Program Memorandum Intermediaries

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

Transmittal A-02-069 **Date: JULY 31, 2002**

CHANGE REQUEST 2134

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

This Program Memorandum (PM) provides additional information for intermediaries and their standard systems and is a follow-up to Transmittal A-02-014, dated February 12, 2002. The following information is being provided to you to ensure an accurate HIPAA implementation.

Date of Receipt

Transmittal A-02-014 stated that the date of receipt will be translator generated. This requirement is being modified. The date of receipt is to be generated upon receipt of a claim, prior to transmission of the data to the data center. The intermediary has the responsibility to ensure the correct date of receipt is populated onto the Medicare Part A Claim/Coordination of Benefit (COB) flat file (flat file) **before** the file gets to the standard system. Section 3600.1 of the Medicare Intermediary Manual, Part 3 further clarifies the reason the intermediaries, rather than the standard system, need to assign the date of receipt. The standard system will process the date of receipt reported in the flat file. If the flat file contains an incorrect date of receipt (e.g., all zeros), the flat file will be rejected back to the flat file's submitter (intermediary or data center) by the standard system with an appropriate error message.

Improper Flat File Format/Size

If the standard system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's submitter (intermediary or data center) by the standard system with an appropriate error message.

Decimal Edits to be Performed by the Intermediary

The IG allows for the units of service segment to contain a decimal. However, Medicare does not process units of service that contain any decimals. Notify your providers/submitters via your next scheduled bulletin that incoming claims where a unit of service contains any decimals will be rounded by Medicare so the standard system can process the resulting numeric unit of service (i.e., if the number to the right of the decimal is 4 or less, round down. If the number to the right of the decimal is 5 or greater, round up).

The IG allows for diagnosis codes to contain a decimal. However, CMS does not process diagnosis codes containing decimals. If an incoming claim contains a diagnosis code with a decimal in the correct position based on the external code source, the intermediary must reformat the diagnosis code into a 6-position alphanumeric field as defined in the Medicare Part A/COB flat file (flat file) where the digits are left justified and space filled when translating the data into the flat file format. The decimal will be assumed between the third and fourth digit (i.e., 999V9bb – "V" represents the assumed decimal and "b" represents a space). If an incoming claim contains a diagnosis code with a decimal in an incorrect position based on the external code source populate (flag) the field with ampersands.

Edits to be Performed by the Standard Systems

Claims containing a diagnosis code flagged with ampersands will be returned to the provider/submitter, via the intermediary, with an appropriate error message.

Medicare Edits Document Updates

The following are Medicare Edits Document (available by August 2, 2002 at www.hcfa.gov/medicare/edi/hipaadoc.htm) changes:

- REF01 (2310A Loop) Medicare Values is changed to '1C or 1G'.
- REF01 (2310A Loop) Edit Logic is changed to 'REF01 must contain the Medicare Provider Number code 1C or the Provider UPIN number code 1G'.
- REF01 (2310B Loop) Medicare Values is changed to '1C or 1G'.
- REF01 (2310B Loop) Edit Logic is changed to 'REF01 must contain the Medicare Provider Number code 1C or the Provider UPIN number code 1G'.
- REF01 (2310D Loop) Medicare Values is changed to '1C or 1G'.
- REF01 (2310D Loop) Edit Logic is changed to 'REF01 must contain the Medicare Provider Number code 1C or the Provider UPIN number code 1G'.
- REF01 (2420A Loop) Medicare Values is changed from '1C' to '1G'.
- REF01 (2420A Loop) Edit Logic is changed to 'REF01 must contain the Provider UPIN number code 1G'.
- REF01 (2420B Loop) Medicare Values is changed from '1C' to '1G'.
- REF01 (2420B Loop) Edit Logic is changed to 'REF01 must the Provider UPIN number code 1G'.
- REF01 (2420C Loop) Medicare Values is changed from '1C' to '1G'.
- REF01 (2420C Loop) Edit Logic is changed to 'REF01 must the Provider UPIN number code 1G'.
- REF01 (2420D Loop) Medicare Values is changed from '1C' to '1G'.
- REF01 (2420D Loop) Edit Logic is changed to 'REF01 must contain the Provider UPIN number code 1G'.

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

These instructions should be implemented within your current operating budget. No systems changes should be needed to carry out these instructions since it should not involve a change from how you are currently operating.

The effective date for this PM is July 31, 2002.

The implementation date for this PM is January 1, 2003.

This PM may be discarded after January 1, 2004.

Medicare contractor questions concerning this PM may be directed to Matt Klischer at (410) 786-7488, or mklischer@cms.hhs.gov.

Any provider, clearinghouse, or other vendor questions related to this PM should be directed to their servicing Medicare intermediary(s).