY 2001 and FY 2002 for the reasonable and allowable costs they incur to use version 4010 of the X12N 837 transactions.

We strongly encourage you to submit SBRs as soon as the specific, reasonable supplemental costs are identified.

The *effective date* for this PM is July 1, 2001.

The *implementation date* for the X12N 837 COB is July 1, 2001.

The standard system release date is July 1, 2001.
Carrier/DMERC internal testing of the release begins July 1, 2001.
Carrier/DMERC EDI trading partner testing begins October 1, 2001.

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

This PM may be discarded after October 1, 2002.

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