Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3264 MLN Matters Number: MM3264
Related CR Release Date: May 14, 2004
Related CR Transmittal #: 175
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Health Insurance Portability and Accountability Act X12N 837 Health Care Claim Implementation Guide ICD-9 and Direct Data Entry Instruction

Note: This article was updated on May 7, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Hospitals

Provider Action Needed

STOP – Impact to You

Medicare will no longer accept outpatient claims [including Direct Data Entry (DDE)] with ICD-9 procedure codes. Claims containing an ICD-9 procedure will be rejected. Medicare will also begin editing all occurrences of certain codes to ensure that they are valid.

CAUTION – What You Need to Know

While ICD-9 procedure codes are the acceptable HIPAA code set for inpatient claims, HCPCS/CPT codes are the valid set for outpatient claims. In addition, other invalid codes, as noted below, will also cause claims to be rejected.

GO – What You Need to Do

Remind billing staffs to use the appropriate codes when submitting inpatient and outpatient claims to assure prompt and correct processing by Medicare. Also, ensure they are aware of the other modifications presented in this article.

Background

ICD-9 procedure codes are considered the Health Insurance Portability and Accountability Act (HIPAA) standard medical code set for inpatient hospital procedures and the HCPCS/CPT codes are the HIPAA standard medical code set for physician services and other health care services (including outpatient hospital procedures). In the past, Medicare did not reject outpatient claims if they contained ICD-9 procedure codes. However, this practice resulted at times in non-compliant coordination of benefits (COB) claims.

As a result, effective October 1, 2004, Medicare will now edit outpatient claims (as defined in Transmittal 107 - CR3031), including those received via DDE to ensure that the pertinent data do not contain ICD-9 procedure codes. Claims containing an ICD-9 procedure code will be rejected.

Medicare will also edit all claims submitted via DDE as well as outpatient and inbound HIPAA X12N 837 claims (as defined in Transmittal 107 - CR3031) to make sure that all occurrences of the data element do not contain invalid codes (these may include an E-code, diagnosis code, value code, occurrence code, or occurrence span code). An invalid code is one that is not listed in the external code source referenced by the HIPAA 837 institutional implementation guide (IG). Any claims containing these invalid codes will be rejected.

Although CMS is committed to implementing the institutional 837 per the HIPAA IG, CMS does not plan to modify the claim correction DDE screen(s) since this transaction is not a covered transaction under HIPAA. The DDE process does not accept as many ICD-9 codes as does an 837. Therefore, if a submitter needs to submit more diagnosis codes, value codes, occurrence codes, or occurrence span codes than CMS processes through the Direct Data Entry system, the submitter will have to send in an 837. If a claim correction is needed, he or she will have to send a corrected 837. The claim correction DDE can not be used since it does not support as many of the codes that are allowed on the 837.

Finally, the purpose of this article is to inform affected providers that one of the requirements listed in CR3031 (MLN Matters article MM3031) has been changed. Specifically, item 7 on page 3 of MM3031 should read "All outpatient HIPAA X12N 837 claims that contain revenue codes of 045X, 0516, or 0526 must also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code.

Additional Information

Providers must note that, effective July 1, 2004, the Medicare intermediaries will NOT require a line item date or date of service for 22X (inpatient Part B Skilled Nursing Facility) claims. 22X is being removed from business requirement 3031.1 within CR3031.

Providers must also note that, effective October 1, 2004, the Medicare intermediaries will apply the following edits:

1. All inbound HIPAA X12N claims and all claims submitted by DDE will be edited to ensure that:

- All occurrences of the E-code are valid;
- All occurrences of the diagnosis code are valid;
- All occurrences of the value code are valid;

- All occurrences of the occurrence code are valid; and
- All occurrences of the occurrence span code are valid.

2. All outpatient HIPAA X12N 837 claims will be edited to ensure that all occurrences of the data element do not contain an ICD-9 procedure code.
3. All outpatient claims received via DDE will be edited to ensure that all occurrences of the data element do not contain ICD-9 procedure codes.

Claims failing these edits will be rejected.

Providers that use Medicare's free billing software are encouraged to download, test, and implement the most current version as soon as possible after it is released.

The official instruction issued to your carrier regarding this change may be found by going to *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R175CP.pdf* on the CMS website.