CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 107 **Date: FEBRUARY 24, 2004**

CHANGE REQUEST 3031

I. SUMMARY OF CHANGES: Intermediaries and intermediary shared systems maintainers must make necessary changes to implement the HIPAA X12N 837 institutional 837 transaction.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
IMPLEMENTATION DATE: July 6, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, 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/Table of Contents
N	24/40.7.1/X12N 837 Institutional Implementation Guide (IG) Edits
R	24/70.1/FI Requirements
R	25/20.6/Edits Performed by the FI

***III. FUNDING:** Contractors are to submit funding requests for any costs incurred in the implementation of this change request (including any necessary translator modifications). You are to provide a detailed explanation for each task for which you are requesting additional funding. Submit any funding requests to Sumita Sen (SSEN@cms.hhs.gov) by March 31, 2004 with an e-mail copy to your applicable Consortium Contractor Management Staff coordinator.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 107	Date: February 24, 2004	Change Request 3031

SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Health Care Claim Implementation Guide (IG) Editing Additional Instruction

I. GENERAL INFORMATION

A. Background: Shared systems changes are needed to process the 837 Institutional X12N HIPAA claim transaction correctly. A number of issues with Coordination of Benefits (COB) transactions with third party payers, including states, have emerged as Medicare has implemented HIPAA transaction and code set standards. Some of these issues stem from Medicare having unique claims processing rules that differ from those used by other payers. We made a number of system and data element changes to implement the HIPAA standards, but some issues were not evident until testing with COB partners began. The claims Medicare sends out for COB are viewed as incoming claims by other payers.

Some of the COB issues stem from Medicare's designation of "inpatient" and "outpatient" claims, which Medicare previously based on the trust fund from which these claims were paid, rather than whether the services were provided on an inpatient or outpatient basis. Data requirements for these so-called "outpatient" claims are different from those of other payers who treat the same claims as inpatient. This difference in the treatment of claims – Medicare treating a claim as outpatient that COB partners treat as inpatient, and the associated data requirements and system edits – creates HIPAA exchange problems when Medicare crosses over these claims to COB partners.

In general, the following bill types are considered outpatient:

13x, 14x	– Outpatient Hospital
23x, 24x	– SNF
32x, 33x, 34x	– Home Health (HHA)
71x	– Rural Health Clinic (RHC)
72x	– Renal Dialysis Facility (RDF)
73x	– Federally Qualified Health Center (FQHC)
74x	– Outpatient Rehabilitation Facility (ORF)
75x	– Comprehensive Outpatient Rehabilitation Facility (CORF)
76x	– Community Mental Health Center (CMHC)
81, 82,	– Hospice
83x	– Hospice - Hospital Outpatient Surgery Subject to Ambulatory Surgery Center Payment Limits (ASC)
85x	– Critical Access Hospital (CAH)

In general, the following bill types are considered inpatient:

11x – Hospital
12x – Inpatient Part B Hospital
18x – Swing Bed
21x – Skilled Nursing Facility (SNF)
22x – Inpatient Part B SNF
41x – Religious Non-Medical Health Care Institution (RNHCI)

There are three types of data requirements that we are addressing to ensure exchange of COB information. First, Medicare will now require certain data elements that are not needed for Medicare claims adjudication but are required by HIPAA. Second, data that Medicare previously allowed but is not permitted by HIPAA will result in claim rejections. Third, certain data that Medicare now edits only for syntax will be edited for content, and will cause claim rejections if it is not valid.

The ICD-9-CM procedure codes were named as the HIPAA standard code set for inpatient hospital procedures. The HCPCS/CPT codes were named as the HIPAA standard code set for physician services and other health care services. The Office of HIPAA Standards (OHS) posted an FAQ stating that "…health plans must realize that reporting hospital outpatient services with ICD-9-CM procedure codes on standard claim transactions is not compliant, and that their good faith efforts to come into compliance must include steps being taken to change this requirement." Based on provider and payer input regarding this issue we have decided not to begin rejecting outpatient claims with ICD-9-CM procedure codes at this time. However, providers and payers should be aware that we plan to begin rejecting outpatient claims with ICD-9-CM procedure codes in an upcoming systems release.

Situations where direct data entry changes are needed will be addressed in an upcoming systems release.

B. Policy: The CMS is committed to implementing the institutional 837 per the HIPAA implementation guide (IG).

C. Provider Education: A provider education article related to this instruction is available at www.cms.hhs.gov/medlearn/matters. Contractors shall post this article to their website, and include it in a listserv message if applicable, within one week of the issuance of this CR. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3031.1	Contractor shall edit 13X, 14X, 22X, 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	Fiscal Intermediary (FI) Shared systems maintainers

	service for each revenue code.	

3031.1.1	Any claims in requirement 1 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.	Fiscal Intermediary (FI) Shared systems maintainers
3031.2	Contractor shall process 13X, 14X, 22X, 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.	FI Shared systems maintainers
3031.3	Any outpatient claims containing Covered Days (QTY Segment) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.	FI Shared systems maintainers
3031.4	Contractor shall edit all 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).	FI Shared systems maintainers
3031.5	Contractor shall edit all claims to ensure each does not contain a NPP000 UPIN.	FI Shared systems maintainers
3031.5.1	Any claims in requirement 5 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.	FI Shared systems maintainers
3031.6	For the outbound X12N 837 HIPAA COB transaction, contractor shall edit all claims to ensure each containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).	FI Shared systems maintainers
3031.7	Contractor shall edit all claims to ensure each does not contain an invalid E-code.	FI Shared systems maintainers
3031.7.1	Any claims in requirement 7 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.	FI Shared systems maintainers
3031.8	The healthcare provider taxonomy codes (HPTCs) shall be loaded by the contractor as contractor-controlled table data, rather than hard coded. Contractor-controlled tables minimize the impact of future updates. The HPTCs are scheduled for update two times per year (tentatively October and April).	FIs and FI Shared systems maintainers
3031.8.1	The HPTC list in requirement 8 should 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	FIs and FI Shared systems maintainers

	WPC on a subscription basis.	

3031.8.2	Contractor shall use the most cost effective means to obtain the HPTC list in requirement 8 for validation programming and updating purposes.	Fis and FI Shared systems maintainers
3031.9	Contractor shall 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.	Fis and FI Shared systems maintainers
3031.9.1	Any claims in requirement 9 received with invalid HPTCs shall be rejected from the flat file with an appropriate error message by the contractor before the flat file is received by the shared system.	Fis and FI Shared systems maintainers
3031.10	Contractor shall edit all 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.	FI Shared systems maintainers
3031.10.1	Any claims in requirement 10 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.	FI Shared systems maintainers
3031.10.2	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.	FI Shared systems maintainers
3031.11	For bill types 12X and 22X, contractor shall edit 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).	Fis and FI Shared systems maintainers
3031.11.1	Any claims in requirement 11 not containing this data shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.	Fis and FI Shared systems maintainers
3031.12	For bill types 12X and 22X, contractor shall 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).	FI Shared systems maintainers
3031.12.1	Any claims in requirement 12 not containing this data shall be rejected by the contractor with an appropriate error message by the shared system.	FI Shared systems maintainers
3031.13	Contractor shall populate the outbound COB files with the Tax ID or SSN identifiers that are present on their provider files.	FI Shared systems maintainers

3031.13.1	If no TaxID or SSN is available for any claims in requirement 13, contractor shall populate NM109 with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data.	FI Shared systems maintainers
3031.14	Within 30 days after publication of this CR, FIs shall notify their providers of the requirements above.	FIs
3031.15	Contractors should continue to ensure that 12X and 22X claims are paid from the Part B Trust Fund.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
3031.4	The complete list of valid HIPPS codes is available at www.cms.hhs.gov/providers/hippscodes/.

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: July 1, 2004 **Implementation Date:** July 6, 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	**Funding for implementation activities will be provided to contractors through the regular budget process.**

Medicare Claims Processing Manual

Chapter 24 - EDI Support Requirements

Table of Contents

(Rev. 107, 02-24-04)

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 107, 02-24-04)

The FI shared system(s) will edit 13X, 14X, 22X, 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(s) will process 13X, 14X, 22X, 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(s) will edit all 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(s) 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(s) 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(s) 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(s) 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 healthcare provider taxonomy codes (HPTCs) must be loaded, by the FIs and FI shared system(s), 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(s) 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(s) will edit all 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" code. Claims 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.

For bill types 12X and 22X, FIs and FI shared system(s) 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 received by the shared system.

For bill types 12X and 22X, the FI shared system(s) 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 errored with an appropriate error message.

70.1 - FI Requirements

(Rev. 107, 02-24-04)

A-01-20, A-02-069, A-02-077, A-02-078, AB-02-20, A-01-63

A - Shared system Claim/COB flat file

If the shared 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 (FI or data center) by the shared system with an appropriate error message. If a syntax error occurs at the standard level, FIs must return the entire transmission (ISA to IEA) to the submitter via the ANSI X12N 997.

The date of receipt is to be generated upon receipt of a claim, prior to transmission of the data to the data center. The FI 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 shared system. The shared 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 (FI or data center) by the shared system with an appropriate error message.

B - Standards

External Keyshop or Imaging Processing

FIs support only the UB-92 version 6.0 as the output format for paper claims received from their external keyshop or imaging processes. However, since CMS will cease to support the UB-92 version 6.0, except for attachment processing, 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, 2003. If FIs decide to use the Medicare Part A Claim/COB flat file as output for these claims, FIs may bypass the IG edits since these claims will not contain all of the data on the inbound ANSI 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. FIs 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. The CMS 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 the shared 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 the shared system's internal claim records); and

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

Additionally, the following HIPAA DDE updates are effective January 6, 2003. DDE systems must:

- Allow for **only** one investigational device exemption number (IDE) per claim (at the claim level);

- Remove employment status code, employer name, and employer address information;

- Allow Other Subscriber Demographic Information (date of birth and gender) if the other subscriber is a person;

- Allow for discharge hour and minute information in the numeric form of HHMM; and

- Allow for correct processing of the unique physicians identifier number in the 2310A (Attending Physician) loop.

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 shared system files, an IG compliant COB transaction can be written.

NOTE: Additional edits may be needed based on further analysis and issues that may be encountered during implementation.

C - Edits Performed by the FI

FIs are to perform standard and IG edits as explained in the IG. *The* IG edits should be standard among all FIs. If a syntax *compliance* error occurs at the IG level, the FI may reject the entire *data interchange*, the functional group, *the transaction*, or *the* claim. At a minimum, it 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 store-and-forward repository (SFR) by the shared system). The following programmatic edits override the IG:

- Claims where the ZIP code exceeds nine 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 shared 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 eight digits (CCYYMMDD), except for date ranges. Claims where the date data exceeds eight positions (and not a valid date range) are to be rejected with an appropriate error message.

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

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

- Number of days (covered, lifetime reserve, etc.) will not exceed four positions. Claims where the number of days exceeds four positions are to be flagged so the shared 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.

- 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 all nines.

- As of April 2003, the CMS changed the service line limit to 449. For claims exceeding 449 service lines, write the first 449 lines to the Medicare Part A Claim/COB flat file (the claim will later be RTP'd by the shared system with an appropriate error message based on the missing 0001 line).

- All spaces will be passed to the Medicare Part A Claim/COB flat file for fields that are not present in the inbound ANSI X12N 837 HIPAA version.

- 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. FIs must round units of service that contain decimals so the shared system can process the resulting numeric unit of service (i.e., if the number to the right of the decimal is four or less, round down. If the number to the right of the decimal is five or greater, round up).

- The IG allows for diagnosis codes to contain a decimal. However, the FI systems do 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 FI 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.

D - Edits Performed by the Shared systems

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

- Claims with numeric data elements containing all nines are to be returned by the shared system to the provider via the FI with an appropriate error message.

- Claims with S9(8)V99 numeric data elements containing an amount greater than corresponding fields set in the core system at 9 digits (S9(7)V99) are to be returned by the shared system to the provider via the FI 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 ANSI X12N 837 will be RTP'd with an appropriate error message because Medicare policy requires a signature on file for payment.

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

For more information on edits, refer to the Medicare Edits Document available at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

E - Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. FIs are required to receive all possible data on the incoming 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared 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. The shared 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. The shared 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. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

FIs are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The FI shared system(s) shall populate the outbound COB files with the Tax ID or SSN identifiers that are present on their provider files.

If no TaxID or SSN is available, the FI shared system(s) shall populate NM109 with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data.

F - Transmission Mode

The CMS recommends that the outbound COB transaction be sent over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. COB trading partners will need to reach agreement on telecommunication protocols. It is the FI choice as to whether it wishes to process the ANSI X12N 997 Functional Acknowledgment from COB trading partners.

G - External Keyshop or Imaging Processing

Data on claims received from the keyshop or image processing systems may not be included on the SFR, depending on shared system design. FIs must create their 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.

H - Summary of Process

The following summarizes all FI steps from receipt of the incoming claim to creation of the outbound COB:

- FI'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 the shared 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 the FI's shared system; and

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

20.6 - Edits Performed by the FI

(Rev. 107, 02-24-04)

A-01-20, A-01-63, A-02-119

FIs perform standard and IG edits as explained in the IG. *The* IG edits are standard among all FIs. If a syntax *compliance* error occurs at the IG level, the FI may reject the entire *data interchange*, the functional group, *the transaction*, or *the* claim. At a minimum, it must return the rejected claim on the confirmation report to the provider if it is not HIPAA compliant. Amounts, percentages, integers, and other fields designated in the IG as numeric are 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 are 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 correspond to the maximum IG length. Incoming alpha-numeric non-Medicare data is 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 is 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) are mapped to the Medicare Part A Claim/COB flat file (and later written to the Store and Forward Repository (SFR) by the FI's shared system. The SFR is a file in the FIs shared system used to hold Non-Medicare data for association with Medicare data at the end of the claims process, so all the incoming data is available for the outgoing transaction.). The following programmatic edits override the IG:

- 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.

- Claims where the ZIP code exceeds 9 positions are left adjusted and the claim is processed.

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

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

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

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

- Claims where the attending, *other*, or operating physician numbers exceed 16 positions are flagged so the shared systems can RTP with an appropriate error message.

- Units of Service may not exceed 7 positions. If the Units of Service entry exceeds 7 positions, the claim is flagged so the shared systems can RTP with an appropriate error message.

- Number of days (covered, lifetime reserve, etc.) may not exceed 4 positions. If the number of days exceeds 4 positions, the claim is flagged so the shared systems can RTP with an appropriate error message

- Credit card and foreign currency data are 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.

The FI IG edit process maps amounts to the Medicare Part A Claim/COB flat file using the COBOL picture of S9(8)V99 (10 positions). Other numeric data elements are mapped to the data size described within the Medicare Part A Claim/COB flat file document. Data fields containing data larger than the data size described within the Medicare Part A Claim/COB flat file document are flagged in one of two ways. If the data is defined on the Medicare Part A/COB flat file as numeric, the field is populated with all nines. If the data is defined on the Medicare Part A/COB flat file as alpha-numeric, the field is populated with ampersands.

For claims exceeding 449 service lines, FIs write the first 449 lines to the Medicare Part A Claim/COB flat file (the claim is later RTP'd by the FI shared system with an appropriate error message).

Prior to April 1, 2003, the number of service lines written to the Medicare Part A Claim/COB flat file was 450, which included a total line. For claims received after March 31, 2003, the shared system uses CLM02 data, as well as other line item claim data, to create a 0001 line for use in internal processing. To generate an 837 COB, the shared system does not enter the 0001 revenue line on the flat file (moving the 0001 line ANSI codes to a Claim Level Adjustment fields on the flat file. To generate an 837 COB, the shared system generates the f lat file total claim charge amount. After March 31, 2003, the 0001 revenue line is not sent on the outbound 837 COB transaction.

FIs pass all spaces to the Medicare Part A Claim/COB flat file for fields that are not present in the inbound ANSI X12N 837 HIPAA version. An "Additional Medicare Edits" document is available at http://cms.hhs.gov/providers/edi/hipaadoc.asp. This

document contains the specifications of edits that Medicare FIs 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 gray in color, then the element is not used. The columns are as follows:

- Element Identifier - This is the ANSI X12N Element Reference Designator (also known as the Abbreviated Element Name) from the HIPAA Implementation Guide.

- Description - This is the ANSI X12N Element Name from the HIPAA Implementation Guide.

- ID - This is the ANSI X12N 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 is 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.

Each FI has the authority to decide how its proprietary reports going back to its submitters are done. They have the authority to provide provider education in lieu of or in addition to the FI reports.