CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2535	**Date: August 31, 2012**
	Change Request 8018

SUBJECT: Chapter 24 Update to Remove Outdated Information

I. SUMMARY OF CHANGES: Chapter 24 is being updated to remove outdated bill type information in sections 60.2.1, 60.2.2, and 60.2.3.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

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	24/60.2.1/FIs, Carriers, RHHIs, A/B MACs, and CEDI HIPAA Claim Level Edits
R	24/60.2.2/X12N 837 Institutional Implementation Guide (IG) Edits
R	24/60.2.3/X12N 837 Institutional Implementation Guide and Direct Data Entry Edits

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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:
Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2535	Date: August 31, 2012	Change Request: 8018

SUBJECT: Chapter 24 Update to Remove Outdated Information

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

I. GENERAL INFORMATION

A. Background: Chapter 24 is being updated to remove outdated bill type information in sections 60.2.1, 60.2.2, and 60.2.3.

B. Policy: N/A.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8018.1	Contractors shall be familiar with the updates in Chapter 24, subsections 60.2.1, 60.2.2, and 60.2.3.	X			X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Matthew Klischer, 410-786-7488 or matthew.klischer@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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.

60.2.1 - FIs, Carriers, RHHIs, A/B MACs, and CEDI HIPAA Claim Level Edits

(Rev.2535, Issued: 08-31-12, Effective: 10-01-12, Implementation: 10-01-12)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare's transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

A. IG Edit Module

The FIs, Carriers, RHHIs, A/B MACs, and CEDI must reject 837 claims that contain implementation guide (IG) or Medicare program-only errors at the claim level. FIs that are unable to reject individual claims in a batch that have IG or Medicare program errors when the batch is syntactically correct, and there are no errors higher in the batch hierarchy that would prevent processing, must install an edit module. This edit module must be able to reject claims that have implementation guide (IG) errors at the claim level (see example below). If a batch of claims passes the basic syntax edits, the edit module will be invoked and only claims that fail the IG edits will be rejected and appropriate error messages issued.

ISA (example 1)
GS (example 2)
ST (example 3)
PROV A
SUBSCRIBER A (example 5)
CLAIM A1 (example 6)
CLAIM A2
CLAIM A3
SUBSCRIBER AA
CLAIM AA1
CLAIM AA2
PROV B (example 4)
SUBSCRIBER B
CLAIM B1
CLAIM B2 (example 6)
CLAIM B3
SE
ST
PROV C
SUBSCRIBER C

CLAIM C1
CLAIM C2
CLAIM C3 (example 6)
PROV D
SUBSCRIBER D
CLAIM D1
CLAIM D2
CLAIM D3
SE
GE
IEA

Example 1 (ISA-IEA level IG edit): Any errors found at this level (envelope) will result in all claims within the ISA-IEA being rejected.

Example 2 (GS-GE level IG edit): Any errors found at this level will result in all claims within the GS-GE being rejected. In this example all claims would be rejected. If a second GS-GE loop followed the first and passed all edits, then any claims within the second GS-GE would be entered into the system providing they passed the IG edits.

Example 3 (ST-SE level IG edit): Any errors found at this level will result in all claims within the ST-SE being rejected. In this example assume only the first ST had errors. In this case claims A1, A2, A3, B1, B2, B3 would be rejected. Claims C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits.

Example 4 (Provider level IG edit): Any errors found at this level will result in all claims for this provider being rejected. In this example assume only the Provider B had errors (such as an invalid provider number). In this case, claims A1, A2, A3, C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits and claims B1, B2, B3 would be rejected.

Example 5 (Subscriber level IG edit): Any errors found at this level will result in all claims for this subscriber being rejected. In this example, claims for Subscriber A (A1, A2, and A3) would be rejected. Claims for Subscriber AA (AA1 and AA2) would be entered into the system providing they passed IG edits.

Example 6 (Claim level IG edit): Any errors found at this level will result in only that claim(s) being rejected. In this example assume only claims A1, B2 and C3 had errors. All of the other claims would be entered into the system providing they passed IG edits.

B. Additional Part A IG Edits

Neither the FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, nor an FI if editing separately shall reject any outpatient claims reported with the “ZZ” qualifier

that contain a Health Insurance Prospective Payment System (HIPPS) Rate Codes. (Note: CR 3264 effective October 1, 2004 clarified that this edit applies to outpatient claims only.)

The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all outpatient claims to identify any that contain a Covered Days (QTY) segment. Outpatient claims containing Covered Days shall be rejected with an appropriate error message, and not forwarded to the shared system.

The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall reject all claims containing a NPP000 UPIN with an appropriate error message, and not forward those claims to the shared system.

For outbound X12N 837 HIPAA COB transactions, the FI shall edit all claims to ensure that any containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall reject all occurrences in inbound claims of invalid: E-codes, condition codes, value codes, occurrence codes, and occurrence span codes with an appropriate error message, and not forward those claims to the shared system.

The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs into a contractor-controlled table designed by the shared system maintainer. HPTCs may not be hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. HPTCs are updated twice a year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge at wwww.wpc-edi.com/codes, or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. FIs are to use the most cost effective means to obtain the list for validation programming and updating purposes.

The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all claims to ensure that submitted HPTCs comply with both the data attributes for the data element as contained in the HIPAA 837 IG, and are valid. To be valid, a HPTC must appear in the latest HPTCs update FIs were required to implement by CMS. HPTCs are not reported in a required data element, but claims received with invalid HPTCs shall be rejected with an appropriate error message, and not forwarded to the shared system.

The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either 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” diagnosis code that is 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, and not forwarded to the shared system. (Note: CR 3264 effective October 1, 2004 clarified that this applies to outpatient claims only.)

FISS shall ensure that a “ZZ” qualifier is populated in the flat file field for HI02-1 when Revenue code 045X, 0516, or 0526 is present in an outpatient claim and an outbound X12N 837 COB transaction is being prepared. (Note: CR 3264 effective October1, 2004 clarified that this applies to outpatient claims only.)

For bill types 12X and 22X, the FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit to ensure 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 with an appropriate error message and not forwarded to the shared system.

60.2.2 - X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 2535, Issued: 08-31-12, Effective: 10-01-12, Implementation: 10-01-12)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare’s transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

The FI shared system shall edit outpatient *claims* to ensure *they* 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 contain 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.

60.2.3 - X12N 837 Institutional Implementation Guide and Direct Data Entry Edits

(Rev. 2535, Issued: 08-31-12, Effective: 10-01-12, Implementation: 10-01-12)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare's transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

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 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.