837: Transactions & Code Sets Constraints

The new HIPAA data transmission format, as specified in the standard implementation guides, provides direction for how compliant transactions should be sent and received by trading partners. The following, addresses specific constraints and identifies a list of options that DHS is currently examining in its pursuit of HIPAA compliance.

The DHS 837 Transactions and Code Sets constraints are:

1. One transactions set per unique Functional Group.
2. Accurate separation of “chargeable” and “reporting” data as identified by the “claim or encounter identified” code. Only one type of data allowed per Transaction Set.
3. Maximum of 5,000 CLM, health claim, segments in a single transaction, which is the same as the guide recommendation.
4. DHS/OMAP can only process 28 service lines, or “detail lines.” HIPAA allows for 50 maximum in the Professional 837.
5. Dollar amounts are limited to seven characters - $99,999.99. (The HIPAA standard X12 allows a min 1/max 18).
6. Units of service not to exceed 999.9 (The HIPAA standard X12 allows min 1/max 15).
7. “Billing provider secondary identification” (837 - Loop 2010AA). This is an OMAP required field. Implementation Guide allows up to 8 repeats of loop. OMAP will use up to 2 in Encounter and 3 in Fee for Service.
8. “Claim frequency code” (837 - Loop 2300). OMAP is not using “replacement of prior claim” data to be for encounter data, but is for Fee for Service.
9. Diagnosis codes. OMAP is using the “principle diagnosis” code and up to three additional “diagnosis codes.” HIPAA allows for 7 additional “diagnosis codes.”
10. “Referring provider name” (837 - Loop 2310A). OMAP will not use for encounter; will use one repeat for FFS. HIPAA allows two repeats with rule to code “referring provider” first and “primary care provider” second if both are needed.
11. “Referring provider secondary identification” (837 - Loop 2310A). Situational loop needed for Fee for Service (but not encounter). OMAP will use up to three repeats. (HIPAA allows up to five repeats).
12. “Claim level adjustments” (837 - Loop 2320). OMAP will process one repeat for encounter claims and up to five for Fee for Service. (HIPAA allows max on five repeats.)
13. “Procedure modifier” (837 - Loop 2400). OMAP will process the first two modifiers. (HIPAA allows up to four to be sent.)
14. “Referring provider” information will be obtained from the claim level; if the information is not available at the claim level only the information associated with the first service line will be used by OMAP.
15. “Line adjustment” “line adjudication information.” OMAP will use only the first adjustment reason code and adjustment amount. HIPAA allows up to 99 repeats.

Additional Clarifications for specified items in the above list, (as requested by Trading Partners, April 25, 2003.)

1. FUNCTIONAL GROUP: HIPAA – An x12 group (GS-GE) used to identify related transaction sets.
CURRENT – There is not an established definition for a functional group, but relating it to what x12 has, a definition could be – "A submission of claims from a recognized provider for payment or reporting purposes."
FUTURE – All ST-SE pair within each functional group are to be the same functional type.

2. DATA TYPE (CHARGEABLE or REPORTABLE): CHARGEABLE – "CH"
HIPAA — Claims where there are monies to be paid. CURRENT – Fee for Service claims.
REPORTABLE – "RP"
HIPAA – When the transaction is being used for purposes other than adjudication of a claim.
CURRENT – For Encounter Data.
FUTURE – Do not mix chargeable and reportable data types per ST-SE groups. Must have "CH" or "RP" entered.

3. MAXIMUM CLM SEGMENTS PER TRANSACTION: HIPAA -- Accepts a maximum of 5000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA implementation guide. Min repeat 1.
CURRENT – Currently there are limits of claims that may be submitted at any one time. For Bulletin Board System, there is an 8-megabyte of data per file limit, however there is no limit to the number of files that may be submitted.
FUTURE: We will accept the recommendations of the HIPAA implementation guides to allow up to 5000 CLM segments per ST-SE pair.

4. MAXIMUM DETAIL LINES/CLAIM: HIPAA – Allows for maximum of 50 detail lines in the professional 837, 50 detail lines in the dental 837, and 999 detail lines in the institutional 837.
CURRENT – MMIS System only takes 28 lines per claim for all claims types.

5. DOLLAR AMOUNT FIELD SIZE: HIPAA – The X12 length is a minimum of 1 to a maximum of 18.
CURRENT – The maximum amount allowed to be paid for a procedure, treatment, or service item. The entered as value is 99,999.99.

6. UNITS OF SERVICE: HIPAA -- The quantity of units, times, days, visits, services, or treatments for the service described by the HCPCS codes, revenue code or procedure code. The X12 length is a minimum of 1 to a maximum of 15. A decimal can be used in the field.
CURRENT -- A quantitative measure of the medical services rendered to or for a recipient. Services include visits, injections, days, hours, mileage, etc. Unit of service is a numeric field and cannot exceed 999.0

7. BILLING PROVIDER SECONDARY ID: HIPAA -- Identifies another or additional distinguishing code number associated with the billing provider. This number can come from one of many different sources. X12 defines this field to be alphanumeric and bet between 1 and 30 bytes long.
CURRENT – At the present time there is not a secondary identification required or used for the referring providers. The current OMAP provider number (6 bytes) will be used.

8. CLAIM FREQUENCY CODE: HIPAA -- Code specifying the frequency of the claim (This is the third position of the Uniform Billing Claim Form Bill Type). Available codes are found in the National Code Source 235. (as of 5/01/03 acceptable codes will be "1" = Original – admit through discharge claim, "7" = Replacement – replacement of prior claims, and "8" = Void (void/cancel of prior claims).
CURRENT -- Code specifying the frequency of the claim (This is the third position of the Uniform Billing Claim Form Bill Type).
CURRENT VALID CODES ARE:
"1" = Original (admit thru discharge claim)
"6" = Corrected (adjustment of prior claim)
"7" = Replacement (replacement of prior claims)
"8" = Void (void/cancel of prior claims)

9. DIAGNOSIS CODES: HIPAA -- An ICD-9-CM diagnosis Code identifying a diagnosed medical condition. The X12 defines this field to be alphanumeric and be between 1 and 30 bytes long. The 837 professional implementation guide shows a use of up to 8 times per segment and the segment can be repeated 1 time. The 837 institutional implementation guide shows a use of 1 principle diagnosis code and up to 12 diagnosis codes per segment and the segment can be repeated 2 times.

CURRENT – Used to identify a diagnosed medical condition per the "ICD 9CM" manual. ICD 9 CM (International Classification of Diseases 9th Revision Clinical Modification) is published by the U.S. Government, and contains the classifications of medical diagnoses and procedures. The current value has a length of 5 bytes and we allow 1 primary and 4 secondary diagnosis codes.

10. REFERRING PROVIDER NAME: HIPAA -- The name of provider who referred the patient to the provider of service on this claim.
CURRENT -- The name of an individual or organization providing goods and/or services known to the State.
FUTURE – DHS will not pull referring provider names from the 837s.

11. REFERRING PROVIDER SECONDARY ID: HIPAA – Additional identification number for the provider referring the patient for service. This number can come from one of many different sources. X12 defines this field to be alphanumeric and be between 1 and 30 bytes long.
CURRENT – At the present time there is not a secondary identification required or used for the referring providers. The current OMAP provider number (6 bytes) will be used.

12. CLAIM LEVEL ADJUSTMENTS: HIPAA – Will be used to make adjustments to previously submitted claims.
CURRENT – At the present time all adjustments are done manually. The reason codes for HIPAA are equivalent to the present EOB codes (which will disappear after HIPAA).
FUTURE – We will accept 837 adjustments electronically.

13. PROCEDURE MODIFIERS: HIPAA -- This identifies special circumstances related to the performance of the service, as defined by trading partners. This is a two byte alphanumeric field. This field can be used up to 4 times per segment and the segment can be repeated 1 time.
CURRENT -- A code that records whether a claim has been pended during adjudication because of fund cutoff for a procedure or by provider type. This is a two byte alphanumeric field. This field can occur up to 3 times.

CURRENT VALID CODES ARE:

HCPCS MODIFIERS
AA = Anesthesia by Anesthesiologist
AB = Medical Direction (own employee) by Anesthesiologist
AC = Medical Direction (not employed) by Anesthesiologist
AD = Supervision > 4 Anesthesia Services
AE = Direction of Residents
AF = Anesthesia - Complicated Hypothermia
AG = Anesthesia - Emerg. Surg
AP = Determination Ref. State
AR = Return Ambulance Trip
AT = Acute Treatment
CC = Proc Code Change
DD = Powdered Enteral Formulae
EP = EPSDT Service
ET = Emerg. Dental Treat
FP = Family Planning Service
LL = Lease/Rental
LR = Lab Round Trip
LS = FDA Monitored - Lens Implant
LT = Left Side
MP = Multiple Patients Seen
NR = New When Rented - Subsequently Purchased
NU = New Equipment
PS = Professional Component
QW = CLIA Waived Test
RP = Replace & Repair
RR = Rental

RT = Right Side
SF = Second Opinion - PRO
TC = Technical Component
TS = Total Global Charges
UE = Used DME
VP = Aphasic Patient
YY = Second Surgical Opinion
ZZ = Third Surgical Opinion

CPT MODIFIERS
20 = Microsurgery
22 = Unusual Services
23 = Unusual Anesthesia
25 = Digital Radiology
26 = Professional Component
47 = Anesthesia by Surgeon
50 = Bilateral Procedure
51 = Multiple Procedures
52 = Reduced Services
54 = Surgical Care Only
55 = Postoperative Management
56 = Preoperative Management
62 = Two Surgeons
66 = Surgical Team
75 = Concurrent Care
76 = Repeat Procedure - Same Physician
77 = Repeat Procedure - Another Physician
80 = Assistant Surgeon
81 = Minimum Assistant Surgeon
82 = Assistant Surgeon - Resident Surgeon Not Available
90 = Reference (outside) Laboratory
99 = Multiple Modifiers

14. REFERRING PROVIDER INFORMATION: HIPAA – Information will be obtained from the claim level; if the information is not available at the claim level only the information associated with the first service line will be used by OMAP.
CURRENT – Referring providers in today's business are not very important. Our emphasis is on who performed the procedure.

15. LINE ADJUSTMENT/LINE ADJUDICATION INFORMATION: HIPAA – Used to report line level adjustments from prior payments, which cause the amount paid to differ from the amount originally charged.
CURRENT – At the present time all adjustments are done manually. The reason codes for HIPAA are equivalent to the present EOB codes (which will disappear after HIPAA).