

# OREGON EDI MEDICAL BILL PROCESSING CHANGE LOG

Updated 5/19/09

**CORRECTION (as of 5/19/09): see yellow highlighted section below, for DN643.**

## NEW CHANGES (as of 2/26/09)

General note on **zero-paid bills**: We have no edits that are explicitly skipped when the total paid is \$0. The diagnosis codes and pointers are skipped if the insurer doesn't pay for any qualifying services at the line level, or if the billing or rendering provider is an ambulance service provider.

Removed **valid-value edits from DMG03 & DMG04** in the 997 edits. The length is still checked. (2/24/09)

Fixed bug that would crash the program when a **service line was reported without any SV segments**. (2/23/09)

Broadened the **taxonomy codes that are not required to provide a diagnosis code (or pointer)**. It was just excusing ambulance services from requiring a diagnosis (2/2/09), but now when rendering or billing provider's taxonomy code has a type of Respiratory, Developmental, Rehabilitative and Restorative Service Providers; Technologists, Technicians & Other Technical Service Providers; Other Service Providers; or classification of Ambulance, then a diagnosis is not required. (2/13/09)

Removed error routine that caused rejects if **DN643 Rendering Bill Provider National Provider ID** was missing; data element is optional. (2/10/09) (See also below, 2/4/09) **(NOTE: error corrected 5/19/09; previous title of "Billing Provider National Provider ID" was incorrect for DN643.)**

**DN567 DME Billing Frequency Code** error changed from 028 to 058 when code is invalid. (2/9/09)

**DN557 Diagnosis Pointer**: Changed 058 error to 064 when it fails to point to a reported diagnosis. This was fixed for the first pointer in November 08; this fixes the rest of the pointers. (2/9/09)

Removed the code that **duplicated errors** reported during standard adjudication editing when a billed product/service had a qualifier incompatible with the SV segment. (2/9/09) (See also 12/8/08.)

When editing **adjudications on service lines** reported using the SV5 segment, rather than use one or the other, the total charge is the sum of the rental + purchase charges. (2/9/09)

Began rejecting **DN643 Rendering Bill Provider State License Number** if not present when **DN647 Rendering Bill Provider National Provider ID** not present. (2/4/09) (See also additional change above, 2/10/09)

Relaxed certain edits on **DN522 ICD-9 CM Diagnosis Code** and **DN557 Diagnosis Pointer**. Ambulances no longer required to report diagnosis codes. When the billing or rendering (bill or line) provider's taxonomy code indicates ambulance (341600000X, 3416L0300X, 3416S0300X, 3416A0800X), then diagnosis codes and pointers are optional. (2/2/09)

Allowed **Oregon-specific (jurisdiction) modifiers (DN718)** with **HCPC product/service codes (DN714)**. **HCPC modifiers (DN717)** were already allowed with **Oregon-specific (jurisdiction) product/service codes (DN715)**. (2/2/09)

Removed date restrictions from **HCPC, taxonomy, adjustment reason, HCPC and jurisdiction modifier, jurisdiction procedure, ADA, revenue codes**. If a code was ever valid, it will always be valid. (1/20/09)

Changed edits to disregard the **date range for the ICD-9 codes**. If the code is in the table of present or past valid ICD-9 values, then it is valid. (1/15/09)

**Admission Date DN513, Discharge Date DN514, and Admitting Diagnosis Code DN535** are not required on outpatient hospital bills. (1/14/09)

Moved admitting diagnosis code existence check from the 997 to the 824. When there is an **Admitting Diagnosis Code DN535**, there must be an **Admission Date DN513**, and vice versa. (12/11/08)

Changed **error code for procedure qualifier** (see 12/8/2008) from 064 to be 054: Must be valid occurrence for segment. (12/10/08)

**DN514 Discharge Date** is required on UB bills. (12/10/08)

Fixed **DN557 Diagnosis Pointer** criteria to match **DN522 Diagnosis** for non-UB bills with **blank DN502 Billing Type Code**. (12/9/08)

Moved **billed product/service qualifier validation** with respect to segment ID from the 997 edits to the 824 edits. (12/8/08) When the wrong qualifier is used for the segment (i.e. **SV5\*ND:00006384371\*UN\*18\*\*4423.32~**) then the qualifier will have the error associated with it and will reference DN0. This is a temporary solution until the IAIABC can come up with a permanent solution.

- The appropriateness of the presence of the billed/paid code modifier is checked in the 824 against the billed code qualifier, not the segment id.
- When a paid modifier is used when it should not be (guide says NOT USED and there is no DN to reference), then DN0 will be used. (12/9/08)

Automated the **NDC valid code file** loading so that the value table is updated every Friday before the EDI program is run. (12/4/08)

When **DN508 Bill Submission Reason Code** = 01 (cancelation), then bypass all edits after that. Invalid sequence of bill submission reason codes will still result in rejection. (11/26/08)

**DME bills** (DN502 = DM) required at least 1 SV5 segment. Now requires at least 1 SV1 or 1 SV5. (11/26/08)

**AK402** now contains the reference number from the X12 data dictionary, not the medical dictionary's DN. (11/24/08)

**DN505 Billing Type Code, DN506 Provider Signature on File Indicator (structural element), DN526, Release of Information Code (structural element), DN507 Provider Agreement Code, DN508 Bill Submission Reason Code, DN577 Admission Type Code, DN515 Contract Type Code, DN741 Contract Line Type Code (structural element), and DN742 Provider Agreement Line Code (structural element)** will only have their lengths checked in the 997 edits if sent; their values will be checked in the 824 edits. (11/24/08)

**Diagnosis Pointer (DN557)** value was checked in the 997, but now it will only be checked in the 824. The length is still checked in the 997. (11/17/08)

When **DN557 Diagnosis Pointer** is a value that doesn't point to a reported diagnosis code, error will now be 064 (Invalid data sequence/relationship). (11/17/08)

**Diagnosis code (DN522)** is now required on a non-UB bill with a blank **type code (DN502)** ONLY when there is an NDC or non-ambulance HCPC code on a any line (billed w/o adjudication or paid > \$0). (11/14/08)

**Diagnosis Pointer (DN557)** is required on those same lines as #1 above. Previously was required regardless of service provided on non-UB. DN557 is only in SV1 segment, so that DN is only checked there. (11/14/08)

Changed error code on **DN502 Billing Type Code** from 064 to 062: required segment not present when the required SV4 or SV5 is not present. (10/31/08)

Added nullity check before attempting to validate **DN522 ICD-9 CM Diagnosis Code** on a UB outpatient bill. Only validates the code if it is reported. (10/30/08)

Fixed subroutine that did not catch all of the segment errors to determine whether to reject an 837 transaction set. Potentially, when only the last element in a segment had an error, the transaction set would be rejected. Now **any errors in a segment will cause a transaction set rejection.** (10/28/08)

Allow **multiple occurrences of a bill in the same file.** (Still requires a proper sequence of DN508 among the accepted transactions.) (10/28/08)

The second diagnosis code was not validated when DN503 = 'A' and the facility code did not require **DN535 Admitting Diagnosis Code**. (10/28/08)

**DN522 Diagnosis Code** is now required for non-UB bills that are not RX, DM, MO and there is a line with an NDC, HCPC or jurisdiction billed code. (10/27/08)

**CAS01 (adjustment group codes), CLM04 (DN502 bill type code)** values will not be validated in the 997, but only the 824. The lengths will be checked in the 997. (10/22/08)

Previously, a bill was found by matching DN500 with the reporter's FEIN. This was incorrect. Now matches a bill by **DN500 Unique Bill ID Number and DN6 Insurer FEIN**. This now requires the new insurer to know the FEIN of the original insurer (and its unique bill id) if they are to replace or cancel a bill. (10/16/08)

**DN639 Rendering Bill Provider First Name** is required only when the rendering bill provider is reported as a person. **DN502 Billing Type Code** is no longer used to determine when **DN639 Rendering Bill Provider First Name** is required. (10/13/08)

## END OF NEW CHANGES

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## PREVIOUSLY PUBLISHED CHANGES (as of 10/1/08):

### DATA REQUIREMENT CHANGES:

- Error 042 – not statutorily valid – is removed. (7/30/08)
- If both DN592 Rendering Line Provider NPI and DN599 Rendering Line Provider State License Number (default = 99999) are both blank, then the error for missing mandatory field will now be associated with DN599 Rend. Line Prov. State License Number (was DN592). (7/21/08)
- The guide says that DN553 (Days/Units Code) in SV103 can have a value of DA (days), UN (units), or MJ (minutes), but in SV204 and SV502, MJ is not listed as a valid code. We follow the guide in this situation. If a single unit associated with a CPT or HCPC code represents 15 minutes of physical therapy, for example, and 30 minutes were billed/paid, then use UN for DN553 and number of units = 2, rather than MJ (minutes) and 30 (units). (7/21/08)
- DN682 (Facility NPI) is now optional when reporting a facility. (8/4/08)
- DN579 (Dispensing fee) is no longer required on all SV4 segments, but it is on all lines from a pharmacy. DN502 (bill type code) = RX. (8/13/08)
- DN501 Total charge per bill is now conditional upon having an SV1, SV2 or SV3 segment in the bill. (8/21)
- DN552 Total charge per line is required where it is available (SV1, SV2, SV3 segments). (8/24/08).
- Allow invalid Revenue Billed Codes—must have valid Revenue Paid Code when paid amount > 0. (8/25/08)

- Country codes must be 2-3 characters long. The IAIABC guide shows valid country codes. We will assume US if no other country is reported. US and USA are valid for United States. At this time, only the structural validation will occur (length of 2-3). Country code should be reported for foreign providers or facilities; that will allow us to ignore the requirement for NPI/FEIN/State License Number for these entities. (9/4/08)
- HI02-1 (diagnosis code qualifier) now allows 'BF' (diagnosis) for UB-04 bills with an admission date. It was only allowing 'BJ' (admitting diagnosis) for UB bills when an admission date was reported. (9/17/08)
- Revenue codes were updated. They include 100 3-digit and 510 4-digit codes (the same list that CA uses) as of 9/24/08.

#### FILE STRUCTURE REQUIREMENT CHANGES:

- File extensions are not preferred, but will not result in a rejected file. Acknowledgments will still not have extensions. (7/30/08)
- RED01 has "BLANK DATA SENT" with the 001-missing required element (7/30/08)
- Error 039 – no match on the database – will only appear if a transaction for which the insurer is reporting is rejected. The error will only appear at the batch level and only one time per insurer. This will not cause a batch to be rejected. (7/30/08)
- Invalid segment terminators caused the overall program to fail when preparing the file to be processed. The program will now tolerate this error, and result in a TA1 rejection. (7/21/08)
- Invalid NM101 elements caused an unhandled exception during program execution, causing the entire program to fail. The program will now tolerate this type of error and report the NM1 segment to be in the same loop as the previous "parent" segment in the 997 file. (7/22/08)
- Be sure to name the file using the FEIN you put on your trading profile documents. (FEIN discrepancies can cause problems routing your acknowledgments back to your folder). (7/21/08)
- NM101 in loop 2420 (rendering line provider) must be 82. (7/21/08)
- Files which are totally unreadable (won't generate a TA1) will no longer crash the program (8/5). An email will be sent to the project team with the file name. It is up to reporters to ask about missing acknowledgments. The team may proactively respond as schedules and workloads permit. (8/4/08)
- For group CAS segments, in loop 2320, this needs to be preceded by the SBR segment first, and then the adjustments. If this isn't done properly our system will reject. (8/14/08)
- if an invalid paid code is reported, need to provide adjudication of the bill showing a "0" payment, adjustment reason of "invalid code." If invalid code submitted by provider but paid anyway, payer is responsible for reporting a valid paid code in the SVD segment. (8/14/08)
- A zero "0" dispensing fee is acceptable, but there must be an amount in the dispensing fee Loop 2400, segment AMT, with AMT01 = D7. (8/14/08)
- DN572 Drug/Supplies billed amount is required in an AMT segment within the 2400 loop after any SV4 segment. (8/21/08)
- Multiple SV segments: The allowable combinations are any singular SV segment in the 2400 loop and the set {SV1, SV5}. Any other combination will result in 997 errors. If the appropriate data (HCPCS codes, etc.) do not match, then errors will occur in the 824. (9/22/08)

