CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10424	**Date: October 30, 2020**
	Change Request 11994

SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Front End Updates for April 2021

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide the April 2021 Combined Common Edits/Enhancements Module (CCEM) edits for the Part A and Part B Medicare Administrative Contractors (A/B MACs) and the Common Electronic Data Interchange (CEDI) contractor. Additionally, this CR directs Shared Systems to appropriately update the CCEM.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 10424	Date: October 30, 2020	Change Request: 11994

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I. GENERAL INFORMATION

A. Background: As part of its efforts to comply with the administrative simplification provisions of HIPAA and its implementing regulations, the Centers for Medicare & Medicaid Services (CMS) instructs its shared systems maintainers and local Medicare contractors to maintain common front-end HIPAA validation edits through a quarterly release Change Request (CR). These edits pertain to the current standards adopted under HIPAA.

The CMS determines the edits, which are to be administered at the front end and documents these edits in a spreadsheet attached to the quarterly CR. The spreadsheets document all of the edits to date, as well as those edits, which are changed, deleted, or added. The spreadsheets change log directs the contractors as to those changes they must make for the quarter. The change log worksheet tab contains only the changes made for this version.

Contractors and shared systems maintainers shall use the attached edits spreadsheets as replacements for the previously issued edits spreadsheets. Contractors are not required to replicate work already done, but are only expected to use the updates to the spreadsheets to build upon their previous core deliverables.

B. Policy: The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the Secretary of Health & Human Services (HHS) to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11994.1	Using the attached edits spreadsheets, contractors shall be responsible for creating test data to generate the Medicare defined TA1 at the interchange level and 999 transaction at the functional group and transaction levels.	X								
11994.2	Contractors shall use the attached edits spreadsheet to	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	implement the appropriate TA1 at the interchange level.									
11994.3	Using the attached edits spreadsheets, contractors shall generate the "Accepted" 999 at both the functional group and transaction levels back to the submitter when the front end translator is able to create a syntactically compliant flat file.	X								
11994.4	Using the attached edits spreadsheets, contractors shall generate the "Fully Rejected" 999 at the functional group and transaction levels based on the attached edits spreadsheets.	X								
11994.5	Using the attached edits spreadsheets, contractors shall generate the "Accepted with Errors" 999 at the functional group and transaction levels based on the attached edits spreadsheets.	X								
11994.6	Shared systems shall use the attached updated edits spreadsheets for the implementation of their CCEM.						X			
11994.6.1	Contractors shall use the attached edits spreadsheets for the implementation of their edits software.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Charlene Parks, Charlene.Parks@cms.hhs.gov , Matthew Klischer, Matthew.Klischer@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Change Log
Changes to the version included for POC Review

Edit Reference	Change	Date	Reason
X223.294.2300.HI01-2.030	Revised 277C edit.	8/10/2020	Removed Internal Payer Use Only Condition Codes 60 & 61.

Spreadsheet Details

- **An Edit Identifier is used to uniquely identify each row in an Edit Spreadsheet. It consists of the following fields separated by periods:**

* TR3 Identifier.

* TR3 Page reference for the segment identified.

* TR3 Loop ID (if there is no loop ID there will be two periods together)

* Segment ID and Element Position

* Edit Number (within the Segment ID / Element Position)

- **The "Accept/Reject" Column will be populated with one of the following values as indicated below:**

* R - The transaction set (ST-SE) is rejected back to the submitter
* E - The transaction set (ST-SE) is passed to the CEM where additional validation occurs. Rejections for both syntax and business reasons will occur at the claim level within the CEM

* T - The error is identified in the translator and an STC record is added to the 837 flat file following the segment that had the error

* C - The error is identified in the CEM, a 277CA flat file, including the business error information, will be generated

- **Acronyms:**

* CSC - Claim Status Code

* CSCC - Claim Status Category Code

* EIC - Entity Identifier Code

- **Edit inclusion methodology:**

* If a segment/element/composite is required, based on either guide usage or by situational rule interpretation, there will be an edit that indicates it must be present
* If a segment/element/composite is not used, based on either guide usage or by situational rule interpretation, there will be an edit that indicates that it must not be present

* If a segment/element/composite does not have either of those explicit notations, the edits listed will apply when the segment/element/component is present

- **Assumptions:**
* The edits included in the spreadsheet are intended to clarify the X12N Implementation Guide instructions or add Medicare specific requirements. Unless otherwise explicitly specified in the EDITS worksheet, all X12 IG instructions must be followed.
* Segments noted as "Pass through, syntax only" will not include CMS specific edits based on system constraints or business rules. This notation indicates that the information is stored on the repository but not used in any CMS system processing.

* Front End processing will determine billing criteria (inpatient, outpatient, POA, etc.) based on the NUBC manual. Specific criteria will not be included in this document.
* Conditional statements regarding inclusion or exclusion of segment/element/composites will be included when they can be consistently enforced by a transaction receiver. In the absence of consistently enforceable criteria, no edit will be included to control inclusion/exclusion.
Example: 2320 COB Payer Amt Paid - there is no way for the receiver to determine whether the claim has been adjudicated by the payer in Loop 2330B, so no edit will be included for that criteria.
* Format definitions, rules, restrictions, guidance, or instructions published by the code set owner of an external code set must be met for a code from an external code set to be noted as "valid"
* If a segment is repeated at the same location with different qualifiers, the segment edit will include a qualifier clause (Only one iteration of 2300.HI with HI01-1 = "DR" is allowed), otherwise the segment edit will just include the number of iterations allowed (Only one iteration of 2310C.NM1 is allowed)

- **Valid dates - dates must be valid according to the calendar for the specific year.**

* Only 01 - 12 are valid for the month positions of the date field

* If month is "01", the day positions may be populated with 01 - 31
* If month is "02", the day positions may be populated with 01 - 28, except during leap years (2008 was a leap year, leap years occur every 4 years) when the day positions may be populated with 01 - 29

* If month is "03", the day positions may be populated with 01 - 31

* If month is "04", the day positions may be populated with 01 - 30

* If month is "05", the day positions may be populated with 01 - 31

* If month is "06", the day positions may be populated with 01 - 30

* If month is "07", the day positions may be populated with 01 - 31

* If month is "08", the day positions may be populated with 01 - 31

* If month is "09", the day positions may be populated with 01 - 30

* If month is "10", the day positions may be populated with 01 - 31

* If month is "11", the day positions may be populated with 01 - 30

* If month is "12", the day positions may be populated with 01 - 31

- **Future Date edits:**

* Edits restricting a date field from being a "future date" should be evaluated against the date the file was received.

- **Numeric edits:**

* Positive/Negative/Zero:

- **Any numeric value with an edit that indicates it must be >= 0 means that negative numbers are not allowed.**

- **Any numeric value with an edit that indicates it must be > 0 means that neither zero nor negative numbers are allowed.**

- **If neither of these explicit edit are present, negative, zero, and positive numbers are allowed.**
* If an edit references a numeric value (must be >=, <= or = with a numeric limitation) implies a numeric content requirement so the standard numeric check will not be included

* The words "digit" or "digits" in an edit implies numeric content

- **Alphanumeric edits:**

* The words "character" or "characters" in an edit implies alphanumeric content

* If the data of an AN element or composite is from an external code list, the standard AN edits will not be included

- **If an edit contains a bracketed clause, [clause], each contractor must supply the information noted in the edit (e.g. receiver code).**

Terms and Definitions

- The flow of the transactions is:

* **Front end processing – commercial translator edits, specific to each contractor.**

- EDI syntax integrity validation

- Valid Segments (e.g. valid segment identifier, number of elements, delimiters)

- Segment order (as defined by the X12 / NCPDP standard)

- Element Attributes (e.g. X12 usage, repetitions, data type, and min/max size)

- Numeric element validation (e.g. leading minus signs, decimal points for R data types)

- X12 / NCPDP syntactical rules

- HIPAA syntax integrity validation based upon adopted specifications (X12 / NCPDP)

- Repeat maximums for segments, loops, elements (when repeating element are used)

- Used and un-used qualifiers, (internal) codes, elements, and segments

- Intra-segment situational data elements (e.g. DTP for auto accident becomes required when CLM011-1 or CLM11-2 is "AA" or "OA")

* **Common edit module – identical processing across contractors**

- External code source validation

- All CMS business rule validation that is evaluated post-translation

- Balancing edits

- Situation based edits

- Code Set edits

- Product Type/Type of Service edits

* **Shared system – CMS claims processing system.**

- **277** – Denotes that a 277 acknowledgement will be returned to the submitter
* 277T – This designation is used when an error is identified in front end processing (before the common edit module is invoked). When this type of error is identified an STC record is added to the 837 flat file following the segment with the identified error
* 277C – This designation is used when an error is identified in the common edit module. When this type of error is identified an STC record is added to the 277 flat file following the segment with the identified error

- **999** – Denotes that a 999 acknowledgement will be returned to the submitter
* 999R – This designation is used when an identified error causes the transaction set (ST-SE) to be rejected back to the submitter. If multiple transaction sets are included in one functional group, only the transaction set with an identified 999R error will be rejected, not all the transaction sets in the functional group
errors before being passed to the CEM for additional validation. When an error is identified an STC record is added to the 837 flat file following the segment with the identified error
Exception: If the 999E is based on usage of a "Not Used" element only a 999E will be generated and sent back to the submitter. No corresponding 277 will be created in the flat file for this type of error

Assumptions

- 277 acknowledgements and 999 acknowledgements are not mutually exclusive

General Edit Rules:

Duplicate ST-SE transaction sets shall be rejected as follows:
CSCC A8: Acknowledgement / Rejected for relational field in error
CSC 746: Duplicate Submission. **Note:** use only at the information receiver level in the Health Care Claim Acknowledgement transaction
EIC: 40: Receiver

These are the priority rules. They supersede the secondary rules whenever there is a conflict between the instructions

- 999R edits stand alone. They are not associated with a corresponding 277 error

- 999E edits are always followed by a 277T edit

* Exception: a 999E based on usage of a "Not Used" element stands alone

- 277C edits stand alone. They are not associated with a corresponding 999 error

- 277T edits are usually preceded by a 999E edit but can stand alone

* Special Case: When an element has more than one error that can be identified in the translator, there can be multiple 277Ts following one 999E
- Envelope edits - if a transaction is recognized as an X12 transaction with envelope errors, it must be acknowledged as shown in the spreadsheet. If envelope errors result in a transaction not being recognized as an X12 transaction, contractors have flexibility on how to acknowledge the transaction

- All Table 1 edits result in a 999R or TA1 rejection

* Exception: "Not Used" elements will be associated with stand-alone 999E edits

- All Table 2 edits related to CMS business constraints will be associated with a 277 edit
* EDI Syntax Integrity Validation (WEDI Level 1) or HIPAA Syntax Integrity Validation, which includes Situational Rule Validation (WEDI Level 2) edits will be associated with a 277T edit

* Common Edit Module validation (WEDI Levels 3 through 6) edits will be associated with a 277C edit

- All Table 2 edits related to CMS technical constraints will be associated with a 999E followed by a 277T edit

* Examples: amounts or quantities for which CMS's internal system size is smaller than the IG allowed maximum

Translators may report up to five Implementation Transaction Set Syntax Error Codes, (IK502-IK506), for reporting one or many transaction set errors. The first error is reported in the first error element (IK502). If there is a second error, it is reported in the second error element (IK503), and so on through the fifth error element (IK506). IK502: 6 "Missing or Invalid Transaction Set Identifier" is in the spreadsheet as an example.

These are the secondary rules. They apply only when they do not violate the priority rules.

- Loops that are not accepted based on Medicare business rules will be associated with a stand-alone 277T edit

- Segments that are not accepted based on Medicare business rules will be associated with a stand-alone 277T edit

- All "… must be populated with accepted AN characters" edits will be associated with a 999R (IK403=6)

- All "… must be # - ## characters" edits will be associated with a 999E (IK403=4 or IK403=5)/277T edit combination

- All "… must be (<, >, =, <=,>=)" edits that establish element length will be associated with a 999E (IK403=4 or IK403=5)/277T edit combination

- All "… must contain at least ## non-space characters" edits will be associated with a 999R edit (IK403=6)

- All "… must be present" edits at the segment level will be associated with a 999R edit (IK304=3)

Exception: if the edit reflects Medicare business rules instead of X12 syntax rules, the edit will be associated with a 277T edit.

- All "…must be present" edits at the element level will be associated with a 999R edit (IK403=1).

Exception: if the edit reflects Medicare business rules instead of X12 syntax rules, the edit will be associated with a 277T edit.

- All "If … is not present, … must be present" edits at the segment level will be associated with a 999R edit (IK304=I6).

- All "If … is present … must be present" edits referring to a relationship between two elements within the same segment will be associated with a 999R edit (IK403=2)

- All "If … is present … must be present" edits referring to a relationship between two different segments will be associated with a 277C edit

- All "If … is present … may be present" edits referring to a relationship between two elements within the same segment, will be associated with a 999R edit (IK403=10)

- All "If … is present … may be present" edits referring to a relationship between two different segments will be associated with a 999R edit (IK304=I9)

- All "… must be valid values" edits will be associated with a 999R edit (IK403=7)

- All "… must be (explicit value)" edits will be associated with a 999R edit (IK403=7)

- All "… must be numeric" edits will be associated with a 999R edit (IK403=6)

- All external code source edits will be associated with a 277C edit

- All "must be an integer" edits will be associated with a 999R edit (IK403=6)

- All "must be a valid date" edits will be associated with a 999R edit (IK403=8)

- All "must be a valid time" edits will be associated with a 999R edit (IK403=8)

- All "must not be present" edits at the segment level will be associated with a 277T edit

- All "must not be present" edits at the element level will be associated with a 999E edit (IK403=I10)

- All "If … NM102 is "2" … must not be present" edits will be associated with a 999R edit (IK403=I13)

- All dollar amounts or numeric elements that use <, >, =, <=, or >= to establish value limits will be associated with a 277T edit

- All edits limiting the number of iterations of a segment will be associated with a 999R (IK304=5)

* **Exception:** All edits limiting the number of iterations of the first segment of a loop will be associated with a 999R (IK304=4)

Segment or Element Specific Edit Rules:

These are the tertiary rules. They apply only when they do not violate the priority or secondary rules.
- In Loops 1000A and 2010AA, NM109 edits referring to "approved electronic submitter" (trading partner management edits) will be associated with a 999R edit (trading partner management edits).

- Elements that are situational in the TR3 but listed as "must not be present" and shaded gray on the edits spreadsheets are not to be mapped to the flat file.