CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1614	**Date: OCTOBER 3, 2008**
	Change Request 6190

Subject: Healthcare Provider Taxonomy Codes (HPTC) Update October 2008

I. SUMMARY OF CHANGES: Intermediaries, Carriers, and DME Contractors must obtain the most recent Healthcare Provider Taxonomy Codes (HPTC) list and use it to update their internal HPTC tables. The attached Recurring Update Notification applies to Chapter 24, Sections 40.7.1, 40.7.2, 40.8.1, and 40.8.2.

New / Revised Material
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	24/40.7.1/X12N 837 Institutional Implementation Guide (IG) Edits
R	24/40.7.2/X12N 837 Professional Implementation Guide (IG) Edits
R	24/40.8.1/X12N 837 Institutional Implementation Guide and Direct Data Entry Edit
R	24/40.8.2/X12N 837 Professional Implementation Guide Edits

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to

be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1614	Date: October 3, 2008	Change Request: 6190

SUBJECT: Healthcare Provider Taxonomy Codes (HPTC) Update October 2008

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

I. GENERAL INFORMATION

A. Background: The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available from the Washington Publishing Company (WPC) http://www.wpc-edi.com/codes/taxonomy in two forms. The first form is a free Adobe PDF download. The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

B. Policy: HIPAA requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim. Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid, and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6190.1	Contractors and maintainers shall use the most cost effective means to obtain the October 2008 HPTC list, which should be available online by the end of the first week in July.	X	X	X	X	X	X	X	X		
6190.2	Contractors and maintainers shall update the current HPTC Tables with the October 2008 HPTC list.	X	X	X	X	X	X	X	X		
6190.3	Contractors shall notify submitters of 837-I and 837-P claims in a Newsletter/Bulletin and	X	X	X	X	X					

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	on their provider Web page of deletions, additions, or modifications in each HPTC update that could affect claims sent to Medicare, and the effective date of those changes. MLN articles are not prepared for code updates.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

A. Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

B. All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Brian Reitz, Brian.Reitz@cms.hhs.gov , 410-786-5001 for professional claims and Matthew Klischer Matthew.Klischer@cms.hhs.gov , 410-786-7488 for institutional claims.

Post-Implementation Contact(s): Brian Reitz, Brian.Reitz@cms.hhs.gov , 410-786-5001 for professional claims and Matthew Klischer Matthew.Klischer@cms.hhs.gov , 410-786-7488 for institutional claims.

VI. FUNDING

A. ***For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):*** No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 1614; Issued: 10-03-08 : Effective:10-01-08 ; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The FI shared system shall edit (via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims, TOBs 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 of service (LIDOS) for each revenue code. Outpatient claims not containing a LIDOS for each revenue code shall be rejected from the flat file with an appropriate error message.

The FI shared system shall edit outpatient claims submitted via direct data entry (DDE) to ensure each contains a LIDOS for each revenue code. Any outpatient claims found without a LIDOS for each revenue code shall be subject to an appropriate on-line error message.

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 shall 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 shall 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 shall edit outpatient claims submitted via DDE to ensure all occurrences of the data element do not contain Covered Days. Any outpatient claims submitted via DDE containing Covered Days shall be subject to an appropriate on-line error message.

The FI shared system shall 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.

The FI shared system shall edit all claims submitted via DDE to ensure each does not contain a NPP000 UPIN. Any claims submitted via DDE containing a NPP000 UPIN shall be subject to an appropriate on-line error message.

For the outbound X12N 837 HIPAA COB transaction, the FI shared system shall 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 shall 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 claims found containing an invalid E-code shall be subject to an appropriate on-line error message.

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 condition code (a condition 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, condition code, value code, diagnosis code, occurrence code, or occurrence span code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any outpatient claim found containing an ICD-9 procedure code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient 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, condition 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 2 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 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 institutional 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 shall 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 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 on an outpatient claim.

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

40.7.2 – X12N 837 Professional Implementation Guide (IG) Edits

(Rev. 1614; Issued: 10-03-08 : Effective:10-01-08 ; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The Part B carriers and durable medical equipment regional carriers (DMERCs) must reject inbound electronic claims that contain invalid diagnosis codes whether pointed to a specific detail line or not.

The Part B carriers and DMERCs shall reject inbound electronic claims that contain a space, dash, special character, or 1 byte numeric in any zip code.

The Part B carriers and DMERCs must reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.

40.8.1 – X12N 837 Institutional Implementation Guide and Direct Data Entry Edits

(Rev. 1614; Issued: 10-03-08 : Effective:10-01-08 ; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The FI shared system shall reject (via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) and TOBs 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims that lack a line item date of service (LIDOS) for each revenue code with an appropriate error message. The FI shared system shall reject outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims that contain an ICD-9 procedure code with an appropriate error message.

The FI shared system shall accept all outpatient claims that include any applicable Health Insurance Prospective Payment System (HIPPS) Rate Code and a "ZZ" qualifier and shall not reject HIPPS codes just because they are not HIPPS skilled nursing facility rate codes.

The FI shared system shall reject all outpatient claims that contain Covered Days (QTY segment in an X12N 837 and equivalent DDE screen field entry) with an appropriate error message.

The FI shared system shall reject all claims that contain a NPP000 UPIN with an appropriate error message.

The FI shared system shall ensure each COB/Medigap claim containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system shall reject all claims that contain an invalid E-code as referenced by the HIPAA 837 institutional IG with an appropriate error message.

The FI shared system shall reject all claims that contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid condition code (a condition 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) with an appropriate error message.

The healthcare provider taxonomy codes (HPTCs) shall be loaded by the FIs 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

updated twice per year (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/or FI shared system 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 institutional IG, and are contained in the approved list of HPTCs. Claims received with invalid HPTCs shall be rejected with an appropriate error message.

The FI shared system shall 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 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 with an appropriate error message.

When preparing a COB/Medigap flat file transaction, the FI shared system shall ensure "ZZ" is in HI02-1 when revenue code 045X, 0516, or 0526 is present on an outpatient claim.

For bill types 12X and 22X, FIs and/or FI shared system shall reject inbound claims if the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are not present (contractors should already be editing other inpatient bill types to ensure these present). Claims not containing these data elements shall be rejected with an appropriate error message.

40.8.2 – X12N 837 Professional Implementation Guide Edits

(Rev. 1614; Issued: 10-03-08 : Effective:10-01-08 ; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The Part B carriers and MACs shall reject inbound electronic claims that contain invalid diagnosis codes whether or not pointed to a specific detail line.

The Part B carriers and MACs shall reject inbound electronic claims that contain a space, dash, special character, or 1 byte numeric in any ZIP Code.

The Part B carriers and MACs shall reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.