

Solicitation for Provider Feedback

We are requesting feedback from individual providers on new data requirements and potential claim rejections involving exchange of claims information for Coordination of Benefits transactions. Associations should not reply.

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.

There are three types of data requirements that need to be addressed to ensure exchange of COB information. First, Medicare would need to 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 would result in claim rejections. Third, certain data that Medicare now edits only for syntax would be edited for content, and would cause claim rejections if it is not valid.

CMS would plan extensive provider education on the new HIPAA data requirements, in combination with new Medicare claims processing edits that would reject claims that do not conform to the new requirements. We believe that this approach would not be unduly burdensome for providers, since providers are currently following these requirements for other payers. However, we want to validate our assumption by soliciting provider feedback on the burden to the provider community. Below is a summary of the new data requirements and the affected provider and claim types.

New edits and affected claim types would be as follows:

New Inpatient/Outpatient Edits	Provider/Bill Type Affected
For outpatient claims, line item date(s) of service must be submitted for each revenue code per the HIPAA Institutional 837 Implementation Guide (IG).	CMHC (76X), CORF (75X), FQHC (73X), HHA (32X, 33X, 34X), OPT (74X), RDF (72X), RHC (71X), SNF (23X, 24X), Ambulance (13X, 23X, 83X, 85X), Outpatient (13X, 14X), Hospice (81X, 82X, 83X), ASC (83X), CAH (85X)

Reject outpatient claims that contain an ICD-9 procedure code per the IG.	CMHC (76X), CORF (75X), FOHC (73X), HHA (32X, 33X, 34X), OPT (74X), RDF (72X), RHC (71X), SNF (23X, 24X), Ambulance (13X, 23X, 83X, 85X), Outpatient (13X, 14X), Hospice (81X, 82X, 83X), ASC (83X), CAH (85X)
Reject claims with invalid E-codes (External cause codes within the ICD-9 code set) per the IG.	All 837 Institutional Claims
Reject claims with invalid taxonomy codes per the IG.	All 837 Institutional Claims
Reject claims with an incorrect patient reason for visit qualifier per the IG.	All 837 Institutional Claims
Reject inpatient claims that do not contain: <ul style="list-style-type: none"> - compliant admission date - compliant admitting diagnosis - compliant admission type - compliant admission source code - compliant patient status code 	SNF (22X), Hospital (12X)

Please send your comments by February 3, 2004 to: Mklischer@cms.hhs.gov
The email subject line must contain the words PROVIDER IMPACT.