1. National Uniform Billing Committee [NUBC]

- UB04 Manual will be updated once a year, October. It will contain all data maintenance items for the year.

- **MLN Matters and CR 5243. Change to billing on Institutional form types**
    1) Report the service facility locator loop (2310E) in an 837I whenever the service was furnished at an address other than the address reported on the claim for the billing or pay-to provider.
    2) Include the taxonomy code
    3) Submit separate batches of claims for each subpart identified by a separate taxonomy code.
    4) Use 9-digit zip code
    5) 837I submitters billing for a subpart, AND that subpart does not have a unique NPI separate from the main entity or another subpart, the subpart that furnished the billed care must be identified in the billing provider loop (2010AA) and the entity to be paid in the Pay-to provider loop (2010AB)
    6) CMS recommends submitting both the OSCAR [Online Survey, Certification and Reporting] number and the NPI on claims submitted through May 22, 2007.

- **Nursing Home Issues**
    - Admission Date
    - Admission Source
    - Admission Hour
    - Levels of care
    - Other issues?

Are you having difficulties with Nursing home claims? Are their elements missing that would be helpful in adjudication? Are there elements required on the transaction that need are not available?

Please forward all issues and concerns to Mary Kay.
MaryKay.McDaniel@azahcccs.gov
[602] 417-4307

FL04, Type of Bill
Page 5 of 9
Exceptions to Inpatient/Outpatient General Designation by Data Element/Form Locator:

	Data Element	Usage Requirement by Type of Bill	
FL12	Admission/Start of Care Date	Required on all inpatient claims [IP], 032X, 033X, and 034X.	
FL13	Admission Hour	Required on all inpatient claims [IP] EXCEPT for 021X	
FL69	Admission Hour	Required ONLY on 011X, 012X, 018X, and 021X	
FL70 a – c	Patient's Reason for Visit	Required on 013X and 085X when: a) Type of Admission Codes 1, 2, or 5 are reported AND b) Revenue Codes 045X, 0516, 0526, or 0762 are reported. May be reported on all other 013X and 085X types of bills at submitter's discretion when this information provides additional information to support medical necessity.	

2. National Uniform Code Committee [NUCC]

CMS Instructions for the 'new' 1500 [08-05]

http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10
Chapter 26.

The new 1500 and Provider Identifiers:

> **Item 24J Form CMS-1500 (08-05)** – Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.
>
> Effective May 23, 2007 and later, do not use the shaded portion. Beginning no earlier than *January 1, 2007*, enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.

CMS Transmittal 1247:

I. GENERAL INFORMATION

On March 19, 2007, CMS released Transmittal 1208, CR5568, which instructed Medicare contractors to continue to accept the Form CMS-1500 (12-90) version due to reports of an incorrectly printed version of the Form CMS-1500 (08-05) that was being sold by some print vendors. Although a tentative date was set at June 1, 2007, CMS intended to gather and review statistics from our contractors in an effort to set a new deadline. The information gathered from our contractors indicates to us that the problem is not as widespread as previously suspected.

Based on the information at hand, providers will now be required to begin submitting the Form CMS-1500 (08-05) only beginning July 2, 2007. It is important to note that this transmittal requires the submission of the revised Form CMS-1500 paper claim form only, and has no bearing on the implementation of the National Provider Identifier (NPI) nor mandates the submission of the NPI by July 2, 2007.

Chapter 1 of the Medicare Billing Manual...

30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for Carrier Processed Claims

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by medical groups and other entities entitled to bill and receive payment for physician services under §§30.2-30.2.8. They are used whether the charges are compensation related or non-compensation related.

A General

Chapter 26 contains general claims processing instructions. A medical group, or other entity entitled to bill and receive payment for physician services uses Form CMS-1500 or the current ANSI X12N billing format to submit claims to Medicare carriers. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 or in the corresponding ANSI X12N location. For paper claims an authorized official of the entity signs in block 31. This official need not be a physician. For EDI claims a certification can be maintained on file. (See CMS EDI Web page (http://www.cms.hhs.gov/providers/edi/edi3.asp) for electronic billing formats.)

B Provider Identification Numbers

Carriers assign a provider identification number (group number) to the medical group, or other entity as a whole. The entity's identification number is entered in block 33. Each physician who performs services for a patient must be identified on Form CMS-1500 in block 24k for the appropriate line item in accordance with instructions in the Medicare Program Integrity Manual. (When an entity bills for an independent substitute physician under a reciprocal or locum tenens billing arrangement, the performing physicians is the physician member of the entity for whom the substitute is providing services.)

Chapter 26 of the CMS Billing Manual

Item 24J Form CMS-1500 (08-05) – Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.

Effective May 23, 2007 and later, do not use the shaded portion. Beginning no earlier than January 1, 2007, enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Item 33a Form CMS-1500 (08-05) - Effective May 23, 2007, and later, you MUST enter the NPI of the billing provider or group. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007. This is a required field.

Item 33b Form CMS-1500 (08-05) - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Effective May 23, 2007, and later, 33b is not to be reported. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.

If the billing provider is the rendering provider, there is no need to complete box 24J.

If the billing provider IS NOT the rendering provider, complete box 24J.

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3. ADA – Dental Claim

Overview

The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim Form by dentists and payers.

The latest version of the dental claim form enables reporting of a National Provider Identifier (NPI), in addition to a current proprietary provider identifier, for both the Billing Dentist/Dental Entity and for the Treating Dentist. This version of the form becomes **valid for use on January 1, 2007**.

Three samples of the ADA Dental Claim Form are available for your review. Comprehensive form completion instructions are contained in the ADA publication titled "CDT-2007/2008."

http://www.ada.org/prof/resources/topics/claimform.asp

4. Remark Code Workgroup

?? Is anyone having difficulties in matching your system adjustment/payment codes to the 835 Remittance Remark Codes? Are your providers having challenges with the 835 transaction? If so, would you be interested in joining a group to review??

Inquires to:

Mary Kay McDaniel
Marykay.mcdaniel@azahcccs.gov
(602) 417-4307

5. X12 News

A. Addendas:

5010 for the dental [5010A1]
Change to the 5010 270 to the search criteria,removed the 4th required search

B. PRESENT ON ADMISSION, 837 - 4010A1 K3 solution
CMS CR5499, MM5499

HIR: 511

Status Date: 2/23/2007. D – Pending Subcommittee Approval

Per the DRA of 2005, by 10/1/2007, CMS is required to identify at least 2 high cost or high volume dx codes with a DRG assignment that has a higher payment weight when present with secondary dx. In order to group dx into the proper DRG, CMS needs to capture a Present On Admission (POA) indicator for all claims involving inpatient admissions to acute care hospitals. CMS believes the best way to accomplish this for claims submitted electronically via 837, 4010 format, will be to use segment K3 in the 2300 loop, data element K301. The element would contain the letters "POA", followed by a single POA indicator for every dx reported on the claim. The POA indicator for the principal Dx should be the first indicator after "POA". POA indicators for secondary dx would follow next if applicable. The last POA indicator must be followed by the letter "Z" to indicate the end of the data element or the letter "X" to indicate the end of the data element in future special data processing.

Response:

DRAFT - The 837 workgroup agrees with the use of K3 for the Present on Admission business need. The POA must be reported in K3 segment in the 2300 loop, data element K301.
Positions 1-3= POA,
Position 4= the POA indicator for the principal dx code.
Position 5 begins the reporting of POA indicators for all other dx codes if applicable.
A "Z" or an "X" must be reported to indicate the end of reporting of the POA indicators for the "other" dx codes.
The byte following the "Z" or "X" value represents the POA indicator for a submitted e-code if applicable. If the segment ends in a "Z" or an "X" value, than the e-code was not submitted.

Values for each byte are:
Y = Yes
N = No
U = unknown
W = clinically undetermined.
1- Represents a space or blank and means the dx code is exempt from reporting of POA.
Z- Indicates the end of reporting of POA indicators for the other dx codes.
X- Indicates the end of reporting of POA indicators for the other dx codes when there are special processing situations

Recommend:

Examples:
K3*POAYNU1Z1~ No exception handling, e-code submitted.
K3*POA1YNU1Z~ No exception handling, no e-code submitted.
K3*POAYNU1XY~ Exception handling, e-code submitted.

C. 5010s available for purchase
www.wpc-edi.com

HIPAA Transaction	45 CFR Part 162	X12N Impl. Guides / TR3's 004010	005010	X12 Standard
Claim - Prof.	K, R	X098 +A1	X222	837
Claim - Inst.	K, R	X096 +A1	X223	837
Claim - Dent.	K, R	X097 +A1	X224	837
Eligibility	L	X092 +A1	X203	270 & 271
Authorization	M	X094 +A1	X217	278
Claim Status	N	X093 +A1	X212	276 & 277
Enrollment	O	X095 +A1	X220	834
Remittance	P	X091 +A1	X221	835
Premium Pmt.	Q	X061 +A1	X218	820

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D. Participation Requested in WEDI 837 Cost Benefit Survey

The WEDI ROI Task Group is asking you to once again take a brief survey with regards to implementation of the X12 5010 version of the 837 Health Care Claim transactions.

If you have implemented, or plan to implement, the HIPAA-adopted X12 837 Health Care Claims transactions, we need your help by completing a survey. WEDI and the Designated Standard Maintenance Organizations (DSMOs) need this information to provide the federal government with an industry-wide cost-benefit analysis for adopting a newer version of the X12 837 under HIPAA – version 5010. To ensure that your responses are included, please complete the survey by **July 2, 2007**.

The survey can be found at http://vovici.com/wsb.dll/s/127f7g2a116 ...

E. Payer to payer PHRs.
[can anyone say OPEN ENROLLMENT Transition Planning????]
Payer-Payer transport of Personal Health Records (PHRs) using an implementation of the Continuity of Care Document (CCD) inside an X12-275 transaction set.

The CCD is a joint effort between ASTM and HL7, to represent the information content of the ASTM Continuity of Care Record (CCR) Standard as an implementation of the HL7 Clinical Document Architecture (CDA) Standard.

The BCBSA/AHIP Implementation Guide for the first version of their Plan-to-Plan Personal Health Record data portability standards was posted for free public download on the home page of the Washington Publishing Company.
The standard can be downloaded for free from WPC – www.wpc-edi.com

F. NCPDP Transactions available:
www.ncpcp.org

Participation Requested in the WEDI/NCPDP Telecommunication Standard Version D.0 and Batch Standard Version 1.2 Surveys

***(Please note that these are different surveys from the WEDI/NCPDP Medicaid Subrogation Survey sent out yesterday*)**

In order to provide the federal government with an industry-wide cost-benefit analysis for adopting new transaction standards or newer transaction standard versions under HIPAA, WEDI is conducting this survey for those within the healthcare industry who plan to implement the NCPDP Telecommunication Standard Implementation Guide Version D.Ø and/or Batch Standard Implementation Guide Version 1.2 standards.

Responses must be submitted by July 10, 2007. Please respond based on your company type. Below are the links to the surveys:

HealthPlan/Payer Survey
http://vovici.com/wsb.dll/s/127f7g2a4ea

Provider Survey
http://vovici.com/wsb.dll/s/127f7g2a4eb

Vendor Survey
http://vovici.com/wsb.dll/s/127f7g2a4e9

6. NPI – National Provider Identifier

- **Enumeration Statistics for Arizona:**

State	Individual	Organization	Total
AZ	32754	9655	42409

- **Data Dissemination Policy Update:**

CMS Delays Dissemination of National Plan and Provider Enumeration System (NPPES) Data

The NPPES Data Dissemination Notice (CMS-6060-N) was published on May 30, 2007. NPPES health care provider data that are required to be disclosed under the Freedom of Information Act (FOIA) will be made publicly available. The FOIA-disclosable data will be made available in an initial file downloadable from the Internet, with monthly update files also downloadable from the Internet, and in a query-only database (the NPI Registry) whereby users can query by NPI or provider name. The Notice stated that these data will be available 30 days after the publication date, and CMS had previously stated that they would be available on June 28, 2007.

CMS believes that health care providers need additional time, beyond what was afforded in the Data Dissemination Notice, in which to view their FOIA-disclosable NPPES data and make any updates or deletions (where permitted) that they feel are necessary. **Therefore, CMS has decided to delay the**

dissemination of FOIA-disclosable NPPES health care provider data until August 1, 2007, 60 days after the publication date of the Notice.

CMS will provide additional information in the near future with respect to the date by which changes would have to be submitted in order to be reflected in the initial downloadable file. CMS understands that the health care industry is in urgent need of the FOIA-disclosable NPPES health care provider data; however, CMS believes it is in the best interests of the industry, and the health care providers in particular, that the NPPES data we will be disclosing be as accurate as possible.

For the latest information on Data Dissemination, as well as a list of the FOIA-disclosable data elements, visit http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp on the NPI website.

Revised NPI Application/Update Form

The NPI Application/Update Form (CMS-10114, 05-07) has been revised and is now available for download on the CMS website... More information on the revisions to the form, as well as a link to the revised form, is available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Announcement_for_Revised_NPI_Application_form.pdf on the CMS NPI website.

7. Other Legislative Updates.

Federal Government activity includes a recent notice in the Federal Register that makes mention of the "Electronic Claims Attachment Standard" and indicates that a final rule for this HIPAA transaction is expected in September of 2008. We'll continue to monitor the timeline of this impending regulation and bring you more details as this proposed deadline approaches.

Other HIPAA items on the federal agenda for 2007 and as stated in the Federal Register, Volume 71, Number 237, 11 December 2006 include:

- Modification to Electronic Transactions and Code Sets - "This proposed rule would provide certain other technical corrections and clarification to the regulations." Expected NPRM on this topic is June 2007.
- Revision to HIPAA Code Sets - Expected NPRM on this topic is March 2007

- **SB 628**
  "Critical Access to Health Information Technology Act of 2007"
  Page 9, Section 3. Replacement of the International Statistical Classification of Diseases.

  - Adoption of ICD-10CM & ICD-10-PCS – October 1, 2008
  - Implementation of ICD-10 – October 1, 2011

  - Adoption of the new transaction standards – April 1, 2009
  - Implementation of the new standards – April 1, 2011

8. AHCCCS “Stuff”.

- Updated FFS 837 Companion Document loaded to main website, dated 6/4/2007
- The NCPDP 5.1 Encounter Companion Document has been approved by NCPDP and is ‘almost’ ready to be posted to the web
- Working on the Encounter 837 Companion Documents
- Validator 824 document were sent out this week. REVIEW PLEASE!!!!