

LIMITATIONS APPENDIX FOR ALL RECORD TYPES
AS OF: 08/01/2011

CARR_LINE_PRFRMG_UPIN_LIM

FULL NAME: Carrier Line Performing UPIN Limitation
DESCRIPTION :
Missing performing provider UPINS on denied carrier claims.
BACKGROUND :
In 1996 it was discovered that the performing provider UPINS were missing on denied carrier claims.
CORRECTIVE ACTION :
A change release was added in CWF in 7/00. A remedy had been worked out prior to 7/00 but other activities precluded its resolution.
SOURCE:
ADMINISTRATIVE DATA:
START DATE : 1996
END DATE : 07/00
CONTACT : OIS/EDG/DMUDD

CHOICES_DEMO_LIM

FULL NAME: Choices Demonstration Limitation
DESCRIPTION :
A programming error created an 'INVALID' indication in the demo text field for CHOICES claims.
BACKGROUND :
In 6/00, the CWF MQA front-end editing revealed that some CHOICES demo claims were coming in with a valid 'H' number in the fixed portion of the claims, but in the first occurrence MCO trailer a numeric packed field (value hex '0100000C') was moved to the MCO Contract Number/Option Code fields. This created an invalid period check of number/code to MCO effective date, resulting in an INVALID indication in the demo info text field.
CORRECTIVE ACTION :
The problem was forwarded to the CWF BSOG staff for further investigation.
SOURCE:
CONTACT : OIS/EDG/DMUDD

CLM_OPPTS_LIM

FULL NAME: Claim Outpatient PPS Limitation
DESCRIPTION :

OPPS claims processed by FISS and APASS had a number of problems with the line item detail data.

BACKGROUND :

In July, 2001 a problem was discovered with the OPPS claims processed by FISS with service dates greater than 8/1/00. Roughly 80% nationally did not have any line items except those that were assigned an APC code; there were also no charges or HCPCS for any services that were bundled into an APC.

It was later discovered that the data processed by FISS was also missing the APC code and that other fields may also be missing: (1) Discount and package flags were not being used; (2) revenue rate is only populated for non-PPS services (3) Revenue line Medicare payment amount field was not always populated and was not reliable. It was also discovered that other revenue center line payment amounts were not being populated correctly between the two Standard Systems (FISS & APASS).

The actual Medicare payment amount were correct and the claim-level data appeared to be accurate.

CORRECTIVE ACTION :

A fix (correcting the problem of missing data) was applied to production effective 8/6/01. A special utility was created to correct history (service dates 8/1/00-8/5/01).

Both the 2000 and 2001 OPPS adjustments were loaded into the NCH in the October and November monthly files. The 2001 OP SAF was completed 1/15/02 and the 2000 OP SAF was completed 1/18/02 (updated through December 2001).

NOTE: The problems with the revenue center line payment amount fields have not been corrected. The correction to these fields is tentatively scheduled for 4/1/03 (it is likely that this date will slip).

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 08/01/00
END DATE : 01/15/01
CONTACT : OIS/EDG/DMUDD

CLM_SNF_VRSN_I_REC_LIM

FULL NAME: Claim SNF Version 'I' Record Limitation
DESCRIPTION :
SNF Version 'I' claims were incorrectly identified in
the NCH Nearline as Inpatient encounter claims.
BACKGROUND :
SNF claims matching the Inpatient encounter data criteria
were incorrectly identified as Inpatient encounters (NCH
Claim Type Code is '61', rather than '20' or '30').
If the SNF claims were identified as Inpatient encounters,
the MCO Paid Switch was set to '1'.
CORRECTIVE ACTION :
The problem was corrected during the NCH quarterly
update in March 2001. The NCH Claim Type was correctly
identified as '20' or '30'. The MCO Paid Switch was
changed to '0'. A patch code trailer was added to the
record: Patch Code '14' and a patch apply date of
'20010330'.
SOURCE:
ADMINISTRATIVE DATA:
START DATE : 07/07/00
END DATE : 01/26/01
CONTACT : OIS/EDG/DMUDD

CLM_TRANS_CD_LIM

FULL NAME: Claim Transaction Code Limitation
DESCRIPTION :
Claim Transaction Code missing from 1999 inpatient
records and there was also a problem identified
in the May and June 2000 data.
BACKGROUND :
Users of the data discovered taht the claim trans-
action code was missing values 2 & 3 for service year
1999 and for the months of May and June, 2000. This
information was confirmed and OIS/BSOG was notified.
CORRECTIVE ACTION :
In July 2000 the problem was fixed and the claim
transaction code contained the correct values.
SOURCE:
CONTACT : OIS/EDG/DMUDD

HHA_AB_SHIFT_LIM

FULL NAME: HHA A/B Shift Limitation
DESCRIPTION :
There were several problems with the final HHA claims
containing both Part A and Part B visits (RIC 'U').
The prorated amounts in value code 64/65 were not

reliable and the claim-level total visit count did not always balance to the PTA & PTB visits.

BACKGROUND :

Although the claim-level reimbursement is correct, the value code 64/65 amounts representing the prorated Part A and Part B trust fund payments are not reliable. The other problem with the HH PPS RIC 'U' data is that the claim-level HHA total visit count does not always balance to the total Part A and Part B visits, as reported in the value code 62/63 amount fields.

CORRECTIVE ACTION :

CMM staff has been consulted and the problem will be corrected at some future date, but in the interim users need to know how to derive the correct prorated amounts from the existing data. The following is the agreed-upon approach:

(1) Assume the claim-level reimbursement amount is correct on all final HHA claims, and properly includes any outlier payment. Nothing needs to be added to the field to derive the total Medicare trust fund payment.

(2) For those final HHA claims (RIC 'U') that report both Part A and Part B visits, drop whatever is reported in the value codes 64 and 65 (Part A/B reimbursement), and substitute the correct prorated amounts derived by:

(a) Adding up Part A and Part B visits, as reported in the value codes 62/63 amount fields (don't use the claim-level total visits because of the out-of-balance anomaly);

(b) Calculating percentage of total visits (from Step 1) attributable to Part A and Part B; and

(c) Applying the percentages to the claim-level reimbursement amount derive the correct Part A and Part B reimbursement (value code 64/65 amounts).

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA_HCPCS_LIM

FULL NAME: Home Health HCPCS Limitation

DESCRIPTION :

It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.

BACKGROUND :

The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be the corresponding HH discipline; however, there is no check to see if the discipline revenue center code appears and that the HCPCS contains the corresponding 'G' code.

CORRECTIVE ACTION :

The Standard Systems has put a fix in to correct this problem.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA_MISG_CLM_LIM

FULL NAME: HHA Missing Claim Limitation

DESCRIPTION :

Incomplete HHA claims date beginning with service year 1998.

BACKGROUND :

The problem is related to the implementaion of the shift of payment for Medicare HHA visits between Part A and Part B trust funds. Claims with dates of service from 1/1/98, with visits that spanned A/B split, were auto canceled in a one time run at the end of June 1998. Although these claims were canceled (and therefore not in the NCH), these claims were paid.

There was a national total of 4,506,501 claims with service dates 1/1/98 and after; of which 63,029 (or 2%) were the missing cancel only claims which needed to be recovered.

All HHA files (NCH, SAF, HCIS) contained incomplete data until the problem was fixed.

CORRECTIVE ACTION :

A Two-Timer Utility was used to recalculate all Home Health benefit periods to determine the correct A or B benefits for claims in house.

A Three-Timer Utility was developed to create a file to identify all HHA claims that were auto-adjusted or auto-canceled in the June 1998 One-Timer and from current claims processing through 5/21/99. The utility automatically processed the automatic adjustments/cancels and submitted the new claims to CWF for approval/posting and sent them to the NCH.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 1/1/98
END DATE : 5/24/99
CONTACT : OIS/EDG/DMUDD

HHA_PPS_LUPA_0023_LINE_LIM

FULL NAME: HHA PPS LUPA '0023' Revenue Center Line Limitation

DESCRIPTION :

There are inconsistencies with the Home Health PPS LUPA claims with the '0023' revenue center line.

BACKGROUND :

One of the Home Health PPS requirements for LUPA claims was that on a LUPA claim the '0023' revenue center line should show zero payment and the per visit amounts should be shown on the visit lines.

Prior to 4/1/02, noncovered revenue center lines were not being submitted to CWF. This should have meant that all LUPA claims in NCH should not have a '0023' revenue center line until after 4/1/02 implementation of noncovered revenue lines on OP, HHA & Hospice claims.

The problem was that one Standard System (APASS) did not implement the requirement correctly. APASS showed the total payment amount for the LUPA on the '0023' line and no payments on the visits. This caused the NCH to have both LUPA claims with no '0023' line and some with the '0023' line.

CORRECTIVE ACTION :

Since APASS payments are accurate and there is no adverse provider impact from this variance, a

resource decision was made not to pursue a fix to this issue in APASS. The RHHI (only one) currently on the APASS system will transition off of APASS onto FISS in 2004 and the variance should be resolved at that time.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 10/01/00
END DATE : 04/01/02
CONTACT : OIS/EDG/DMUDD

HHA_PPS_RIC_CD_ADJSTMT_LIM

FULL NAME: Home Health PPS RIC Code Adjustment Limitation
DESCRIPTION :

The Record Identification Code (RIC) on Home Health PPS claims were not being adjusted properly.

BACKGROUND :

The value code on HHA claims that are auto-adjusted in CWF are not being changed to agree with the adjustment being made to the RIC code. For example, the HHA claims are initially received as a Part B (RIC 'W' with a value code '63'); then subsequently adjusted to Part A (RIC 'V'), but the value code is not changed to '62'.

CORRECTIVE ACTION :

A Change Request was written to correct this problem. The change was implemented March 2001.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA_PTA_OVRD_TRLR_LIM

FULL NAME: HHA Part A Overlaid Trailer Limitation

DESCRIPTION :

Overlaid revenue center lines on HHA RIC 'V' claims

BACKGROUND :

During the Version 'I' conversion, it was decided that each segment of a claim would contain a maximum of 45 revenue center lines. During the month of June 2000 the CWFMQA began receiving the new format, but the NCH was not scheduled to receive the new format until July 2000. Since NCH was not ready, CWFMQA converted the 'I' claims back to the Version 'H' format. A typo in the code caused the additional revenue lines to overlay revenue lines on the base/initial record/segment.

The problem occurred in 2,627 HHA Part A (RIC 'V') claims with between 46-58 revenue center lines and

NCH Weekly Process dates 6/16/00, 6/23/00, 6/30/00 and 7/7/00 (both Version 'H' and 'I' files). There were 2,277 claims for service year 2000; 324 claims for 1999 and 40 claims for 1998 and 1 claim for 1997.

NOTE: Instead of being the last line on the claim, revenue code '0001' was embedded within the other revenue lines on the base record.

CORRECTIVE ACTION :

In the NCH Version 'I' files, the annual service year 2000 files, service year 1999 and 1998 trickles were patched. The 18-month final service year 2000 SAF was created after the fix was applied. The 18-month service year 1999 was patched. A patch code '15' was created with a patch applied date of 06/29/2001.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA_RFRL_CD_LIM

FULL NAME: HHA Referral Code Limitation

DESCRIPTION :

HHA referral code was blanked out.

BACKGROUND :

For Home Health PPS claims, the HHA referral code was blanked out since the beginning of HHPPS (10/1/00).

CORRECTIVE ACTION :

CWFMQA put a fix in which will be effective with claims with an NCH Weekly Process Date 3/16/01.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 10/01/00

END DATE : 03/16/01

CONTACT : OIS/EDG/DMUDD

HHA_TOT_VISIT_CNT_LIM

FULL NAME: HHA Total Visit Count Limitation

DESCRIPTION :

NCH HHA recovered claims may be missing the claim-level total visit count.

BACKGROUND :

During the recovery of NCH dropped claims it was discovered that there is a possibility that some or all of the HHA claims may be missing the total visit count. There were 997,422 recovered HHA claims.

The field comes in from CWF but is also derivable from looking at revenue center trailer information, in combination with the Claim From Date. Beginning in 7/1/99, with HHA claims received with service dates 7/1/99 and after, the claims processing systems started counting visits based on the number of HHA visit revenue center lines. Prior to 7/1/99, the count was derived by adding up the units field associated with the HHA visit revenue centers.

To identify these claims, look for service year 1998 and 1999 HHA claims with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X, 059X with missing total visit count. If the Claim From Date is less than 7/1/99, derive the total by adding up the Revenue Center Unit count for each of these visit revenue centers. If the Claim From Date is greater than 6/30/99, derive the total by counting each visit revenue code line item as 1 visit.

CORRECTIVE ACTION :

During the history conversion to Version 'I' the NCH and SAFs were patched to correct the problem. Any service year prior to 2000 could be involved. The patched record will be annotated with an NCH Patch Code = 12.

The patched claims will have an NCH Weekly Process Date of 12/10/99, 12/17/99, or 1/7/00.

SOURCE: NCH

CONTACT : OIS/EDG/DMUDD

IP_IME_GME_LIM

FULL NAME: Inpatient IME/GME Limitation

DESCRIPTION :

Special payment records to reimburse teaching hospitals for direct/indirect graduate medical education costs (IME/GME payment records) were mistakenly put into the NCH.

BACKGROUND :

During the recovery from CWF history of NCH dropped claims, we were unaware that the files contained the IME/GME payment records. Normally, these claims are received in separate transmittals from the FFS claims and full UB-92 encounters; and are not stored

in the NCH. The total number of IME/GMEs inserted was 181,693, representing \$57.76 million in reimbursement; involving service years 1998 and 1999.

To identify these claims, look for service years 1998 and 1999 inpatient claims with claim related condition codes 04 and 69. Condition code '69' is the identifying characteristic.

NOTE: There could be identical full inpatient encounter claims in history that match to these erroneous IME/GME records, except that they will not contain a condition code '69'. If the IME/GMEs are not deleted, it is possible when running the final action algorithm that the IME/GME record will remain and the full inpatient encounter claim could be dropped.

CORRECTIVE ACTION :

The IME/GME claims were not removed from the NCH, due to the impact it would have on the balancing counts. They were removed from the 1999 service year SAFs. The 1998 finalized SAFs were not rerun to incorporate the relevant dropped claims (only missing receipts for 6/18/99 and 6/25/99 weeks); the IME/GMEs are not in the 1998 SAFs.

SOURCE: NCH

CONTACT : OIS/EDG/DMUDD

MCO_PD_SW_LIM

FULL NAME: Claim MCO Paid Switch Limitation

DESCRIPTION :

The MCO paid switch made consistent with criteria used to identify an inpatient encounter claim.

BACKGROUND :

During the NCH Version 'I' conversion, history was populated with an NCH Claim Type Code that will identify the record as an inpatient encounter claim. When applying the CWF logic to identify an inpatient encounter claim, it was discovered that when all the criteria was met the MCO paid switch was sometimes a blank or '0' (reflecting that the MCO did not pay the provider).

CORRECTIVE ACTION :

With the inception of the Version 'I' processing (7/00), if all the criteria for identifying an inpatient encounter claim is met but the MCO paid

switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back to 7/1/97 service year thru date.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MLTPL_REV_CNTR_0001_CD_LIM

FULL NAME: Multiple Revenue Center '0001' Code Limitation

DESCRIPTION :

Multiple total charge '0001' revenue center codes appearing on outpatient, hospice and home health claim records.

BACKGROUND :

On outpatient, home health and hospice it appears that more than one '0001' revenue center code is showing up on the claims. The first total charge line adds the revenue center codes above it correctly; the problem exists below the first total charge line where garbage may be present due to the FI Standard System not clearing out fields before processing the next claim. We believe the error began with the change-over to a different claims processing contractor in 1/98.

CORRECTIVE ACTION :

CWF created an edit to reject multiple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH_PATCH_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT_AMT_EXCEDG_CHRG_AMT_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed \$500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than \$500,000 but greater than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over \$500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT OIS/EDG/DMUDD

PPS_CPTL_DRG_WT_NUM_LIM

FULL NAME: Claim PPS Capital DRG Weight Number Limitation

DESCRIPTION :

Field erroneously blanked out on segments 2-10.

BACKGROUND :

During the Version 'I' conversion of all service years (1991-6/30/00) the following field was erroneously blanked out on segments 2-10.

During the Version 'I' planning process, it was decided that all codes, dates, numbers, names and percent fields would be populated on all segments of a claim; but

amount, counts, and quantities would be zeroed out on segments 2-10 to eliminate the risk of overstating values.

CORRECTIVE ACTION :

This data can not be recovered.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PPS_CPTL_DSCHRG_FRCTN_PCT_LIM

FULL NAME: Claim PPS Capital Discharge Fraction Percent Limitation

DESCRIPTION :

Field erroneously blanked out on segments 2-10.

BACKGROUND :

During the Version 'I' conversion of all service years (1991 through 6/30/00) the following field was erroneously blanked out on segments 2-10.

During the Version 'I' planning process, it was decided that all codes, dates, numbers, names and percent fields would be populated on all segments of a claim; but amount, counts, and quantities would be zeroed out on segments 2-10 to eliminate the risk of overstating values.

CORRECTIVE ACTION :

This data can not be recovered.

SOURCE:

CONTACT : OIS/EDG/DMUDD

REV_CNTR_IDE_NDC_UPC_LIM

FULL NAME: Revenue Center IDE, NDC, UPC Limitation

DESCRIPTION :

Missing data in the REV_CNTR_IDE_NDC_UPC_NUM field.

BACKGROUND :

Prior to Version 'I', this field housed only the 7-position exemption number assigned by the FDA to an investigational device after a manufacturer has been approved to conduct a clinical trial on that device. With Version 'I', this field expanded to 24 positions to accommodate the future receipt of the National Drug Code and the Uniform Product Code. The CWFMQA editing process was moving the IDE to the expanded field, but then incorrectly blanked it out (positions 8-24 should be blank).

CORRECTIVE ACTION :

CWFMQA fixed the code and the problem was corrected with claims processed with NCH weekly process date 9/15/00.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 06/09/00

END DATE : 09/08/00
CONTACT : OIS/EDG/DMUDD

REV_CNTR_TOT_CHRG_AMT_LIM

FULL NAME: Revenue Center Total Charge Amount Limitation

DESCRIPTION :

Revenue center total charge amount field being populated on segments 2-10 of the Version 'I' record.

BACKGROUND :

Under Version 'I', a decision was made that any amount, count and quantity field would be zeroed out to eliminate the risk of overstating values during an accumulation.

CORRECTIVE ACTION :

The CWFMQA front-end process was modified to zero out the total charge amount field in segments 2-10.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/01/00
END DATE : 02/02/01
CONTACT : OIS/EDG/DMUDD

TOT_CHRG_AMT_LIM

FULL NAME: Claim Total Charge Amount Limitation

DESCRIPTION :

The total charge amount field in the fixed portion was truncated on outpatient, hospice and home health claims.

BACKGROUND :

For outpatient, hospice and home health claims, the total charge amount field in the fixed portion was truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH_PACTCH_CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99
END DATE : 05/14/99
CONTACT : OIS/EDG/DMUDD

CARR_LINE_RX_NUM_LIM

FULL NAME: Carrier Line Prescription (RX) Number

DESCRIPTION :

Invalid data found in the prescription number (RX) field on the carrier claim.

BACKGROUND :

MMA required the implementation of a Competitive Acquisition Program (CAP) for Part B drugs and biologicals not paid on a cost or prospective payment system basis. Under this program, physicians are given the choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from the CAP if competitive pricing will not result in significant savings or have an adverse impact on access to these drugs.

During an analysis of carrier claims to review CAP physician and vendor claims it was discovered that these claims contained invalid data.

In both the NCH and NMUD claims from 7/1/2006 - 12/12/2006 will contain invalid data in the CARR_LINE_RX_NUM field. The problem was caused by a coding error in the CWFMQA front-end process. Due to the coding error the prescription (RX) number was never passed to the NCH or NMUD.

CORRECTIVE ACTION :

A fix was put into the CWFMQA code to move the RX number on the host files into the appropriate field on the CWFMQA file that is used in the NCH process. The fix was implemented 12/12/2006.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/01/06
END DATE : 12/12/06
CONTACT : OIS/EDG/DIDPM

CLM_POA_IND_CD_LIM

FULL NAME: Claim Present on Admission Indicator

Code Limitation

DESCRIPTION :

DESCRIPTION:

Missing present on admission (POA) indicators on the NCH claims.

BACKGROUND :

A problem has been discovered with the Inpatient claims received from CWF from July 6, 2009 through October 4, 2009. The claims received during this timeperiod have no POA indicators. The problem was a result of a defect in the conversion code used by CWF to convert the new 5010 record format back to the 4010 format for the NCH. The reason CWF was converting the claims to the 4010 format was because they implemented the 5010 format beginning in July 2009 but the NCH is still using the 4010 until 1/3/2011.

CORRECTIVE ACTION :

CORRECTIVE ACTION:

CWF will be sending in adjustment claims to correct the problem. The claims will come into the NCH the week of December 19, 2009. There were approximately 3 million claims missing the POA indicator.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 7/6/09
END DATE : 10/5/09
CONTACT
CONTACT act: OIS/EDG/DIDPM

CARR_LINE_MTUS_CNT_LIM

FULL NAME: Carrier Line Miles/Time/Units/Services Count Limitation

DESCRIPTION :

DESCRIPTION:

Inaccurate data reflected in the MTUS field for anesthesia claims.

BACKGROUND :

BACKGROUND:

A problem was found with the CARR-LINE-MTUS-CNT field on the NCH carrier claims when an anesthesia claim (CARR-LINE-MTUS-IND-CD = '2') is submitted with minutes. The problem is happening now because as of July 6,2009, the shared system maintainers (SSM) and CWF maintainers began using the 5010 claim format (will be NCH Version 'J' format) which has expanded this field from S999 to S9(7)V999.

When anesthesia claims are being received with minutes, MCS (SSM) converts them to units, which is causing the field to the right of the decimal to be utilized when the claims are transmitted to CWF.

For example,14 minutes converted to units (15 minutes = 1 unit) converts to 0.9 units. CWF maps 0.900 to the MTUS field and sends that on to the NCH. Since the NCH has not implemented Version 'J', the data in the NCH

will reflect '0'.

The NCH and other downstream systems are still using the Version 'I' format (4010 data) and will be until January 3, 2011. It was our understanding since the implementation of the HIPAA 5010 project that no 5010 data would be coming in to NCH until January 3, 2011.

CORRECTIVE ACTION :

CORRECTIVE ACTION:

The problem has been forwarded to the CWF BAMG staff for further investigation.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/05/2009

END DATE : UNKNOWN

CONTACT

CONTACT ACT: OIS/DG/DIDPM

H3PM.R RIF_LIMALL_PNEW
08/01/2011
