AHCCCS 5010 Technical Consortium

October 29, 2009
2:30 - 4:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Facilitator: Lori Petre

Speakers: Dennis Koch
Mary Kay McDaniel

Handouts: Agenda
5010 File Formats/Versions - HIPAA Transactions, including newly mandated transactions
820 4010-5010 Side by Side
820 v5010 Normal Detail Example
820 v5010 Sanction Adjustment Example
820 v5010 No Capitation Payment Empty 820 File
Standards Updates, October 2009, including AHCCCS Claim Attachment Flow and Process

Abrazo Health
Christine Cheesman*
Veronica Rivera*
JoAnn Ward*

ADES
Brian Lensch*
Derik Leavitt
Donna Schneider

ADHS
Kayla Caissi

AETNA
Todd Cassell
Maurice Hill*
Cathy Jackson-Smith*
Wendy Lytle*
Angelica Perea*
Timothy Salazar*

AHCCCS
Cindy Altman*
Deborah Burrell
Dwanna Epps
Robert Heppler
Lynn Hopkins
Zina Horrell
Cheryl Kelly*
Dora Lambert*

Americhoice
Jain Ashwin
Karen Saelens

Care 1st Arizona
Susan Castaneda
Susan Cordier
Kathy Thurman

Iasis Healthcare
Jaime Perikly
Mike Sisson

Pima Health Systems
Susan Harrison*

Scan Healthplan
Jackie Berry*
Marc Carren*
Ron Fulton*
Julie Shannon*
Vicki Wright*

UHC
Kathleen Morken*
Amy Osborn*
Rajesh Ramachandran
Sean Stepp*

UPH
Kim Bolton*
Kathy Steiner*

Yavapai County
Becky Ducharme*
Jean Willis*

AHCCCS Technical Consortium 5010 Compliance
October 29, 2009, 2:30 – 4:00 pm

Overall Status Update — Lori Petre

The AHCCCS Consortiums will resume on a monthly basis. The next meeting is expected to be scheduled the early part of December.

The HIPAA Project timeline includes Level 1 and Level 2 compliance dates and proposed implementation deadlines. (*See* New Mandated HIPAA Transactions). There will be no contingency for the 5010, per CMS. To allow for some leeway and a "built-in contingency," AHCCCS will be implementing the transactions ahead of schedule. Staggering this schedule will allow AHCCCS to better allocate resources.

10/01/10 is the planned switch date for the 820. This will be a clean cut-over with Trading Partners. This should smooth the transition with Translator and Validator.

Although the timeline matrix includes all of the required transactions, not all of the transactions listed are pertinent for Health Plans (HPs) and contractors. Some of the dates are targeted for FFS providers. In these cases, the HPs will rely on their own guidelines and dates.

There is some flexibility to make adjustments to 820, 834, 837 encounters and related transactions if HPs have issues with implementation dates. A supplemental document listing the incremental dates (testing, etc.) will be provided. The 275 transaction is a contractual requirement that will be addressed separately in scheduled meetings with the Plans.

Test files will be available for HPs input prior to the start of testing. Some of the AHCCCS tools are proprietary and cannot be shared. For example, an excellent tool is the .CHM files, which are the implementation guides for the 5010. They include the 4010 guide and all that is different for the 5010.

Of all the 5010 transactions, the 820 has the fewest changes. In contrast, the 834 has about a dozen supporting documents and considerable changes.

820 Version 5010 Walkthrough — Dennis Koch

List serves are now available for the 834, 820 and FTP server. *See* listserv.azahcccs.gov to sign up. Other lists will be added as needed. The complete 820 Issues List is not contained in today's handouts but will be forwarded and posted to the Consortium website.

4010-5010 Side-by-Side

Examples of changes evidenced on the 4010-5010 Side-by-Side worksheet are as follows. Grey highlighting represent items that will not or will no longer be used.

BPR04 Financial Information

The ACH or CHK are currently sent for payments. They can no longer be used. "NON" will be substituted.

The following segments are new but will not be used:

- DTM Creation Date
- RDM Premium Receiver's Remittance Delivery Method
- N1 Intermediary Bank Information
- REF Premium Receivers Identification Key
- 2310A Summary Line Item
- 2000B Individual Remittance
- REF Reference Information

RMR03 Payment Action Code

Whether this code refers to partial or full payment needs to be reviewed.

2312A Service, Promotion, Allowance or Charge Information

Segment is new and will not be used unless HPs decide they need this. Requirement 2315A Member Count (count of all members in the file) would be used.

2300B Individual Premium

RMR02 Reference Identification Voucher Date (date pay CAP payment) will be located here.

Voucher Transaction Examples

Normal Detail Example

This structure is being modifying due to a problem with the particularly large 820 file sent to the HPs in October. ENT01 is only a 6-digit number and will not hold a longer number. To resolve this, one ENT segment will be created for every AHCCCS ID to hold multiple RMR segments which will show vouchers and voucher amounts paid.

Sanction Adjustment Example

The RMR segment for will show up as ENT with no data segment in the amount shown.

No Capitation Payment Empty 820 File Example

This transaction was developed for the September release. There is no capitation where the 820 comes through - there is just a dummy file.

An example for a Voucher Date transaction will also be provided and forwarded.

Other Business

A large payment (4 months) is scheduled for 11/11/09. The last file contained 7 months of risk adjustments. From a systems perspective, AHCCCS needs to make large file processing easier. To this end, the carriage return/line feed <CR><LF> will replace the ~ as a segment delimiter. This will, in essence, unwrap the file. A standard translator should suffice with these changes. If any Health Plan has an issue with these changes, please notify Dennis.

HIPAA UPDATES — Mary Kay McDaniel

CMS has issues with a Request For Information [RFI] - Monitoring of Compliance with the Transactions and Code Sets, National Provider Identifier and Unique Employer Identifier Rules

It is expected that additional Administrative Simplification legislation, to include enforcement of standards will escalate by the end of December. .

The reasons providers do not file complaints against payors who are not following the guidelines will be addressed by CMS. Medicare and OESS attend all standard and industry meetings, telling payors and providers how to fill out the complaint form. It is strongly recommended that HPs review the RFI request at FedBizOpps.gov:

https://www.fbo.gov/index?s=opportunity&mode=form&id=c36f484d89a612042657ea430a89c848&tab=core&_cview=0&cck=1&au=&ck

Everyone has a different way of implementing the 1500 and UB but a standard does exist - a standard billing unit. There will be an education piece for this unit.

Mark-up copies for Health Care Reform are under review. All the versions seen to date contain an administrative simplification piece. They will be taking the version number for the assigned mandated HIPAA transaction out of legislation. It is being pushed down to the individual standards-setting organization. How to manage three versions of a transaction will become a real challenge (4010, 5010, 6020).

Turning implementation guides/TR3s/compliance documents around within 24 months will be the goal of the standard-setting organizations.

Additional Requirements for Health Plans

General rule #6 states that "from 3/17/2009 through 12/31/2011, a health plan may not delay or reject a standard transaction, or attempt to adversely affect the other entity or the transaction, on the basis that it does not comply with another adopted standard for the same period." HPs will be accepting the 4010 and 5010 simultaneously because the 5010 will not be ready. More information is on this topic is expected.

Please remember that transactions are not just a format, they are also the allowed data set. There is a minimum and maximum level of information to be shared. If a piece of data is not on a specific transaction, a HP cannot simply ask provider for it unless it is asked for in a different format or file

Tools for 5010

Implementation Guides are now only available through purchase. The federal government no longer provides. The Implementation Guide/TR3 Technical Report for X12 is owned and copywrited by X12.

Washington Publishing Company @www.wpc-edi.com is the creator of the original *.chm files* and provides an introductory view of them online.

eEmergence tool @www.e-emergence.com is an expensive 4010-5010 side-by-side list but also includes information about how the change will affect operations.

DisaCert @ www.disacert.org is a testing service that measure compliance. AHCCCS has a Foresight product called "Community Manager" that also provides on-line testing.

X12 Update

The last meeting was in September; the next will meet in January. The Acknowledgement Reference Model [X12 ARM] is nearly done and the WEDI Workgroup Model is following. The next version of the X12 transactions being worked on are the 6020s.

HL7 Update

The last meeting was in September; the next will meet in January in Phoenix. The RIM/2009 Normative Edition is in the mail.

NCPDP Update

AHCCCS has been working with the Post-Adjudicated Claim Work Group. There have been some changes, with clarifications about bringing definitions & descriptions into the version that we will use. It is hoped that the next ballot will clear the next version. The last meeting was in August, the next will meet in November.

Issues regarding Medicare Part D drugs include a tighter view of prescribers, i.e., those excluded or deceased. Discussion about how to handle this revision will affect those doing eligibles.

The Dual Eligible Recipients and Medicare Advantage Plans will "define a consistent process across all state Medicaid plans to allow for the electronic processing of claims for Part B covered products." There is an issue with NDC codes on the UB.

The NCPDP is pulling all their code sets out of their implementation guide and putting them into an external document. This will necessitate monitoring code changes every quarter.

NUBC

AHCCCS will be submitting a request for a new Condition Code for non-emergent use of the ER. This was well received across Medicaid. Hoping for approval and a late 2010 implementation..

NUCC

The NUCC has published a survey regarding changes necessary for the 1500 form. The public comment period ends COB 11/20/09.

WEDI Update

Numerous workgroups are available for all those who participate in electronic data interchange. Topics cover Companion Guide Principles, Transactions, ICD-10, and Security.

ICD-10

Medical code sets are based on date of service. Both the ICD-9 and ICD-10 will be received for well over 24 months.

There is no crosswalk between ICD-9 and ICD-10 but there is general equivalencies mapping, called GEM. The difficulty is that one ICD-9 can be cross-walked to several ICD-10s and it is therefore necessary to determine which one to use. Many workgroups are discussing the use of audit trails along each payor individual or GEM and urge that audit trails be maintained and made public. There is a significant number of codes and compound codes

The clinical/technical service group currently meets concerning the pros and cons of using diagnosis codes versus SNOMED codes. There are those who suggest creating more SNOMED codes and there are those who claim a diagnosis code can be created for every SNMED code. As a result, diagnosis codes for the 1500 would not be needed if SNOMED codes were used exclusively.

AHCCCS did an overall system assessment on ICD-10, including approach documents and outlines of some operational impacts. This information will be shared as the study progresses.

CAQH-CORE

Existing legislation includes references to the CORE Phase I and II rules.

CORE Phase I and II rules are also included in HITSP components. The process begins with HITSP selecting a standard which, in turn, is submitted to DHHS. After a one-year testing period, the standard then becomes the rule. It is strongly suggested that the CORE Requirements for Phase 1 and II for the 270-271 be studied.

Example: The Interoperability Specification (IS09), comprised of numerous concepts, was approved in 12/2008 and will become recognized in 12/2009. It contains three constructs, T40 Patient Healthplan Verification, T88 Health and Authorization/Referral, Request and Response, and T85 Administrative Transport to Health Plan. Page 5, Section 1, 1.1, paragraph 1 of the T40 states that the "X12 Implementation Guides is constrained by HITSP via the CAQH CORE Phase I and Phase II Operating Rules."

CORE is a set of operational rules (*see* www.caqh.org). The Eligibility and Benefits Data Content example (page 9 of "Standards Updates") shows service types for 270-271 transaction. Written definitions for eligibility codes are lacking. This deficiency might be addressed by CORE Phase III.

National eHealth Collaborative

Newborn reporting is addressed in new NeHC initiatives

HIT Policy Committee

Recommendations for electronic health records have been submitted.

HITSC - HIT Standards Committee

Recommendations under section 3003 of the PHSA are expected to become law by December.

AHCCCS Claim Attachment Project

The newly implemented Claims Attachments process for the 275 transaction is viewable on page 14 of Standards Updates." The process has thus far been successful. Mountain Vista, Maricopa Medical Center, IASIS (doing unsolicited) are up and alive.

Overall Status Update **Lori Petre**

The December meeting under way will focus on the 834. Issues with the timeline and difficulties with the current 834 should be forwarded, along with examples and specific comments to lori.petre@azahcccs.gov.

Corrections to the minutes should be directed to AHCCCS Technical Coordinator@azahcccs.gov.