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

Key Words

HIPPA, edits, MM3264, MM3337, claims, rejections, implementation, guide, outpatient, inpatient, MM3031, CR3031, PPS

Provider Types Affected

Medicare providers who bill Medicare fiscal intermediaries (FIs)

Key Points

- The effective date of the instruction is July 1, 2004.
- The implementation date is July 6, 2004.
- MLN Matters article MM3031 was re-issued on August 30, 2004.
- MM3031 was revised and clarified as follows:
    - MM3264 revised item 7 on page 3 of MM3031, which should read “All outpatient HIPPA X12N 837 claims that contain revenue codes of 045X, 0516, or 0526 must also contain an HI02-1code of “ZZ” along with a compliant “Patient Reason for Visit” diagnosis code.
    - MM3337 changed the requirement for Medicare FIs to edit outpatient claims to ensure each contains a line item date or dates of service (LIDOS) for each revenue code.
    - MM3337 states that effective for claims submitted on or after October 1, 2004, the Centers for Medicare & Medicaid Services (CMS) will require a single date in the LIDOS field on all outpatient claims and inpatient Part B claims.
    - Medicare FIs will reject any claim where the LIDOS field contains a range of dates.
- Effective July 1, 2004, Medicare systems are enforcing additional HIPPA edit instructions related to X12N 837 Institutional Claims; these changes are required by the HIPPA Implementation Guides for the 837 transaction.
- Changes in the following three primary categories will take effect on July 1, 2004:

  - Medicare will now require certain data elements that are not needed for Medicare claims adjudication, but are required by HIPPA.
  - Data that Medicare previously allowed, but is not permitted by HIPPA , will result in claims rejections.
  - 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.
- 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; and
  - 85X Critical Access Hospital (CAH).
- Medicare considers the following bill types as inpatient:
  - 11X Hospital;
  - 12X Inpatient Part B Hospital;
  - 18X Swing Bed;
  - 21X Skilled Nursing Facility (SNF);
  - 22X Inpatient Part B SNF; and
  - 41X Religious Non-Medical Facility (RNHCI).
- The itemized changes that Medicare systems will now implement are:
  - For all outpatient claims, all line items must contain a date or dates of service for each revenue code or the claim will be rejected;
  - Any outpatient claims containing Covered Days (QTY Segment) will be rejected with an appropriate error message;

- 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/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp* on the CMS website;
- All claims containing a NPP000 UPIN will be rejected; and
- 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. Medicare does not require or use E codes, but if they are sent, they must be valid.
    - All claims that contain healthcare provider taxonomy codes (HPTCs) must have HPTCs that comply with the implementation guides or they will be rejected. Medicare does not require or use taxonomy codes, but if they are sent, they must be valid;
    - All HIPAA X12N 837 claims that contain revenue code 045X, 0516, or 0526 must also contain an H102-1 code of "ZZ" along with a HIPAA-compliant "Patient Reason for Visit" diagnosis code or it will be rejected; and
    - 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.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3031.pdf* on the CMS web site.

The official instructions (CR3031) regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R107CP.pdf* on the CMS web site.