

TO: All Providers
FROM: CareFirst of Maryland, Inc.
DATE: May 16,2002
SUBJECT(S): Health Insurance Portability and Accountability Act (HIPAA)
Institutional 837 Health Care Claim - Outpatient Hospice
Implementation Direction

Health Insurance Portability and Accountability Act (HIPAA)
Institutional 37Health Care Claim - Home Health Implementation
Direction

Updates to Common Working File (CWF) Editing of Intermediary
Claims for Durable Medical Equipment (DME) and
Prosthetic/Orthotic Devices

Health Insurance Portability and Accountability Act (HIPAA) Institutional 837 Health Care Claim - Outpatient Hospice Implementation Direction

This instruction provides additional information for intermediaries and their standard systems and is a follow-up to Transmittal A-02-014, Change Request 2028, dated February 12, 2002.

Outpatient Hospice Claims via the 837

The 837 2300 loop Admission Date segment must be used to report the start of care date for outpatient hospice claims.

Intermediaries should advise their submitters/providers via their next scheduled bulletin (or Web site) to use the 2300 loop Admission Date segment to submit the start of care date for outpatient hospice claims for test (and later, for production) version 4010 claims and to submit "0001" as a default value for the hour and minute (HHMM) part of the admission date data element if the information is not available.

Outpatient Hospice claims via Direct Data Entry (DDE)

The admission hour (HH) is available via DDE whereas the minutes (MM) are not. Notify your submitters/providers via your next scheduled bulletin (or Web site) to submit a compliant numeric hour (“00” is acceptable if unknown) for outpatient hospice claims submitted via DDE. For purposes of coordination of benefits (COB) processing, the HH and MM must be submitted by your standard system. Your standard system will create a default value of “01” for the MM and submit this value for COB.

(Source: Program Memorandum A-02-036; Change Request 2135)

The effective date for this PM is May 1, 2002.

The implementation date for this PM is October 1, 2002.

Health Insurance Portability and Accountability Act (HIPAA) Institutional 837Health Care Claim - Home Health Implementation Direction

Home Health Claims via the 837

In Program Memorandum (PM) A-02-014, Change Request 2028, dated February 12, 2002, we advised intermediaries and their standard systems to await further instructions regarding how to process home health claims using the 4010 format. Intermediaries must advise their home health submitters/providers via their next scheduled bulletin (or Web site) to use the 2300 loop Admission Date segment to submit the admission date/start of care date for home health claims for test (and later, for production) version 4010 claims and to submit “0001” as a default value for the hour and minute (HHMM) part of the admission date data element if the information is not available.

The home health care information (CR6) segment could contain the start of care date. Forward any data received in CR6 to the repository to be sent for coordination of benefits (COB). However, this data should not be used to process the claim.

Home Health Claims via Direct Data Entry (DDE)

The admission hour (HH) is available via DDE whereas the minutes (MM) are not. Notify your submitters/providers via your next scheduled bulletin (or Web site) to submit a compliant numeric hour (“00” is acceptable if unknown) for home health claims submitted via DDE. For purposes of COB processing, the HH and MM must be submitted by your standard system. Your standard system will create a default value of “01” for the MM and submit this value for COB.

(Source Program Memorandum A-02-037; Change Request 2137)

The effective date for this PM is May 1, 2002.

The implementation date for this PM is October 1, 2002.

Updates to Common Working File (CWF) Editing of Intermediary Claims for Durable Medical Equipment (DME) and Prosthetic/Orthotic Devices

I - GENERAL INFORMATION

A - Background:

The purpose of this Program Memorandum (PM) is to provide updated instructions regarding the CWF processing of intermediary claims for DME and prosthetic/orthotic devices. Provider billing instructions for these services are not changed by this PM.

The lists of HCPCS codes defined as DME or as prosthetics/orthotics are updated annually. In CWF processing of carrier claims, the updating of tables of codes for these service categories results in the automatic updating of edits. However, in CWF processing of fiscal intermediary claims, the category tables cannot be accessed and therefore individual edit lists must be updated. In recent years, the conforming updates to fiscal intermediary edit lists have been overlooked and variations between these lists and the category tables must now be corrected.

B - Policy:

The most recent annual update to the fee schedules for DME and prosthetics and orthotics is published in PM AB-01-126. Billing instructions for these services are found in §3629 of the Medicare Intermediary Manual, §463 of the Home Health Agency Manual, §441 of the Hospital Manual, §534 of the Skilled Nursing Facility Manual and §412 of the Outpatient Physical Therapy/Comprehensive Outpatient Rehabilitation Facility/Community Mental Health Center Manual.

II - BUSINESS REQUIREMENTS

Claims Processing Requirements:

Req. #		
2092.1		
2092.2		
2092.3		
2092.4		
2092.5		
2092.6		
2092.7		
2092.8		

III - Possible Design Considerations and Supporting Information

A - Inputs:

X-Ref Req. #	
N/A	

B - Outputs:

X-Ref Req. #	
N/A	

C - Interfaces:

X-Ref Req. #	
N/A	

D - Provider Impact:

X-Ref Req. #	
N/A	

E - Contractor Financial Reporting /Workload Impact: This instruction corrects edits for which intermediaries currently have claims suspended which they are unable to process. It will not be possible to process such claims systematically until this instruction is implemented.

F - Dependencies: This Change Request is not dependent on any other current Change Request or on any pending regulation/instruction.

G - Testing Considerations: N/A

IV - Attachment(s) N/A

(Source: Program Memorandum A-02-031; Change Request 2092)

The effective date for this instruction is October 1, 2002.

The implementation date for this PM is October 1, 2002.

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. ALL BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE AT NO COST FROM OUR WEB SITE AT www.marylandmedicare.com.

Questions regarding this bulletin should be directed to the provider relations department at (866) 488-0545.

