CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 175 **Date: MAY 14, 2004**

CHANGE REQUEST 3264

I. SUMMARY OF CHANGES: This transmittal includes instructions for Intermediary shared systems maintainers to make necessary changes to implement the HIPAA X12N institutional 837 transaction.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	24/40/7.1 - X12N 837 Institutional Implementation Guide (IG) Edits

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Change Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 175	Date: May 14, 2004	Change Request 3264

SUBJECT: Additional Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Institutional Health Care Claim Implementation Guide (IG) Instruction and Clarification of Transmittal 107/Pub 100-04 (CR 3031)

I. GENERAL INFORMATION

A. Background: The ICD-9 procedure codes were named as the HIPAA standard medical code set for inpatient hospital procedures. The HCPCS/CPT codes were named as the HIPAA standard medical code set for physician services and other health care services (including outpatient hospital procedures). Medicare has not been rejecting outpatient claims if they contain ICD-9 procedure codes, but this results in non-compliant coordination of benefits (COB) claims. Medicare will no longer accept outpatient claims (including Direct Data Entry (DDE)) with ICD-9 procedure codes. In addition, Medicare will begin editing all occurrences of certain codes to ensure that they are valid. Previously, some occurrences were not edited for validity resulting in the possibility of non-compliant COB claims. This instruction includes requirements for DDE.

B. Policy: The CMS is committed to implementing the institutional 837 per the HIPAA IG. The CMS does not plan to modify the claim correction DDE screen(s) since claim correction is not a covered transaction under HIPAA. DDE does not accept as many ICD-9 procedure codes as an 837. As a result, DDE claim correction screens cannot be used for correction of ICD-9 procedure codes in excess of DDE screen capacity. Likewise, a DDE claim correction screen cannot be used to correct diagnosis codes, or occurrence span codes in excess of the DDE screen limits. Corrections to codes that exceed the DDE screen limits must be submitted via a corrected 837. This instruction is effective with claims received October 4, 2004 and later.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article's release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

D. Transmittal 107 (Pub. 100-04, CR 3031, dated February 24, 2004) Corrections: Business requirement 3031.1 has been changed to remove bill type 22X. Business requirement 3031.10 has been changed to read "Contractor shall edit all outpatient HIPAA X12N 837 claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code." Business requirement 3031.10.2 has been changed to read " For the outbound X12N 837 HIPAA COB

transaction, contractor shall ensure a “ZZ” qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present on an outpatient claim.”

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3264.1	Contractors shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG).	FI Shared systems maintainers
3264.2	Contractors shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG).	FI Shared systems maintainers
3264.3	Contractors shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG).	FI Shared systems maintainers
3264.4	Contractors shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG).	FI Shared systems maintainers
3264.5	Contractors shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG).	FI Shared systems maintainers
3264.6	Any claims submitted via DDE containing an invalid E-code, value code, diagnosis code, occurrence code, or occurrence span code shall be subject to on-line edits.	FI Shared systems maintainers
3264.7	Contractors shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code.	FI Shared systems maintainers
3264.8	Any claims in requirement 3264.7 containing an ICD-9 procedure code shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.	FI Shared systems maintainers
3264.9	Contractors shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims received via DDE to ensure each does not contain an ICD-9 procedure code.	FI Shared systems maintainers

3264.10	Any claims in requirement 3264.9 containing an ICD-9 procedure code shall be subject to on-line edits.	FI Shared systems maintainers
3264.11	Contractors shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid E-code.	FI Shared systems maintainers
3264.12	Contractors shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid diagnosis code.	FI Shared systems maintainers
3264.13	Contractors shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid value code.	FI Shared systems maintainers
3264.14	Contractors shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid occurrence code.	FI Shared systems maintainers
3264.15	Contractors shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid occurrence span code.	FI Shared systems maintainers
3264.16	Any inbound HIPAA X12N 837 claims containing an invalid code (E-code, value code, diagnosis code, occurrence code, or occurrence span code) shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.	FI Shared systems maintainers
3264.17	Business requirement 3031.1 has been changed to remove bill type 22X. Contractor shall adjust the edit.	FI Shared systems maintainers
3264.18	Business requirement 3031.10 has been changed to read "Contractor shall edit all outpatient HIPAA X12N 837 claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code." Contractor shall adjust the edit.	FI Shared systems maintainers
3264.19	Business requirement 3031.10.2 has been changed to read " For the outbound X12N 837 HIPAA COB transaction, contractor shall ensure a "ZZ" qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present on an outpatient claim." Contractor shall adjust the edit.	FI Shared systems maintainers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov 410-786-7488 **Post-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov 410-786-7488	**These instructions should be implemented within your current operating budget.**

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 175, 05-14-04)

The FI shared system will edit 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims to ensure each contains a line item date or dates of service for each revenue code. Claims not containing a line item date or dates of service for each revenue code shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. These claims containing an ICD-9 procedure shall be rejected by the shared system with an appropriate error message before the flat file is received by the shared system.

The FI shared system will process 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims containing a service line date range in the following manner:

1. Process the "from date."

2. Store the "through date" for possible 837 coordination of benefits transaction creation.

The FI shared system will edit all *outpatient* claims to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a "ZZ" qualifier are accepted (not just HIPPS skilled nursing facility rate codes).

The FI shared system will edit all outpatient claims to ensure each does not contain Covered Days (QTY Segment). Outpatient claims containing Covered Days shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all claims to ensure each does not contain a NPP000 UPIN. Claims containing a NPP000 UPIN shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound X12N 837 HIPAA COB transaction, the FI shared system will edit all claims to ensure each containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system will edit all claims to ensure each does not contain an invalid E-code. Claims containing an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any found shall be subject to on-line edits.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid E-code, value code, diagnosis code, occurrence code, or occurrence span code shall be subject to on-line edits.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be subject to on-line edits.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid E-code, value code, occurrence code, or occurrence span code. These shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The healthcare provider taxonomy codes (HPTCs) must be loaded, by the FIs and FI shared system, as contractor-controlled table data, rather than hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. The HPTCs are scheduled for update two times per year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Use the most cost effective means to obtain the list for validation programming and updating purposes.

The FIs and FI shared system will edit all claims to ensure that HPTCs that have been submitted comply with both the data attributes for the data element as contained in the HIPAA 837 IG, and are contained in the approved list of HPTCs. HPTCs are not required data elements. Claims received with invalid HPTCs shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all *outpatient* claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" *diagnosis* code. *Outpatient c*laims containing an invalid "Patient Reason for Visit" code (a "Patient Reason for Visit" code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound HIPAA X12N 837 COB transaction, the FI shared system shall ensure a "ZZ" qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present *on an outpatient claim*.

For bill types 12X and 22X, FIs and FI shared system will be responsible for editing to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected from the flat file with an appropriate error message before the flat file is *accepted* by the shared system.

For bill types 12X and 22X, the FI shared system will edit to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via direct data entry (these are already required for other inpatient bill types). Claims not containing this data shall be subject to an appropriate on-line error message.