TIBCO Foresight® Instream®

Release Notes Addendum: Guideline Updates

Software Release 8.7.0
August 2017

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Introduction to Guideline Updates for TIBCO Foresight® Instream® Release 8.7.0

Overview

Instream® validates transactions according to industry standards, organizational guidelines, and specific business rules.

Instream is shipped with TIBCO Foresight-supplied healthcare-related guidelines that contain types 1-7 HIPAA rules. These guidelines are maintained and regularly updated by TIBCO Foresight to ensure compliance with implementation guides published by industry standards organizations.

For a complete listing of HIPAA and other healthcare-related guidelines provided with Instream and other TIBCO Foresight products, refer to **ForesightHIPAAguidelinelist.pdf**.

About this Document

This document is an addendum to the Instream version 8.7.0 Release Notes. It details updates made to the TIBCO Foresight-supplied guidelines between the release of Instream version 8.6.0 (August 2016) and Instream version 8.7.0 (July 2017).

This includes changes originally contained in Interim Updates to Guidelines versions 8.6.0.1 through 8.6.0.3. Changes originally released in an interim update are noted in the description of the change.

Interim Updates to Guidelines

Interim Updates to Guidelines are provided by TIBCO Foresight between releases of Instream and are distributed through the TIBCO Support system.

In order to receive automated emails when an update is available, you must subscribe to the products you are interested in.

To receive emails:

1. Sign into TIBCO Support (https://support.tibco.com) using your credentials.
2. From the dropdown menu beside your user name, select Product Interests and Knowledge Base Subscriptions.
3. Click as desired to subscribe to products of interest.
4. Configure your subscriptions for those products.
5. Click Save Interests.

To download updates:

1. Sign into TIBCO Support (https://support.tibco.com) using your credentials.
2. Select Downloads > Hotfixes > Available Downloads.
3. Click on Foresight.
4. Select Guidelines_Standards.

Guideline Updates

The description of guideline changes includes the guideline, issue, solution, and impacted error messages. This listing is in sequential order by Change number.

In this section:

- **New Error(s)** are error messages that have been added to the guideline as a result of the associated change.
- **Updated Error(s)** are error messages that have updated message text as a result of the associated change.
- **Related error(s)** are error messages for which generation may be impacted by the associated change, although the text of the messages did not change.
- **Retired error(s)** are error messages that are no longer triggered due the associated change (typically the removal of an edit).

  Note: When a message is "retired," the text for the retired number remains in the FSBRErrs.txt file so that TIBCO Foresight® Transaction Insight® users are able to view error messages generated in past releases of the product.

Change #: FINS-985

Guideline(s): 5010837P.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Edits placed on the CTP04 quantity based on the NUCC restriction for paper claims are unnecessary. Per X12n, RFI 1924, the only edits needed are for element type R and min/max 1/15.

Solution
Edits based on the NUCC restriction for paper claims were removed.

Retired error
41195 The maximum length for the Drug Quantity (Loop 2410, CTP04), is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.

Change #: FINS-991

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Edits placed on the CTP04 quantity based on the NUCC restriction for paper claims are unnecessary. Per X12n, RFI 1924, the only edits needed are for element type R and min/max 1/15.

Solution
Edits based on the NUCC restriction for paper claims were removed.

Retired error
41716 The maximum length for the Drug Quantity (Loop 2410, CTP04), is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.

Change #: FINS-1087

Guideline(s): 5010-835.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Error 42513 refers to 2100CLPCAS as representing the sum of the CAS segments in the claim line balancing formula. This may be misleading.

Solution
The text for Error 42513 was changed from 2100CLPCAS to 2100CASTotals.

Updated error
42513 The Previous Claim does not balance, formula used 2100CLP03 (#2100CLP03#) - 2100PCASTotals (#2100CLPCAS#) = 2100CLP04 (#2100CLP04#).

Change #: FINS-1126

Guideline(s): 5010-837X298.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Guideline 5010-837X298.std uses Error 40846, which is in the error number range for the 5010837P.std guideline.

Solution
Error number 40846 in the 5010-837X298.std was changed to Error 47358.

New error
47358 Within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value "U") may occur no more than once.

Change #: FINS-1135

Guideline(s): 5010837P.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
The business rule on the SVD05 Quantity does not allow for negative numbers, which causes issues when voiding claims.

Solution
The business rule on the SVD05 has been changed to allow for the use of negative numbers.

Change #: FINS-1136

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
The business rule on the SVD05 Quantity does not allow for negative numbers, which causes issues when voiding claims.

Solution
The business rule on the SVD05 has been changed to allow for the use of negative numbers.

Change #: FINS-1141

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Presence of the 2320 CAS17 Claims Adjust Reason Code with no 2320 CAS18 Monetary Amount should generate an error.

Solution
Rules were added to the CAS06, 09, 12, 15, and 18 monetary amounts indicating that, if the previous Claims Adjust Reason code is present (CAS05, 08, 11, 14, 17) and the monetary amounts are not present, an error is generated. This change was made for the 2320 CAS and the 2430 CAS segments.

New errors
41717 The Claim Level Adjustment Monetary Amount (2320, CAS06), is required when the Claims Adjustment Reason Code (2320, CAS05) is present.

41718 The Claim Level Adjustment Monetary Amount (2320, CAS09), is required when the Claims Adjustment Reason Code (2320, CAS08) is present.

41719 The Claim Level Adjustment Monetary Amount (2320, CAS12), is required when the Claims Adjustment Reason Code (2320, CAS11) is present.

41720 The Claim Level Adjustment Monetary Amount (2320, CAS15), is required when the Claims Adjustment Reason Code (2320, CAS14) is present.

41721 The Claim Level Adjustment Monetary Amount (2320, CAS18), is required when the Claims Adjustment Reason Code (2320, CAS17) is present.

(Continued)

41722 The Line Adjustment Monetary Amount (2430, CAS06), is required when the Claims Adjustment Reason Code (2430, CAS05) is present.

41723 The Line Adjustment Monetary Amount (2430, CAS09), is required when the Claims Adjustment Reason Code (2430, CAS08) is present.

41724 The Line Adjustment Monetary Amount (2430, CAS12), is required when the Claims Adjustment Reason Code (2430, CAS11) is present.

41725 The Line Adjustment Monetary Amount (2430, CAS15), is required when the Claims Adjustment Reason Code (2430, CAS14) is present.

41726 The Line Adjustment Monetary Amount (2430, CAS18), is required when the Claims Adjustment Reason Code (2430, CAS17) is present.

Change #: FINS-1142

Guideline(s): 5010-835.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Presence of the 2100 CAS17 Claims Adjust Reason Code with no 2100 CAS18 Monetary Amount should generate an error.

Solution
Rules were added to the CAS06, 09, 12, 15, and 18 monetary amounts indicating that, if the previous Claims Adjust Reason code is present (CAS05, 08, 11, 14, 17) and the monetary amounts are not present, an error is generated. This change was made for the 2100 CAS and the 2110 CAS segments.

New errors
42678 The Claims Adjustment Monetary Amount (2100, CAS06), is required when the Claims Adjustment Reason Code (2100, CAS05) is present.

42679 The Claims Adjustment Monetary Amount (2100, CAS09), is required when the Claims Adjustment Reason Code (2100, CAS08) is present.

42680 The Claims Adjustment Monetary Amount (2100, CAS12), is required when the Claims Adjustment Reason Code (2100, CAS11) is present.

42681 The Claims Adjustment Monetary Amount (2100, CAS15), is required when the Claims Adjustment Reason Code (2100, CAS14) is present.

42682 The Claims Adjustment Monetary Amount (2100, CAS18), is required when the Claims Adjustment Reason Code (2100, CAS17) is present.

42683 The Service Adjustment Monetary Amount (2110, CAS06), is required when the Claims Adjustment Reason Code (2100, CAS05) is present.

42684 The Service Adjustment Monetary Amount (2110, CAS09), is required when the Claims Adjustment Reason Code (2100, CAS08) is present.

42685 The Service Adjustment Monetary Amount (2110, CAS12), is required when the Claims Adjustment Reason Code (2100, CAS11) is present.

42686 The Service Adjustment Monetary Amount (2110, CAS15), is required when the Claims Adjustment Reason Code (2100, CAS14) is present.

(Continued)

42687 The Service Adjustment Monetary Amount (2110, CAS18), is required when the Claims Adjustment Reason Code (2100, CAS17) is present.

Change #: FINS-1181

Guideline(s): 5010837D.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Edit 42182 on the 5010837D patient loop is not triggering as expected.

Solution
A business rule variable was updated and the edit now generates as expected.

Related error
42182 The Coordination of Benefits (COB) Payer Paid Amount (2320 AMT) is required when the Line Adjudication Information (2430 Loop) is present.

Change #: FINS-1189

Guideline(s): 5010-270X279.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Error 43690 should be set to a situational edit (HIPAA Type 4). Currently it is set to a code table check (HIPAA Type 5).

Solution
The $fsdeflt.apf file was updated to change Error 43690 from HIPAA Type 5 to HIPAA Type 4.

Related error
43690 The Subscriber Eligibility/Benefit Date (Loop 2110C DTP03) must not be used because it was already sent in element (Loop 2100C DTP03).

Change #: FINS-1204

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
CheckList business rules created in TIBCO Foresight® EDISIM® versions 6.14.x and earlier do not function as expected.

Solution
Guideline 5010837I.std was edited with EDISIM® version 6.15.0 and the CheckList business rules now function as expected.

Change #: FINS-1207

Guideline(s): 5010-MEDICAREA.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.1 – Interim Update to Guidelines (October 2016).

Issue
Edit 95336 incorrectly generates an error indicating too many decimals are contained in the MOA01.

Solution
The business rule was updated to allow up to two decimals in the MOA01.

Related error
95336 The Percentage as Decimal (2320, MOA01) is limited to 0, 1 or 2 decimal positions.

Change #: FINS-1209

Guideline(s): 5010-835.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.2 – Interim Update to Guidelines (December 2016).

Issue
The rules on the 1000A, N404 and 1000B, N404 were incorrectly validating non-US Zip Codes and generating Error 42459.

Solution
The rules on the 1000A, N404 and 1000B, N404 were corrected to report on US Zip Codes only.

Related error
42459 The Zip Code number was not valid.

Change #: FINS-1216

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.2 – Interim Update to Guidelines (December 2016).

Issue
Edit 41694 allowed invalid Social Security Numbers (SSNs) to pass validation.

Solution
A problem with the guideline ordinal numbers has been corrected and Error 41694 now generates as expected.

Related error
41694 The Social Security number must be a string of exactly nine numbers with no special characters.

Change #: FINS-1228

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.2 – Interim Update to Guidelines (December 2016).

Issue
The business rule on Loop 2000C, HI02.02 and HI03.02 (Patient Reason For Visit) pointed to an incorrect DOS value. This caused Error 41552 to generate incorrectly.

Solution
The business rule on Loop 2000C, HI02.02 and HI03.02 (Patient Reason For Visit) has been updated to point to the correct DOS value.

Related error
41552 The ICD10 Diagnosis Code #Current_Element# was not valid on statement date #PStatementDate2#.

Change #: FINS-1230

Guideline(s): 5010837P.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.2 – Interim Update to Guidelines (December 2016).

Issue
The 2320 CAS02 element at the Subscriber level was marked as Optional instead of Mandatory. This allowed claims with missing 2320 CAS02 elements to pass validation.

Solution
The 2320 CAS02 element was changed to Mandatory.

Change #: FINS-1240

Guideline(s): 5010-HIX-834X220.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.2 – Interim Update to Guidelines (December 2016).

Issue
Error 46653 generates when FF-Shop with extended definition is included. This behavior does not support the requirements set forth in the HIX-834X220 CMS companion guideline (July 2016), page 34, which state:
"12 Note: The FFE Individual Marketplace **will not** include the extended definition in the ASC X12 834 data whereas the FF-SHOP **does** include the extended definition…."

Solution
The associated business rule was updated to require extended definitions for FF-Shop.
Note: Functionality for Individual did not change; only non-extended definitions are allowed.

Related error
46653 (HIX) The Reporting Category Reference ID (2750, REF02) must be a valid Special Enrollment Period Reason Code for SHOP.

Change #: FINS-1279

Guideline(s): EAN2002_2014_S4.std and EAN2002_2014_S3.std

Originally contained in an earlier Guideline Release? No

Issue
The 2014 version of the EANCOM 2002 Standard should be supported as an EDIFACT derivative.

Solution
EAN2002_2014_S4.std and EAN2002_2014_S3.std will be shipped with TIBCO Foresight® EDISIM® 6.17.0.

Change #: FINS-1287

Guideline(s): 5010837P.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.3 – Interim Update to Guidelines (March 2017).

Issue
Edit 41079 runs at the end of the loop, which causes the HL segment to be referenced in the 999 instead of the DTP segment.

Solution
Edit 41079 now executes on the DTP segment, which generates the DTP segment in the 999. Additionally, edits 41080, 41140, and 41141 were deemed too restrictive and removed from the guideline.

Note: Customers may determine whether or not they want to send the accident date (DTP) when the CLM11.01 or CLM11.02 is equal to EM.

Retired errors
41080 The Date-Accident segment (Loop, 2300, DTP) is only required when the Related-Causes Code (Loop 2300, CLM11.01 or CLM11.02) is equal to AA or OA. If not required, do not send.

41140 The Date-Accident segment (Loop, 2300, DTP) is required when the Related-Causes Code (Loop 2300, CLM11.01 or CLM11.02) is equal to EM and either the OA or AA is also present in the CLM11. If not required, do not send.

41141 The Date-Accident segment (Loop, 2300, DTP) is only required when the Related-Causes Code (Loop 2300, CLM11.01 or CLM11.02) is equal to EM and either the OA or AA is also present in the CLM11. If not required, do not send.

Change #: FINS-1288

Guideline(s): 834-X220.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.3 – Interim Update to Guidelines (March 2017).

Issue
The SE record shows a different SVALU when compared to other documents:
`SVALU 31|0015|110|SE*29*0075.`

Solution
The SE record SVALU was changed to match other document types:
`SVALU 31|TRSE|110|SE*29*0075.`

Change #: FINS-1304

Guideline(s): 5010-277CAX214.std

Originally contained in an earlier Guideline Release? No

Issue
Edits triggered by deactivated status code 448 are no longer necessary.

Solution:
All edits checking for claim status code 448 were removed.

Retired errors
45852 The Free Form Message Text (STC12) is required when the Health Care Claim Status Code has been sent.

45853 The Free Form Message Text (STC12) is Only required when the Health Care Claim Status Code has been sent. Otherwise, do not send.

Change #: FINS-1305

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.3 – Interim Update to Guidelines (March 2017).

Issue
The 5010837I.std checks validity of Diagnosis codes by the Through date, regardless of the claim being Inpatient or Outpatient. If the claim has a range of dates and the claim is for outpatient services, the diagnosis codes should be checked against the From date.

This involves the following HI segments:
HI - Principal diagnosis
HI - Admitting diagnosis
HI - Patient reason for visit
HI - External cause of injury
H - Other diagnosis.

Solution
Rules were updated and added to check for:

- Inpatient, and use the through date
- Outpatient, and use the From date.

This involves the following HI segments:
HI - Principal diagnosis
HI - Admitting diagnosis (No chang to rule. DX is only allowed on inpatient claims, and the rule is currently validating based on Through date.)
HI - Patient reason for visit (Used on outpatient claims; rule was changed to look for outpatient and From date.)
HI - External cause of injury
HI - Other diagnosis.

New errors
41727 The ICD9 Diagnosis Code #Current_Element# was not valid on statement date #SStatementDate1#.

41728 The ICD10 Diagnosis Code #Current_Element# was not valid on statement date #SStatementDate1#.

41729 The ICD9 Diagnosis Code #Current_Element# was not valid on statement date #PStatementDate1#.

41730 The ICD10 Diagnosis Code #Current_Element# was not valid on statement date #PStatementDate1#.

Change #: FINS-1306

Guideline(s): 5010-837X298.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.3 – Interim Update to Guidelines (March 2017).

Issue
Edit 47358 triggers on the 2320 SBR01 whenever more than one of the SBR01 codes is sent outside of “U” within a transaction. This is not a condition for the 5010-837X298.std.

Solution
Edit 47358 was removed.

Retired error
47358 Within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value "U") may occur no more than once.

Change #: FINS-1320

Guideline(s): 5010837I.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.3 – Interim Update to Guidelines (March 2017).

Issue
New frequency code Q, (reopening/reconsidering a final determination or decision on a previously adjudicated claim that is outside of a payers timely filing limits) does not allow the use of REF - Payer Claim Control Number (REF01=F8). Currently, REF - Payer Claim Control Number (REF01=F8) is only used when frequency codes are 7 or 8.

Solution
Based on the X12 Interpretation Portal RFI 1278, the associated rule was updated to allow for REF – Payer Claim Control Number (REF01=F8) when the frequency code is Q, but not require REF – Payer Claim Control Number (REF01=F8) be present.

Updated error
41287 The Payer Claim Control Number (Loop 2300, REF) must not be sent if the value in the CLM05.03 does not equal 7, 8 or Q.

Change #: FINS-1334

Guideline(s): 5010-270X279.std and 5010-271X279.std

Originally contained in an earlier Guideline Release? Yes. 8.6.0.3 – Interim Update to Guidelines (March 2017).

Issue
Edits 43701 and 43879 do not accurately represent the TR3 note regarding the use of 2000C/D TRN's when the subscriber is not the patient.

Solution
Edits 43701 and 43879 were removed. New edit 45765 was added at the 2000C TRN and triggers when the 2000C TRN is used when the patient is not the subscriber (2000C HL04=1).

New error
45765 The Subscriber Trace Number (2000C TRN) should not be sent when the subscriber is not the patient (2000C HL04=1).

(Continued)

Retired errors

43701 The Trace number (TRN) is sent at the dependent level only when the subscriber is not the patient.

43879 The Trace number (TRN) is sent at the Dependent level only when the subscriber is not the patient.

Change #: FINS-1348

Guideline(s): 277-X213.std

Originally contained in an earlier Guideline Release? No

Issue

The Health Care Claim Request for Additional Information (277) guideline should be added.

Solution

The Health Care Claim Request for Additional Information (277) guideline has been added as:

- 277-X213.std (types 1-2)
- PDSX5010-277X213.std (types 1-2)

Change #: FINS-1428

Guideline(s): 275-X151.std, 277-X150.std, and 277CA-X214.std

Originally contained in an earlier Guideline Release? No

Issue

The 275-X151.std, 277-X150.std, and 277CA-X214.std guidelines were found to be encrypted after installation of Interim Guideline Update 8.6.0.3.

Solution

The issue was resolved.

New and Updated Guidelines

This section lists guidelines that have been added or updated in TIBCO Foresight® Instream® Release 8.7.0. The listing includes new/changed guidelines originally contained in Interim Updates to Guidelines versions 8.3.0.1 through 8.6.0.3.

New Guidelines	
Guideline	**GuidelinePlus**
277-X213.std (types 1-2)	PDSX5010-277X213.std (types 1-2)
277-X228.std (types 1-2)	PDSX5010277X228.std (types 1-2)
Updated Guidelines	
Guideline	**GuidelinePlus**
275-X151.std	*n/a*
277-X150.std	*n/a*
277CA-X214.std	PDSA5010277CAX214.std
5010-270X279.std	PDSA5010-270X279.std
5010-271X279.std	PDSA5010-271X279.std
5010-834X220.std	PDSA5010-834X220.std
5010-835.std	PDSA5010-835.std
5010-837X298.std	PDSA5010-837X298.std
5010-HIX-834X220.std	PDSA5010HIX-834X220.std
5010-MEDICAREA.std	PDSA5010-MEDICAREA.std
5010837D.std	PDSA5010837D.std
5010837I.std	PDSA5010837I.std
5010837P.std	PDSA5010837P.std

APF File Changes

This section lists updates that have been made to the $fsdeflt.apf file provided with the newest release of Instream. This includes all changes made since the previous release of the product (Instream Release 8.6.0, August 2016).

New Entries

```
41717=3,4,8,1,,,,8,1,

41718=3,4,8,1,,,,8,1,

41719=3,4,8,1,,,,8,1,

41720=3,4,8,1,,,,8,1,

41721=3,4,8,1,,,,8,1,

41722=3,4,8,1,,,,8,1,

41723=3,4,8,1,,,,8,1,

41724=3,4,8,1,,,,8,1,

41725=3,4,8,1,,,,8,1,

41726=3,4,8,1,,,,8,1,

41727=3,5,8,7,024,X1,21,8,I6,

41728=3,5,8,7,024,X1,21,8,I6,

41729=3,5,8,7,024,X1,21,8,I6,

41730=3,5,8,7,024,X1,21,8,I6,

42678=3,4,8,1,,,,8,1,

42679=3,4,8,1,,,,8,1,

42680=3,4,8,1,,,,8,1,

42681=3,4,8,1,,,,8,1,

42682=3,4,8,1,,,,8,1,

42683=3,4,8,1,,,,8,1,

42684=3,4,8,1,,,,8,1,

42685=3,4,8,1,,,,8,1,

42686=3,4,8,1,,,,8,1,
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```
42687=3,4,8,1,,,,8,1,

45765=3,4,8,7,848,,,8,I10,

47358=3,4,8,7,024,X7,,8,7,

91412=3,2,8,6,,,,8,7,

91413=3,2,8,6,,,,8,7,

91414=3,2,8,6,,,,8,7,

95405=3,8,8,7,024,X1,,8,7,

95406=3,8,8,7,024,X1,,8,7,
```

Changed Entries

```
43690=3,4,8,7,024,X7,453,8,I10,
```