Medlearn Matters
Information for Medicare Providers
CMS CENTERS for MEDICARE & MEDICAID SERVICES

Related Change Request (CR) #: 3031 **Medlearn Matters Number:** MM3031

Related CR Release Date: February 24, 2004

Related CR Transmittal #: 107

Effective Date: July 1, 2004

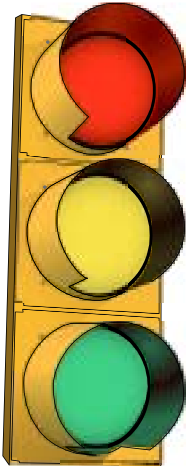
Implementation Date: July 6, 2004

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

Provider Types Affected

All Medicare providers who bill Medicare Fiscal Intermediaries (FIs).

Provider Action Needed



STOP – Impact to You

Effective July 1, 2004, Medicare systems are enforcing additional HIPAA edit instructions related to X12N 837 Institutional Claims. These changes are required by the HIPAA Implementation Guides for the 837 transaction.

CAUTION – What You Need to Know

It is important for you to become familiar with the changes outlined in this article. Failure to comply with these changes will result in claim rejects and accompanying payment delays.

GO – What You Need to Do

Be sure your billing processes comply with these changes to continue correct and timely payments. Refer to the Background section for an itemized list of the required changes.

Background

When preparing for HIPAA implementation, CMS focused first on inbound claims. As CMS tested with providers, we worked through changes that needed to be made. Once the inbound claim process was in order, CMS began to work on the coordination of benefits (COB) transaction. Medicare sends almost 80% of all claims out to trading partners as a COB record. Many new issues have arisen since the trading partners treat these COB records, also known as crossover claims, as inbound claims. Issues surfaced where Medicare's business rules were different from other payers. The changes that will take effect in July fall into three primary categories:

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- 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 claims rejections.
- Third, certain data that Medicare now edits only for syntax will be edited for content and will cause claim rejections if the data is not valid.

One source of confusion between CMS and COB trading partners is the distinction between inpatient and outpatient bill types. This instruction specifies how each bill type is categorized by Medicare. In general, Medicare considers the following bill types as outpatient:

13X, 14X	Outpatient Hospital
23X, 24X	Skilled Nursing Facility (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)
81X, 82X	Hospice
83X	Hospice – Hospital Outpatient Surgery subject to Ambulatory Surgery Center (ASC) Payment Limits
85X	Critical Access Hospital (CAH)

In general, the following bill types are considered as 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 Facility (RNHCI)

Following is a summary of the itemized changes that Medicare systems will now implement, but you should also look at the CR for all technical details:

1. For all outpatient claims, all line items must contain a date or dates of service for each revenue code or it will be rejected.
2. Any outpatient claims containing Covered Days (QTY Segment) will be rejected.

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3. All claims will be edited to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a "ZZ" modifier are accepted (not just HIPPS SNF rate codes). A complete list of valid HIPPS codes may be found at http://www.cms.hhs.gov/providers/hippscodes/.
4. All claims containing a NPP000 UPIN will be rejected.
5. All claims containing an invalid E-Code (an E-Code not listed in the external code source referenced by the HIPAA 837 institutional implementation guide) will be rejected. Note that Medicare does not require or use E codes, but if they are sent, they must be valid.
6. All claims that contain healthcare provider taxonomy codes (HPTCs) must have HTPCs that comply with the implementation guides or they will be rejected. Note that Medicare does not require or use taxonomy codes, but if they are sent, they must be valid.
7. All HIPAA X12N 837 claims that contain revenue code 045X, 0516, or 0526 must also contain an HI02-1 code of "ZZ" along with a HIPAA-compliant "Patient Reason for Visit" diagnosis code or it will be rejected.
8. All inpatient claims must contain the admission date, admitting diagnosis, admission type code, patient status code, and admission source code or the claim will be rejected. Medicare previously did not require these elements on 12X or 22X bill types, but now they will be required.

Providers and their submitters should carefully review these requirements to ensure that claims are not unnecessarily rejected effective July 6, 2004.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3031 in the CR NUM column on the right, and click on the file for that CR.

For additional information on HIPAA, please visit:

http://www.cms.hhs.gov/hipaa/hipaa2/links/default.asp

For additional information on the implementation guides, please visit:

http://www.wpc-edi.com/hipaa/HIPAA_40.asp

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