

The Ninth National HIPAA Summit™

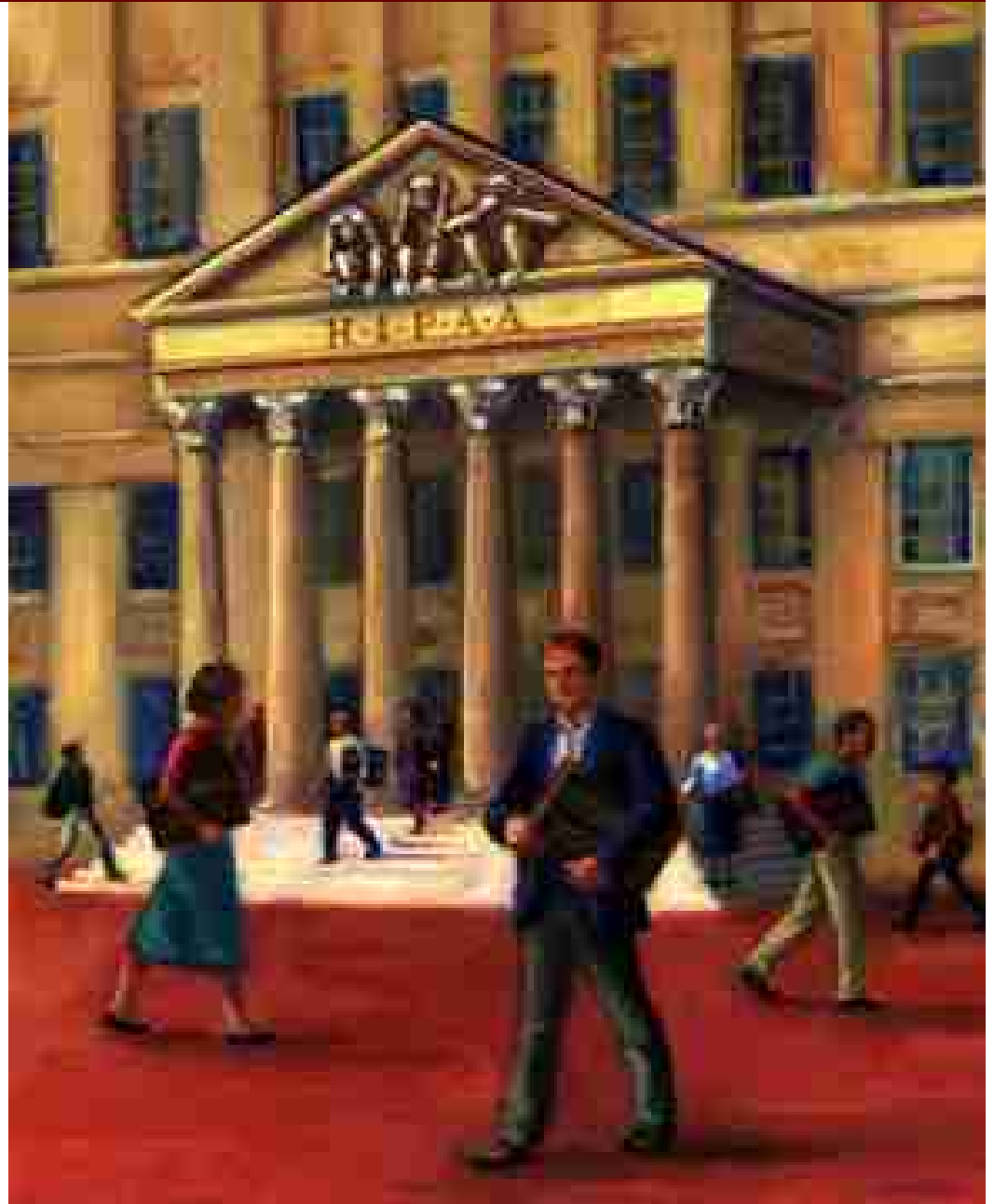
The Leading Forum on Healthcare Privacy, Confidentiality, Data Security and HIPAA Compliance

HIPAA Transactions Testing Update

Kepa Zubeldia, M.D.

September 13, 2004

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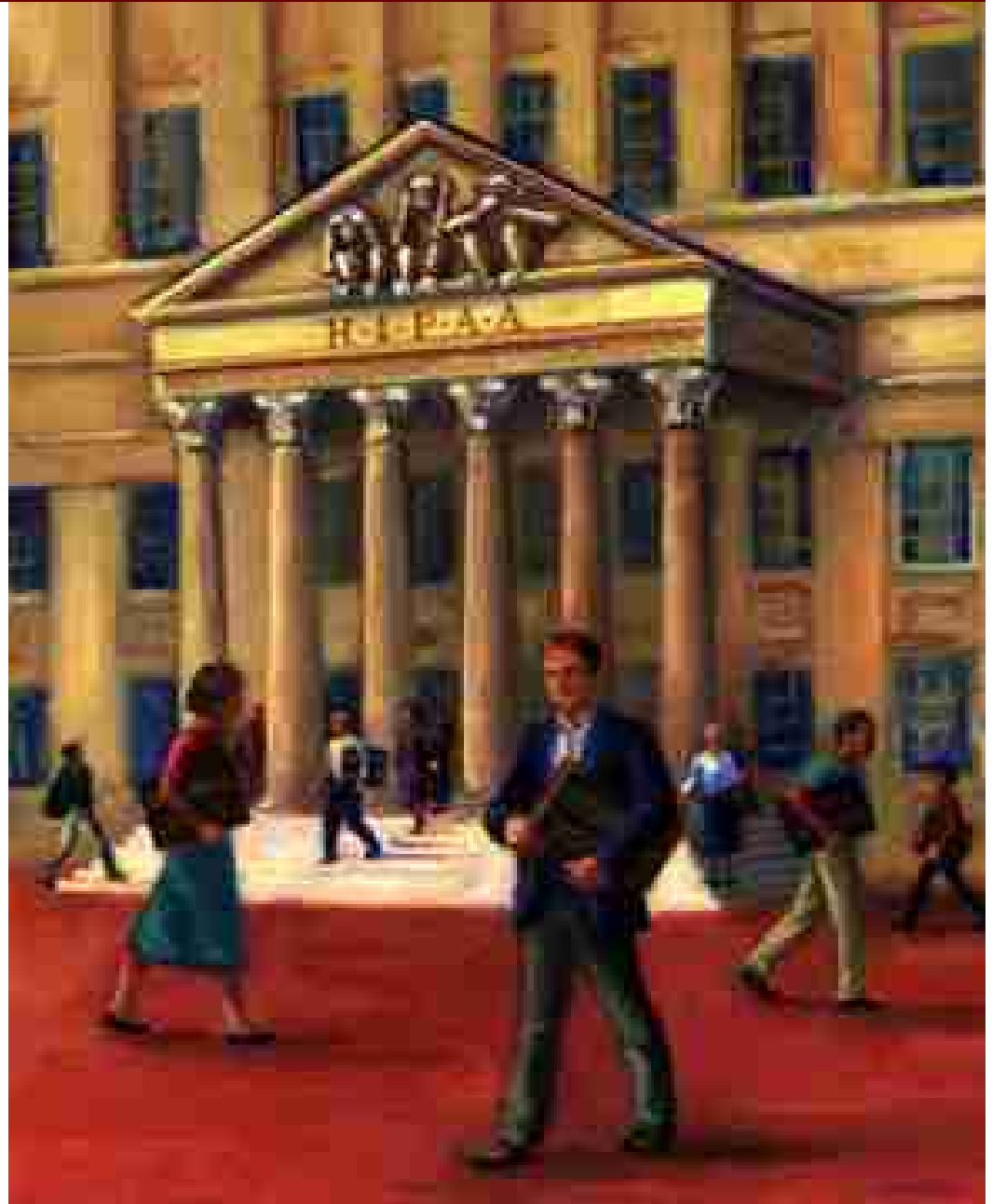
The Leading Forum on Healthcare Privacy, Confidentiality, Data Security and HIPAA Compliance

HIPAA Transactions Convergence

Kepa Zubeldia, M.D.

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Topics

- Before HIPAA – The HIPAA goal
- Reality today
- Companion Guide Portal
- Progress Report
- Convergence Project
- Open invitation

The HIPAA Law (1996)

“SEC. 1175. (a) CONDUCT OF TRANSACTIONS BY PLANS.—

“(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

“(A) the health plan may not refuse to conduct such transaction as a standard transaction;

“(B) the insurance plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

“(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

Transactions NPRM, May 17 1998

“The health care industry recognizes the benefits of EDI and many entities in that industry have developed proprietary EDI formats. **Currently, there are about 400 formats for electronic health care claims being used in the United States.** The lack of standardization makes it difficult to develop software, and the efficiencies and savings for health care providers and health plans that could be realized if formats were standardized are diminished.”

Final Rule, Transactions, August 17, 2000

“In addition, we disagree with commenters that we should add a new “usage” statement, “not required unless specified by a contractual agreement,” in the implementation guide. We believe that the usage statement would have the same effect as allowing trading partners to negotiate which conditional data elements will be used in a standard transaction. Each health plan could then include different data requirements in their contracts with their health care providers. Health care providers would then be required to use a variety of guidelines to submit transactions to different health plans. **This would defeat the purpose of standardization.**”
(Page 50323)

§ 162.915 Trading partner agreements.

A covered entity must not enter into a trading partner agreement that would do any of the following:

- (a) Change the definition, data condition, or use of a data element or segment in a standard.
- (b) Add any data elements or segments to the maximum defined data set.
- (c) Use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s).
- (d) Change the meaning or intent of the standard’s implementation specification(s).

High expectations from HIPAA

The HIPAA standard transactions will be acceptable to all covered entities (payers and clearinghouses)

- If a provider or clearinghouse sends a claim that meets the HIPAA Standard (IG) then the payer is required to accept it without imposing additional requirements.

The Reality Today

There are many additional requirements imposed by the payers

- Contractual
- Other laws and regulations
- Telecommunications
- Implementation restrictions
- Data formatting requirements
- Data content requirements
- Most additional requirements are reasonable

Examples of Requirements

- Used / not used segments and elements
 - Functionality not yet implemented
- Data formatting requirements
 - No punctuation in names and addresses
 - Maximum of xx bytes in patient account number
 - Dollar amounts must have trailing “.00”
- Data content requirements
 - Provider identifiers (may go away with NPI)
 - Anesthesia units or minutes
 - Specific provider name spelling
 - Unique code set restrictions, procedure modifiers, etc.

Where are these requirements?

- Payer HIPAA “Companion Guides”
- Provider Bulletins and Newsletters
- Instructions for filing different types of claims
 - DME, Anesthesia, Home Health, Ambulance, etc.
- Joe’s head
- Does anybody know why we require this?

How many sets of requirements?

- Before HIPAA
 - Transactions NPRM reports 400 formats in use
 - Proprietary formats under the control of each payer or clearinghouse
- After HIPAA
 - Three standard X12 formats for claim + NCPDP
 - National standard, not under the control of any one payer or clearinghouse
 - Claredi has identified 980 “Companion Guides” as of September 1, 2004 for the X12 HIPAA transactions. Number keeps growing.

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Click the links to view the actual documents. For documents without links, please contact the payer.

We currently have edits for:

- Acordia National: 837P
- Admar Health Network: 837P
- Advocate Health Center: 837I
- Advocate Health Partners: 837P, 837I
- AEtna: 837P, 837I
- AFL-CIO Food and Beverage Dealer's Trust Fund: 837P, 837I
- Alabama Medicaid: 837P (Version 12.0 5/10/04), 837I (Version 10.0 1/28/04), 837D (Version 9.0 12/12/03)
- Alliance PPO Inc. (Maryland): 837P, 837I
- Americaid Community Care (Dallas/Fort Worth): 837P, 837I
- Americaid Community Care (Houston): 837P, 837I
- American Imaging Management, Inc.: 837P
- American Lifecare: 837I
- American Medical Security, Inc.: 837P
- American Postal Workers Union Health Plan: 837P, 837I
- AmeriChoice of New Jersey: 837P, 837I
- AmeriChoice of New York: 837P, 837I
- AmeriChoice of Pennsylvania: 837P, 837I
- AmeriHealth Administrators Inter-Country Health Plan: 837I
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- Amerihealth Mercy Health Plan: 837P, 837I
- Anthem Blue Cross and Blue Shield (Midwest): 837P (Nov03), 837I (Nov03), 837D (May03)
- Anthem Blue Cross and Blue Shield (Virginia): 837P (Version 2.1 Nov03), 837I (Version 2.0 Aug03), 837D (Version 2.1 Nov03), 270 (Aug03), 271 (Aug03), 276 (Aug03), 277 (Aug03)
- Anthem Blue Cross and Blue Shield(West): 837P (10/20/02), 837I (10/20/02)
- Apex: 837P, 837I
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- Blue Cross and Blue Shield of Minnesota: 837P (Apr03), 837I (Apr03), 270, 271 (Apr03)
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- Blue Cross Blue Shield of South Carolina: 837P (10/17/03), 837I (9/29/03), 837D(1/7/04), 270 (12/2/03)
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- Blue Shield of Idaho: 837P (Nov03), 837I (Nov03)
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- South Carolina Medicaid: 837P (Version 1.8 4/27/04), 837I (Version 1.7 4/22/04), 837D (Version 1.7 3/19/04), 835 (Version 1.3 1/5/04), 834 (Version 1.0 7/29/03), 820 (Version 1.1 9/24/03)
- Southern Health Services, Inc.: 837P, 837I
- South West Medicare: 837P
- Special Risk International: 837P, 837I
- State Farm Group Medical and Individual Health Insurance Companies: 837P, 837I
- SummaCare Health Plan: 837P, 837I
- Tennessee Medicaid: 837P (Sept03), 837I, 837D
- Three Rivers Health Plans, Inc.: 837P, 837I
- TRICARE: 837P, 837I, 276, 277, 278 Request
- Triple S: 837P, 837I, 837D
- Tufts Associated Health: 837I
- UNICARE Major Accounts: 837P, 837I
- UnitedHealthCare: 837P, 837I, 820
- United States Automobile Association: 837P, 837I
- Unity Health Plan: 837I, 837P
- Univera Healthcare: 837P, 837I
- University Health Plan: 837P, 837I
- UPMC Health Plan: 837P, 837I
- Upper Peninsula Health Plan: 837P, 837I
- U.S. Health Care: 837I
- Utah Health Information Network (UHIN): 837P, 837I
- Utah Medicaid: 837P (Version 6), 837I (Version 2), 837D (Version 4), 270, 271, 276 (Version 2), 820
- Vermont Medicaid: 837P (3/20/03), 837I (4/1/03), 837D (3/28/03)
- Virginia Medicaid: 837D (Version 1.3 5/1/04), 837I (3/1/04), 837P (Version 1.3 5/1/04), 278 Request (2/23/04), 278 Response (2/23/04), 820 (8/5/03), 834 (5/1/04), 270 (8/6/03), 271 (8/6/03), 276 (8/5/03), 277 (8/5/03)
- Vytra Healthcare: 837P
- Washington Medicaid: 837I (Version 1.05 2/4/04), 837P (Version 1.05 2/4/04), 837D (Version 1.05 2/4/04), 270 (Version 1.02 10/20/03)
- WEA Trust: 837P (Version 2.0 10/3/03), 837I (Version 2.0 10/3/03), 837D (Version 1.0 9/29/03), 276, 835, 271 (Version 1.1), 278 Response (Version 1.0)
- WebMD: 837I, 837P, 837D
- Wellcare: 837P, 837I
- Wellmark Blue Cross and Blue Shield of Iowa/South Dakota: 837P (Version 1.03 8/1/03), 837I (Version 1.04 8/15/03), 837D (Version 1.01 7/1/03), 276 (Version 1.01 7/1/03), 270 (Version 1.01 7/1/03), 835 (Version 1.0 7/1/03)
- West Virginia Medicaid: 837P (Version 1.1 11/18/03), 837I (Version 1.1 11/18/03), 837D (Version 1.1 11/18/03)
- Winterbrook: 837P, 837I
- Wisconsin Physician Services: 837P
- Wisconsin Medicaid: 837P (Jun03), 837D (Jun03), 837I (Jun03)
- Xantus Healthplan of Tennessee: 837P, 837I

Many more are in development and will be available soon.

- Alabama Medicaid: 270 (Version 5.0 11/20/03), 271 (Version 4.0 9/16/03), 276 (Version 5.0 11/20/03), 277 (Version 5.0 11/25/03), 278 Request (Version 2.0 7/24/03), 820, 834, 835
- Alabama Medicare: 837P (Dec03)
- Anthem Blue Cross and Blue Shield (Midwest): 270, 271, 276, 277, 278 Request, 278 Response, 834
- Anthem Blue Cross and Blue Shield (Virginia): 278 Request (Aug03), 278 Response (Aug03)
- Arkansas Medicaid: 278 Request, 278 Response
- Alaska Medicaid: 837P (Version 3 12/29/03), 837I (Version 3 12/29/03), 837D (Version 3 12/29/03), 270 (Version 1 12/29/03), 271 (Version 1 12/29/03), 276 (Version 1 12/29/03), 278 Request (Version 1 12/29/03), 278 Response (Version 1 12/29/03)
- Blue Cross and Blue Shield of Alabama: 837I (Aug02), 276 (Dec03), 278 Request (Oct03)
- Blue Cross Blue Shield of Arizona: 270, 271, 278, 820, 834
- Blue Cross Blue Shield of Connecticut: 837P (Release 03 Nov03), 837I (Release 03 Nov03)
- Blue Cross Blue Shield of Illinois: 278 Request
- Blue Cross of Idaho: 837P (Version 1.1), 837I (Version 1.1), 837D (Version 1.1)
- Blue Cross and Blue Shield of Minnesota: 276 (6/30/04), 277 (6/30/04), 834 (Apr03)
- Blue Cross Blue Shield of Rhode Island: 270 (Version 1.3 5/1/04), 271 (Version 1.3 5/1/04), 276 (Version 1.3 5/1/04), 277 (Version 1.3 5/1/04), 278 Request (Version 1.2 5/1/04)
- Blue Cross Blue Shield of South Carolina: 276 (12/2/03), 278 Request (12/29/03), 834 (5/7/03)
- CareFirst Blue Cross Blue Shield: 270 (4/30/04), 276 (4/30/04)
- Claim Management Service: 837I
- Coventry Health Care: 837I, 837D, 270, 276
- Dean Health: 820
- Empire Blue Cross Blue Shield: 835
- Florida Medicaid: 276, 277, 270, 271, 278 Request, 278 Response
- Georgia Medicare: 837P (Jan04)
- Group Health Incorporated: 276, 270, 820, 834, 835

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- Anthem Blue Cross and Blue Shield (Virginia): 278 Request (Aug03), 278 Response (Aug03)
- Arkansas Medicaid: 278 Request, 278 Response
- Alaska Medicaid: 837P (Version 3 12/29/03), 837I (Version 3 12/29/03), 837D (Version 3 12/29/03), 270 (Version 1 12/29/03), 271 (Version 1 12/29/03), 276 (Version 1 12/29/03), 278 Request (Version 1 12/29/03), 278 Response (Version 1 12/29/03)
- Blue Cross and Blue Shield of Alabama: 837I (Aug02), 276 (Dec03), 278 Request (Oct03)
- Blue Cross Blue Shield of Arizona: 270, 271, 278, 820, 834
- Blue Cross Blue Shield of Connecticut: 837P (Release 03 Nov03), 837I (Release 03 Nov03)
- Blue Cross Blue Shield of Illinois: 278 Request
- Blue Cross of Idaho: 837P (Version 1.1), 837I (Version 1.1), 837D (Version 1.1)
- Blue Cross and Blue Shield of Minnesota: 276 (6/30/04), 277 (6/30/04), 834 (Apr03)
- Blue Cross Blue Shield of Rhode Island: 270 (Version 1.3 5/1/04), 271 (Version 1.3 5/1/04), 276 (Version 1.3 5/1/04), 277 (Version 1.3 5/1/04), 278 Request (Version 1.2 5/1/04)
- Blue Cross Blue Shield of South Carolina: 276 (12/2/03), 278 Request (12/29/03), 834 (5/7/03)
- CareFirst Blue Cross Blue Shield: 270 (4/30/04), 276 (4/30/04)
- Claim Management Service: 837I
- Coventry Health Care: 837I, 837D, 270, 276
- Dean Health: 820
- Empire Blue Cross Blue Shield: 835
- Florida Medicaid: 276, 277, 270, 271, 278 Request, 278 Response
- Georgia Medicaid: 837P (Jan04)
- Group Health Incorporated: 276, 270, 820, 834, 835
- Harvard Pilgrim Health Care: 270 (1/1/04)
- Idaho Medicaid: 837P, 837D, 837I
- Illinois Medicaid: 270 (Mar04), 271 (Mar04)
- Indiana Medicaid: 276 (Version 4.1 Jun04), 277 (Version 4.1 Jun04), 278 Request (Version 3.0 Feb04), 278 Response (Version 3.0 Feb04)
- Iowa Medicaid: 276 (Version 1.1 3/30/04), 277 (Version 1.1 3/30/04)
- Kansas Medicaid: 837P (4/5/04), 837I (4/5/04), 837D (4/5/04), 834 (11/12/03), 835 (6/24/04), 270 (11/12/03), 271 (11/12/03), 276 (11/12/03), 277 (11/12/03), 278 Request (11/12/03), 278 Response (11/12/03)
- Kentucky Medicaid: 837P (Version 1.2), 837D (Version 1.1), 837I (Version 1.1)
- Louisiana Medicaid: 837P, 837I, 837D
- Maryland Medicaid: 820
- Medical Card Service (MCS): 276 (Version 1.2.1 Nov03), 277 (Version 1.2.1 Nov03), 270 (Version 1.2.1 Nov03), 271 (Version 1.2.1 Nov03), 835 (Version 1.2.1 Nov03)
- Medica: 837P (6/30/04), 837I (6/30/04), 276 (6/30/04), 277 (6/30/04)
- Minnesota Medicaid: 835
- Mississippi Medicaid: 278 Request (Version 2.0 9/29/03), 278 Response (Version 2.0 9/29/03), 820 (Version 4.0 9/29/03), 835 (Version 4.0 9/29/03)
- National Heritage Insurance Company (Texas Medicaid): 270, 271, 276 (3rd Revision Aug03), 277 (3rd Revision Aug03), 835
- Nebraska Medicaid: 270, 271
- Nevada Medicaid: 837P (11/12/03), 837I (11/12/03), 837D (11/12/03), 270 (Version 3), 271 (Version 3), 276 (11/12/03), 277 (11/12/03), 278 Request (11/12/03), 278 Response (11/12/03), 820 (9/23/03), 834 (Version 1.3 Aug03)
- New Mexico Medicaid: 820, 834, 270 (10/3/03), 271 (11/19/03)
- Noridian Medicare (MN): 835, 837P
- North Dakota Medicaid: 270 (Oct03), 271 (Oct03), 276 (Oct03), 277 (Oct03), 278 Request (Oct03), 278 Response (Oct03)
- Ohio Medicaid: 278 Request, 278 Response
- Oregon Medicaid: 820 (11/3/03)
- PacificCare: 835 (Version 1.0 Jul03)
- Paramount: 834, 835
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- South Carolina Medicaid: 276 (Version 1.0 7/28/03), 277 (Version 1.0 7/28/03), 270 (Version 1.1 3/30/04), 271 (Version 1.1 3/30/04), 278 (Version 1.0 7/28/04)
- South Dakota Medicaid: 837P (Version 1.0 Jun03), 837I (Version 1.0 Jun03), 270 (Version 1.0 Jun03), 276 (Version 1.0 Jun03), 278 Request (Version 1.0 Jun03)
- Tennessee Medicaid: 270, 271, 276, 277, 278 Request, 278 Response, 820, 834, 835
- THIN/Trailblazers Medicare: 270, 271, 278, 837D, 837P, 837I, 834
- TRICARE: 835, 270, 271
- UGS Medicare: 837I
- Virginia Medicaid: 835 (11/17/03)
- Washington Medicaid: 271 (10/20/03), 834 (Version 1.05 3/24/04)
- Wisconsin Medicaid: 270, 271

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Claredi's Companion Guide Portal

- Free resource on the Internet
- Lists all the companion guides we have identified, with version number and date
- Links to the guides themselves
 - Only for guides available through the Internet (65%)
 - Some guides are restricted distribution
- Next task: locate the NCPDP "Payer Sheets"

Statistics as of September 1, 2004

- 837P – 262
- 837I – 223
- 837D – 76
- 835 – 12
- 270 – 46
- 276 – 51
- 278 Request – 22
- 271 – 36
- 277 – 42
- 278 Response – 12
- 834 – 13
- 820 – 12

Final Rule, Transactions, August 17, 2000

“In addition, we disagree with commenters that we should add a new “usage” statement, “not required unless specified by a contractual agreement,” in the implementation guide. We believe that the usage statement would have the same effect as allowing trading partners to negotiate which conditional data elements will be used in a standard transaction. Each health plan could then include different data requirements in their contracts with their health care providers. **Health care providers would then be required to use a variety of guidelines to submit transactions to different health plans. This would defeat the purpose of standardization.**”
(Page 50323)

But...

- Companion guides don't tell the whole story
 - Many edits are not documented in the guides
 - Some guides' requirements are not enforced
- Reading the guides is very difficult
 - Most providers' offices can't read more than 2-5
 - Most vendors won't implement more than 2-5
 - Medicare, Medicaid(s), Blues
- There has to be an easier way
- How do we help in **converging** these requirements into common requirements?



HIPAA TRANSACTIONS CONVERGENCE PROJECT

Claredi's Convergence Project

- To help the healthcare industry converge on a manageable set of requirements for the HIPAA transactions
- To help identify the divergent requirements
- To automate the identification of requirements in a machine processable format
- To provide a convergence model usable for other transactions like those in the NHII
- Free, open to the entire industry

Convergence → Interoperability

- Data Content standards driven by NUBC, NUCC, ADA DeCC, NCPDP, WEDI, others
 - Industry should adopt these standards as reference point, or “target for convergence”
- Feedback mechanism: compare transaction requirements among participants
 - Deviation from requirements defined by Content Committees, industry associations and others
 - Deviation from other requirement from same payer
 - Deviation from requirements from other payers

HIPAA Convergence Requirements Lists

- General Convergence Lists
 - Define common requirements as target for convergence
 - Bill type
 - Type of claim
 - Lists defined by NUBC, NUCC, DeCC and NCPDP for the entire industry
- Payer Specific Lists
 - Defined by each payer for their own needs
 - Concise, limited only to payer-specific needs
 - Does not replace companion guides. Supplements them.
 - Eventually these lists **should go away** (Probability 0%)

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► **Convergence Project**

Public Requirement Lists

Sign On

 **HIPAA TRANSACTIONS
CONVERGENCE PROJECT**

Claredi is sponsoring the Convergence Project as a mechanism to help the industry converge on a common set of HIPAA Transaction Requirements by identifying the data requirements contained in [companion documents](#) and comparing requirements among multiple lists. The goal is to minimize the need for unique data requirements in companion documents and to help reduce the burden of companion documents.

Claredi provides free access to the HIPAA Transaction Requirements Lists, a visual comparison tool, and the ability for payers and others to define and maintain their own requirement lists for all the HIPAA Transactions. Access is free after [registering with Claredi for this project](#). If you need assistance in creating or maintaining your own requirement lists for this project, please contact Claredi Customer Support at 1-866-444-0339, option 5.

Requirement Lists may be viewed and also downloaded in machine-readable form. If you need these lists in other formats, or sent to you automatically on a subscription basis, contact Claredi Sales at 1-866-444-0339, option 6. If you want Claims or other HIPAA Transaction data matched against requirement lists, open a [Claredi Classic](#) Account.

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HIPAA TRANSACTIONS
CONVERGENCE PROJECT

Disclaimer

Claredi's Convergence Project reflects only the good faith interpretation of requirements for HIPAA transactions made by the publisher of each list. These interpretations are not reviewed or approved by Claredi or any governmental or private entity. Publisher's or other person's interpretations may differ. Claredi disclaims all warranties and accepts no liability for user's reliance or use of Claredi's Convergence system.

- Click on List name for summary, 'CSV', or 'XML' to see the Requirements.
- To download the individual files, right-click on the CSV or XML option and choose 'Save As ...'

Other Global Lists

Publisher	List Name	Transaction	Downloads	
Claredi	Alabama Medicaid 837D	837D	CSV	XML

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Publisher	List Name	Transaction	Downloads	
Claredi	Alabama Medicaid 837D	837D X097A1	CSV	XML
Claredi	Alabama Medicaid 837I	837I X096A1	CSV	XML
Claredi	Alabama Medicaid 837P	837P X098A1	CSV	XML
Claredi	Alaska Medicaid 837D	837D X097A1	CSV	XML
Claredi	Alaska Medicaid 837I	837I X096A1	CSV	XML
Claredi	Alaska Medicaid 837P	837P X098A1	CSV	XML
Claredi	Anthem Blue Cross and Blue Shield of Virginia 837D	837D X097A1	CSV	XML
Claredi	Anthem Blue Cross and Blue Shield of Virginia 837I	837I X096A1	CSV	XML
Claredi	Anthem Blue Cross and Blue Shield of Virginia 837P	837P X098A1	CSV	XML
Claredi	Anthem MidWest 837D	837D X097A1	CSV	XML
Claredi	Anthem MidWest 837I	837I X096A1	CSV	XML
Claredi	Anthem MidWest 837P	837P X098A1	CSV	XML

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Claredi	Bill Type 11x Hosp. Inpatient, discharged (Medicare non-PPS)	837I	X096A1	CSV	XML	
Claredi	Bill Type 11x Hosp. Inpatient, discharged (Medicare PPS)	837I	X096A1	CSV	XML	
Claredi	Bill Type 11x Hosp. Inpatient, discharged (non-Medicare)	837I	X096A1	CSV	XML	
Claredi	Bill Type 11x Hosp. Inpatient, not discharged (Medicare non-PPS)	837I	X096A1	CSV	XML	
Claredi	Bill Type 11x Hosp. Inpatient, not discharged (Medicare PPS)	837I	X096A1	CSV	XML	
Claredi	Bill Type 11x Hosp. Inpatient, not discharged (non-Medicare)	837I	X096A1	CSV	XML	
Claredi	Bill Type 12x Hospital - Inpatient (Medicare Part B only)	837I	X096A1	CSV	XML	
Claredi	Bill Type 13x Hospital - Outpatient	837I	X096A1	CSV	XML	
Claredi	Bill Type 14x Hospital - Other	837I	X096A1	CSV	XML	
Claredi	Bill Type 17x Hospital - Subacute Inpatient	837I	X096A1	CSV	XML	
Claredi	Bill Type 18x Hospital - Swing Beds, discharged	837I	X096A1	CSV	XML	
Claredi	Bill Type 18x Hospital - Swing Beds, not discharged	837I	X096A1	CSV	XML	
Claredi	Blue Cross Blue Shield Anthem West of Colorado 837I	837I	X096A1	CSV	XML	
Claredi	Blue Cross Blue Shield Anthem West of Colorado	837P		CSV	XMI	

Convergence Project

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Requirement List: Blue Cross Blue Shield of Florida 837P

Published by: Claredi

004010X098A1 - 837 Professional

Element	Choice	Operator	Data	Default
Submitter Contact Communication Number1-ED (837P.1000A.PER.PER04)	Required	Presence of Element		
Billing Provider Additional Identifier-1B (837P.2000A.2010AA.REF.REF02)	Required	String Length	5	
Payer Primary Identifier-PI (837P.2000B.2010BB.NM1.NM109)	Required	Equal To (Numeric)	590	
Claim Submission Reason Code (837P.2000C.2300.CLM.CLM05.CLM0503)	Required	One of Selected Codes	1	
Claim Attachment Report Type Code (837P.2000C.2300.PWK.PWK01)	Not Used			
Claim Attachment Transmission Code (837P.2000C.2300.PWK.PWK02)	Not Used			
Claim Attachment Control Number (837P.2000C.2300.PWK.PWK06)	Not Used			
Claim Principal Diagnosis Code (837P.2000C.2300.HI.HI01.HI0102)	Required	Presence of Element		
Service Line Unit Count- F2 (837P.2000C.2300.2400.SV1.SV104)	Not Used			
Application Reason Code		Equal To		

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Claredi	Blue Cross Blue Shield of Arizona 837I	837I X096A1	CSV	XML
Claredi	Blue Cross Blue Shield of Arizona 837P	837P X098A1	CSV	XML
Claredi	Blue Cross Blue Shield of California 837D	837D X097A1	CSV	XML
Claredi	Blue Cross Blue Shield of California 837D	837D X097A1	CSV	XML
Claredi	Blue Cross Blue Shield of California 837I	837I X096A1	CSV	XML
Claredi	Blue Cross Blue Shield of California 837I	837I X096A1	CSV	XML
Claredi	Blue Cross Blue Shield of California 837P	837P X098A1	CSV	XML
Claredi	Blue Cross Blue Shield of California 837P	837P X098A1	CSV	XML
Claredi	Blue Cross Blue Shield of California 837I	837I X096A1	CSV	XML
Claredi	Blue Cross Blue Shield of Georgia 837P	837P X098A1	CSV	XML
Claredi	Blue Cross Blue Shield of Illinois 837D	837D X097A1	CSV	XML
Claredi	Blue Cross Blue Shield of Illinois 837I	837I X096A1	CSV	XML
Claredi	Blue Cross Blue Shield of Illinois 837P	837P X098A1	CSV	XML

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Some files can harm your computer. If the file information below looks suspicious, or you do not fully trust the source, do not open or save this file.

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File type: XML Document
From: ns.claredi.com

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- **My Requirement Lists**
- Compare Requirement Lists
- Logout



Bill Type 11x Hosp. Inpatient, not discharged (Medicare PPS)

837I - 004010X096A1 - 837 Institutional

Select the Elements you want to include in this Requirement List.

Note that you can organize the elements by Element name or Location by clicking on the respective link.

[Show Partial List](#)

Include in List	Location	Element
<input type="checkbox"/>	837I.ST.ST01	Transaction Set Identifier Code
<input type="checkbox"/>	837I.ST.ST02	Transaction Set Control Number
<input type="checkbox"/>	837I.BHT.BHT02	Transaction Set Purpose Code
<input type="checkbox"/>	837I.BHT.BHT03	Transaction Set Originator Application Transaction Identifier
<input type="checkbox"/>	837I.BHT.BHT04	Transaction Set Creation Date
<input type="checkbox"/>	837I.BHT.BHT05	Transaction Set Creation Time
		Transaction Set Claim Or

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<input type="checkbox"/>	837I.2000C.2300.CLM.CLM11.CLM1102	Claim Related Causes Code2	
<input type="checkbox"/>	837I.2000C.2300.CLM.CLM11.CLM1103	Claim Related Causes Code3	
<input type="checkbox"/>	837I.2000C.2300.CLM.CLM11.CLM1104	Claim Auto Accident State Or Province Code	
<input type="checkbox"/>	837I.2000C.2300.CLM.CLM11.CLM1105	Claim Accident Country Code	
<input type="checkbox"/>	837I.2000C.2300.CLM.CLM12	Claim Special Program Indicator	
<input type="checkbox"/>	837I.2000C.2300.CLM.CLM18	Claim Explanation Of Benefits Indicator	
<input type="checkbox"/>	837I.2000C.2300.CLM.CLM20	Claim Delay Reason Code	
<input checked="" type="checkbox"/>	837I.2000C.2300.DTP.DTP03	Claim Discharge Hour	
<input type="checkbox"/>	837I.2000C.2300.DTP.DTP03	Claim Statement From Or To Date-R D8	
<input type="checkbox"/>	837I.2000C.2300.DTP.DTP03	Claim Statement From Or To Date-D8	
<input checked="" type="checkbox"/>	837I.2000C.2300.DTP.DTP03	Claim Admission Date And Hour	
<input checked="" type="checkbox"/>	837I.2000C.2300.CL1.CL101	Claim Admission Type Code	
<input checked="" type="checkbox"/>	837I.2000C.2300.CL1.CL102	Claim Admission Source Code	
<input checked="" type="checkbox"/>	837I.2000C.2300.CL1.CL103	Claim Patient Status Code	
<input type="checkbox"/>	837I.2000C.2300.PWK.PWK01	Claim Attachment Report Type Code	
<input type="checkbox"/>	837I.2000C.2300.PWK.PWK02	Claim Attachment Transmission Code	
<input type="checkbox"/>	837I.2000C.2300.PWK.PWK06	Claim Attachment Control Number	
<input type="checkbox"/>	837I.2000C.2300.PWK.PWK07	Claim Attachment Description	
<input type="checkbox"/>	837I.2000C.2300.CN1.CN101	Claim Contract Type Code	

Bill Type 11x Hosp. Inpatient, not discharged (Medicare PPS)

837I - 004010X096A1 - 837 Institutional

When you have identified the elements you want in the list, specify what your requirement is for each element on this page

(Not Used, Not Allowed, Allowed, or Required; the Operator; and any related Data value used for comparison).

If the element is a 'code' type, it has a select set of items that can be chosen. In this case, a code value will appear in the Data column for the element. If you have a code with many items, you can use the 'select all' feature to select them all (if you want) or the 'deselect all' feature to deselect any you don't want to use.

Hint: Use the CTRL or SHIFT keys while clicking to select multiple items.

Element	Choice				Operator	Data	Default
	Not Used	Not Allowed	Allowed	Required			
Claim Type Of Bill Facility Type Code	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Equal To (String)	11	
Claim Type Of Bill Claim Frequency Code	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Not Equal To (String)	1,2,3,4,6,9,B,(
Claim Discharge Hour	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Presence of Element		
Claim Admission Date And Hour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Presence of Element		

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Compare Requirement Lists

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Edit Requirement List: Bill Type 11x Hosp. Inpatient, discharged (Medicare non-PPS)

837I - 004010X096A1 - 837 Institutional

List Name:	<input type="text" value="Bill Type 11x Hosp. Inpatient, discharged (Medicare non-PPS)"/>
Sequence Number:	<input type="text" value="0"/> Seq. Number is used to order your lists for convenience.
Description: (Allows limited HTML) Publically visible on Global Lists	<div></div>
Notes: (text only) Not Publically visible	<div></div>
<input checked="" type="checkbox"/> Make List Global (Available to world)	
<input type="button" value="Save"/>	

Claredi - My Data Requirements - Microsoft Internet Explorer

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HIPAA TRANSACTIONS

CONVERGENCE PROJECT

Compare Requirement Lists

Choose up to 10 Requirement Lists to compare, by selecting the checkboxes on the left. When you are ready to compare, click 'Compare'.

Only lists for similar transactions may be compared to each other.

My Own Lists

Diff	Publisher	List Name	Transaction
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, discharged (Medicare non-PPS)	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, discharged (Medicare PPS)	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, discharged (non-Medicare)	837I X096A1

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Diff	Publisher	List Name	Transaction
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, discharged (Medicare non-PPS)	837I X096A1
<input checked="" type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, discharged (Medicare PPS)	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, discharged (non-Medicare)	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, not discharged (Medicare non-PPS)	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, not discharged (Medicare PPS)	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 11x Hosp. Inpatient, not discharged (non-Medicare)	837I X096A1
<input checked="" type="checkbox"/>	Claredi	Bill Type 12x Hospital - Inpatient (Medicare Part B only)	837I X096A1
<input checked="" type="checkbox"/>	Claredi	Bill Type 13x Hospital - Outpatient	837I X096A1
<input checked="" type="checkbox"/>	Claredi	Bill Type 14x Hospital - Other	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 17x Hospital - Subacute Inpatient	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 18x Hospital - Swing Beds, discharged	837I X096A1
<input type="checkbox"/>	Claredi	Bill Type 18x Hospital - Swing Beds, not discharged	837I

<input type="checkbox"/>	Claredi	List Name 43	837I X096A1
<input type="checkbox"/>	Claredi	ODJFS Claims Required Data - Not Compound	NCPDP B1
<input type="checkbox"/>	Claredi	ODJFS Claims Required Data - Compound	NCPDP B1
<input type="checkbox"/>	Claredi	ODJFS Claims - COB	NCPDP B1
<input type="checkbox"/>	Claredi	ODJFS Claims - DUR / PPS	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims Required Data - Not Compound	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims Required Data - Compound	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims Required Data - HMO Provider ID	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims - COB	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims - DUR / PPS	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claim reversal	NCPDP B2

Compare Clear All

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main.claredi.com -- 11 September 2004 -- 11:11:26 PM MDT

Name	Bill Type 11x Hosp. Inpatient, discharged (Medicare PPS)	Bill Type 12x Hospital - Inpatient (Medicare Part B only)	Bill Type 13x Hospital - Outpatient	Bill Type 14x Hospital - Other
Claim Type Of Bill Facility Type Code	Required Equal To (String) (11)	Required Equal To (String) (12)	Required Equal To (String) (13)	Required Equal To (String) (14)
Claim Type Of Bill Claim Frequency Code	Required Equal To (String) (1)	Required Not Equal To (String) (2,3,4,6,9,A,B,C,D,E)	Required Not Equal To (String) (6,9,A,B,C,D,E)	Required Not Equal To (String) (2,3,4,6,9,A,B,C,D,E)
Claim Discharge Hour	Required Presence of Element	Not Allowed	Not Allowed	Not Allowed
Claim Statement From Or To Date- D8				Required Presence of Element
Claim Statement From Or To Date-R D8				Not Allowed
Claim Admission Date And Hour	Required Presence of Element	Required Presence of Element	Required Presence of Element	Required Presence of Element
Claim	Required		Required	Required

Home Health Mental Status Code1	Not Allowed	Not Allowed	Not Allowed	Not Allowed
Claim Principal Diagnosis Code	Required Presence of Element	Required Presence of Element	Required Presence of Element	
Claim Admitting Diagnosis Reason For Visit-BJ	Required Presence of Element	Not Allowed		
Claim Admitting Diagnosis Reason For Visit-ZZ	Not Allowed	Required Presence of Element		
Claim Diagnosis Related Group Code		Not Allowed	Not Allowed	Not Allowed
Claim Principal Procedure Code-BP	Not Allowed	Not Allowed	Not Allowed	Not Allowed
Claim Other Procedure Code1-BO	Not Allowed	Not Allowed	Not Allowed	Not Allowed
Claim Treatment Code1	Not Allowed	Not Allowed	Not Allowed	Not Allowed

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File Edit View Favorites Tools Help					
	Code1-BO				
	Claim Treatment Code1	Not Allowed	Not Allowed	Not Allowed	Not Allowed
	Claim Days Count-LA	Required Presence of Element		Not Allowed	Not Allowed
	Claim Days Count-CA	Required Presence of Element	Not Allowed	Not Allowed	Not Allowed
	Claim Days Count-NA	Required Presence of Element		Not Allowed	Not Allowed
	Claim Days Count-CD	Required Presence of Element		Not Allowed	Not Allowed
	Home Health Discipline Type Code	Not Allowed	Not Allowed	Not Allowed	Not Allowed
	Home Health Total Visits Prior To Recertification Date	Not Allowed	Not Allowed	Not Allowed	Not Allowed
	Home Health Total Visits Projected During	Not Allowed	Not Allowed	Not Allowed	Not Allowed

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<input type="checkbox"/>	Claredi	Wellmark Blue Cross and Blue Shield 837I	837I X096A1
<input type="checkbox"/>	Claredi	Wellmark Blue Cross and Blue Shield 837P	837P X098A1
<input type="checkbox"/>	Claredi	Blue Cross Blue Shield of Alabama 837D	837D X097A1
<input type="checkbox"/>	Claredi	List Name 43	837I X096A1
<input type="checkbox"/>	Claredi	ODJFS Claims Required Data - Not Compound	NCPDP B1
<input type="checkbox"/>	Claredi	ODJFS Claims Required Data - Compound	NCPDP B1
<input type="checkbox"/>	Claredi	ODJFS Claims - COB	NCPDP B1
<input type="checkbox"/>	Claredi	ODJFS Claims - DUR / PPS	NCPDP B1
<input checked="" type="checkbox"/>	Claredi	OKMMIS Claims Required Data - Not Compound	NCPDP B1
<input checked="" type="checkbox"/>	Claredi	OKMMIS Claims Required Data - Compound	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims Required Data - HMO Provider ID	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims - COB	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claims - DUR / PPS	NCPDP B1
<input type="checkbox"/>	Claredi	OKMMIS Claim reversal	NCPDP B2

Compare Clear All

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Segment Identification	Not Used	Not Used	
Segment Identification	Not Allowed	Required Equal To (String) (10)	
Compound Dosage Form Description Code		Required Presence of Element	
Compound Dispensing Unit Form Indicator		Required Equal To (String) (1,2,3)	
Compound Route of Administration		Required Presence of Element	
Compound Ingredient Component Count		Required Less Than or Equal To (Numeric) (25)	
Compound ProductID Qualifier		Required Equal To (String) (03)	
Compound ProductID		Required Presence of Element	
Compound Ingredient Quantity		Required Presence of Element	
Compound Ingredient Drug Cost		Not Used	
Compound Ingredient Basis of Cost Determination		Not Used	
Segment Identification	Required Equal To (String) (11)	Required Equal To (String) (11)	
Ingredient Cost Submitted	Not Used	Not Used	

Convergence Project Requirements Lists

- Will be published by NUBC, NUCC, ADA DeCC and NCPDP
- Payers should publish their own specific lists
- Claredi provides the infrastructure
 - Free industry access to requirement list database
 - Each list publisher maintains its own lists
- Claredi will define initial set of payer-specific lists as part of our Companion Guide implementations, to seed the directory

The goal: **Convergence**

- A single web portal where the companion guides can be referenced and the requirements can be published
- Easy to read and understand requirements lists
- Downloadable in machine readable format (XML, CSV)
- Easy to compare requirements among lists
- Does not replace Companion Guides
- Ultimate goal is **convergence** of requirements
 - Only lists that should remain are the NCPDP, ADA DeCC, NUBC and NUCC-defined lists (Probability 0%)
- Free access to the industry
- Open invitation to participate to all interested parties

Questions?

- Kepa.Zubeldia@claredi.com

Convergence Project URL

- <http://www.claredi.com/convergence>