AHCCCS 5010 834 Consortium

Tuesday, July 19, 2011
2:00 p.m.

AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Facilitator: Lori Petre

Handouts: Agenda

Attendees: Teleconference attendees are shown with an *

Abrazo Health
Mike Flynn
Veronica Rivera
JoAnn Ward

ADES
David Gardner

ADHS
Kevin Gibson
Madan Gopal
Rupesh Mamrdi
Terry Speaks
Tim Stanley

AETNA
Jamie Almanza
Robert Dole
Cathy Jackson-Smith
Alice Johnson

AHCCCS
Deborah Burrell
Dwanna Epps*
Lynn Hopkins
Ester Hunt
Cheryl Kelly*
Dora Lambert*
David Mollenhauer
Dawn O'Dell
Brent Ratterree
Rhonda Zollars

HealthChoice
Mike Sisson

Iasis Healthcare
Jesse Perlmutter

SchallerAnderson
Patricia Weyrich*

Scan Healthplan
Selva Abeyta
Knochole Myles-Rosales

UHC
Debra Alix
Carolyn Anderson*
Helen Bronski
Jeffrey Greenspan

Arizona Technical Consortium
Tuesday, July 19, 2011 – 2:00 p.m.

Lori Petre opened the meeting by advising that for today's Agenda we will first have 5010, then a brief break so that attendees who are here only for the 5010 portion of the meeting should feel free to leave, then we will cover other technical updates on other initiatives.

5010 STATUS UPDATES — Lori Petre

Timelines are as communicated in April. We are operating on revised timeline with our interim plan and with full compliance by July 1, 2012. CMS has approved our extension to 7/1/2012. CMS is also concerned that communication was clear with impacts to trading partners, so we are following up to ensure that this is case.

Just a reminder - All Plans, except outgoing Program Contractors, must implement 5010 834 and 820 by 10/1/2011. If Plans do not believe they will be able to do so, please let Lori Petre and Dennis Koch know as soon as possible.

270/271 and 276/277 are currently in external testing and are scheduled for implementation on October 1. Component documents are on the website as well as other testing related information. Everyone is welcome to use or refer to any of the posted documentation.

Reminder - 5010 transactions that are on hold after requirements completion (implementation for 7/1/2012) 835 (remittance advice), 277PSI (pended remittance advice), 278 (prior authorization) and NCPDP (pharmacy claims and encounters) transactions.

5010 short term solutions have been completed on a reverse map so you can start testing 837 5010 whenever you are ready. Plans may choose to continue doing 4010 encounters through 6/30/1012 should you choose to do so.

Lori asked if there were any questions. There were none.

Lori advised she'd sent a reminder e-mail last week of what the three changes are for the 834 that will be effective 10/1/2011. 1. Changing date and time for ISA9 and 10 at the request of several plans; 2. Renewal date in reporting loop; and 3. Implementation of the Errata. Test files are supposed to be ready and Dennis will follow-up. The revised companion guide is out on the website. Lori reminded everyone to keep looking at the website, as it is regularly updated. The website will have the most current information. All Technical Consortium meeting materials and most everything in between is posted.

Lori then introduced David Mollenhauer (a consultant working with AHCCCS on the 5010 project documentation), who spoke about 837 documents and timelines:

- 837 encounter companion guide was posted July 14 – 837 claims companion guide will be posted week of July 19;
- NCPDP companion guide is still in progress;
- 278 companion guide is still in progress.

All Companion Guides (CG) are posted to the AHCCCS website at the following location:
==>Plans, Providers, Contractors & Vendors Menu
==>Electronic Data Interchange (EDI) Resources
==>EDI Technical Documents

We currently have both the 4010a documents posted here as well as the new 5010a CGs that have been completed. These documents are stored in a PDF format and are accessible by double clicking on either the 4010a or 5010a link.

The 837 CGs include Professional, Institutional, and Dental code sets. Because these documents are quite large (approx 150 pages) and mostly comprised of spreadsheets it was not possible to create a single Word document. We created separate Excel documents, converted them to PDF documents and then merged all the PDF documents into one CG. The page numbering will be off but will be correct within each sub-section. Use the "quick tabs" by clicking on desired section within the Table of Contents (page 2) of the CG. This will jump you to the appropriate section without having to scroll through many pages. We have included the transaction information (837 P vs 837 I vs 837 D) in the top row of each page.

Description and walkthrough of our Companion Guide.

We are using one of the approved Companion Guide formats from WEDI and DISA. It is comprised of 5 sections:

1. Transaction Instruction (TI) Introduction – standard HIPAA and ASC X12 background information – this information is the same in all CGs
2. Included ASX X12 Implementation Guides – this section identifies which transactions are included in this guide.
3. Instruction Tables – These tables identify any exceptions, explanations, or clarification to the Technical Report-Type 3 document for the specified transaction. This table is used by the trading partner to identify any unique characteristics or values that must be included in order for the transaction to be accepted and processed. These will include Interchange values, Application Sender and Receiver Codes, Version Identifiers and Receiver and Subscriber Identifiers.
4. TI Additional Information – this section includes any business scenarios, business rules, limitations, FAQs, or other information that the Trading Partner wishes to communicate to assist in successful transactions being sent and processed. AHCCCSA has elected to include our Transaction Notes in this section. These are the mapping tables that we used to determine what segments and elements we need to process through our system. It is from these Notes that we determine any items that should be included in section 3 – Instruction Table.
5. TI Change Summary – This will include a summary of the changes that we make as we update our documentation and release additional versions of the CGs.

Explanation of how the Transaction Notes are organized.

- The tables include all segments and elements that are part of transaction – see TR3.
- We grey out any lines that are NOT USED according to the TR3
- We identify and grey out any segments or elements that are NOT USED BY AHCCCS – our definition is "AHCCCS does not use the segment or element for processing or updating of the adjudication system (PMMIS). The field may still be required by a Validator. Follow TR3 guidelines."
- We identify any expected values or specific usage
- We also format using spacing, color, hi-lighting to make the tables easier to read and use

CMS made available a side-by-side mapping from 4010 to 5010. We have used this format for our 837 Transaction Notes.

In addition to posting the CGs we have also posted copies of the 837 Transaction Notes as Excel spreadsheets. These have been posted to the following location on the AHCCCS website::

==>Plans, Providers, Contractors & Vendors Menu
==>Electronic Data Interchange (EDI) Resources
==>HIPAA 5010 Consortiums and Documentation
There are 2 tables for posting notices; one for Providers and one for the Health Plans

David stated that if you require any Transaction Notes that previously only posted within the CG and were not posted as Excel spreadsheets, let us know and we will be happy to post a copy of them for your use. AHCCCS' goal is to be in compliance with no issues. Lori also advised that we have also posted some testing overviews with reminders as to naming conventions and how often we can process transactions.

The attendees were asked if there were any questions. There were none.

Lori advised that this was the end of the 5010 updates and if anyone was not interested in the rest of the Agenda, they were free to leave at this point.

…email comments regarding status to lori.petre@azahcccs.gov.

OTHER TECHINCAL UPDATES Lori Petre

Lori advised that at the moment all technical updates are posted to the Technical Consortium, but Lori will probably add another tab to help distinguish 5010 from other Technical updates in the future.

Status Code B Update:

Overview - Separate payments, for procedures identified as Status Code B from Medicare Physician Fee Schedule, should not be paid when other services provided by the same provider on the same date for a recipient. Services should be bundled under a single payment.
Contractors are required to implement this logic by January 1, 2012.
Lori will send e-mail with specifics.

AHCCCS will make reference table where we store the defined Status Code B procedures available to the plans as a component of the bi-monthly reference extracts.

Claims should not be denied as inappropriate; as the service is valid they should just be valued/paid as zero.

Future consideration may be given to add up to two additional status codes to this logic and Contractors will be notified when and if this occurs.

Question was asked when reference table would be available. Lori stating that she was meeting with Lynn Hopkins in ISD this week, and will update everyone the ETA of this table as well as several others we will be noting today when more information is known.

Attendees were asked if there were any further questions. None.

Multiple Surgeries:

In December 2010, AHCCCS made several changes related to the criteria for and evaluation of Multiple Surgeries. Contractors are required to implement this logic by January 1, 2012.

Lori will send e-mail with specifics.

AHCCCS will make reference table where we store the defined Multiple Surgery procedures available to the plans as a component of the bi-monthly reference extracts.

Attendees were asked if there were any further questions. None.

OPFS changes for October 1:

Dates of service 10/1/2011 and after.

1. Implementation of an Urban and Rural Outpatient Cost to Charge ratio to replace the current Statewide Outpatient Cost to Charge ratio.
    a. Will be stored as a provider specific rate on PR050 depending up whether the facility is urban or rural.
    b. Out of state facilities reimbursed under OPFS will default to the urban percentage. This value will continue to be stored in RF618.

2. A new Peer Group Modifier (PGM) will be added for Pediatric Hospitals. All other PGM's will remain.

3. Payment methodologies associated with the payment of services associated with clinic revenue codes (051X) will be revised.

4. Bundling methodologies will be changed to be based upon episode of care (full claim) rather than date of service.

5. A secondary bundling methodology will be added for Observation services not associated with an ER or Surgery.

6. Current PGM's and OPFS schedule amounts will be evaluated and rebased.
    a. This will be reflected in updates to existing tables.

All Contractors who utilize the OPFS methodology must implement matching logic by no later than October 1, 2011.

In the last meeting, Lori promised updates to the outpatient hospital cap decision tree. Lori went through the chart, pointing out the changes.

Attendees were asked if there were any questions. None.

Medicaid NCCI:

We are currently planning on loading all code pairs supplied by CMS for Medicaid, and will address any exceptions as future evaluations. In order to complete this work we will modify the existing RF128 table to accommodate both OPFS (hospital) and Professional values by adding a form type designation, and the table will be renamed appropriately. This table will also be updated to reflect a source designation to indicate if the value is Medicare CCI, Medicaid CCI or AHCCCS coding policy. This table will continue to be available to Contractors in its updated form, but will including both OPFS and Professional relationships. Claims editing will be modified to read the CL128 table for both OPFS and Professional claims. Encounter editing will be added to read the modified table for both OPFS and Professional encounters.

All Contractors must implement matching logic by no later than October 1, 2011.

Medically Unlikely Edits:

We are currently planning on loading all defined MUE's supplied by CMS for Medicaid. In order to complete this work we will need to add a new table(s) (Professional, Hospital and DME) to store the MUE data by procedure by effective date. This new table(s) will b added to the Health Plans bi-monthly Reference extracts. New Claims and Encounters edits will be defined and added for the MUE's. MUE's are applied like daily limits within a single claim, to a provider and recipient on a date of service. It is not our intent at this time to replace our current procedure daily limit guidelines with the MUE's. Error detect relationships will be established to "detect"/bypass MUE editing when the AHCCCS daily limits on RF127 and/or RF113 are not equal. RF127 and RF113 daily limits will take precedence.

All Contractors must implement matching logic by no later than October 1, 2011.

Questions- For MUE, is AHCCCS planning for now or future Gap fills?
No. We will continue daily limits.

The CCI table, will be able to look at history?
Yes. Test version will be production download.

For CCI heading, if health plan already uses, should health plan scrap or just compare?
Need to evaluate as what you currently have may not be equal to Medicaid specific CCI. Please send to Lori as a follow up.

Lori then asked if there were any further questions. None.

Benefit Limits for October 1:

Lori sent out a few weeks ago a system benefit impact matrix similar to last year's, but has reformatted three limits for October 1, there are two other limits on table that we do not believe CMS will implement. Attendees were encouraged to review this document and all related communications as they are sent as updates.

Inpatient Day Limit:

The criteria for determining which claims/encounter are considered is outlined in the document: Adults 21 and over, non-QMB dual provider type 02 etc... The inclusion of Outpatient Observation services in excess of 24 hours makes this a bit more complicated, but hopefully this along with the other changes being made to observation under OPFS will result in fewer claims/encounters which result in this situation.

Exceptions as outlined in the document include: Maricopa Burn Unit; Days qualified as psychiatric; Encounters submitted by BHS; Transplant stage related days; Same day admission/discharge claims/encounters; etc...
Question: For members who have changed plans, how will plans know what has been paid? The Transition Form is being updated to include this information and it will also be tracked with Encounters, just like Physical Therapy last year. The updated Transition form should be available in the next few weeks.

Lori advised that she was still working on a test scenarios matrix for the limits.

Question: Is there a place where hospitals can go to see how many units have been used? Lori's response was not at the moment.

Respites:

Lori stated that this was simple change to the current limit of 720 hours to a limit of 600 hours per benefit period (10/1 – 9/30 of each year) Applies to all eligible members (adult and child) with no exception for QMB, etc...

Criteria as outlined are for two procedures 1 for daily and 1 for hourly billing.

Other Limits:

Limits related to ED have been put on hold. CMS says we can't do these how we proposed so further evaluation will occur.

Non-ER transportation – this is before CMS, they are asking questions and we do not necessarily expect them to approve our current proposal. Regardless, this will not be an October 1 implementation and would be no earlier than January 1.

Office Visit – Also on hold.

Question: Can we expect any additional limits to be added outside of these: No, there is nothing else for October 1 or January 1.

Question: When can we expect hospital rate sets? No later than September 1.

Question: When can we expect the CCI/MUE reference table? Lynn Hopkins thought around August 15, but we will follow-up.

Lori advised the attendees that she was trying to provide a matrix questions and answers related to the Benefit Limits maintained and distributed to the group.

The attendees were then asked if there were any more questions regarding benefits. None.

Lori advised that there would be one additional technical project not discussed today related to 340B pricing and that more information would be coming as timelines and approach were determined.

Data Validation Changes to Methodology:

Lori advised that a letter went out July 5. We are in the process of looking at data validation processes and defining a revised approach. We will be sending out more information on these efforts as we progress.

ICD10 Status:

The ICD10 status was reviewed. AHCCCS will not be using any cross-walks or GEM's.

Initial impact of our systems have been completed. We are also working on an initial impact for documentation, policies, etc...

…email comments regarding HIPAA Updates to ahcccshipaaworkgroup@azahcccs.gov

QUESTIONS Lori Petre

There being nothing further, the meeting was adjourned.

The Meeting adjourned at 3:50 p.m.

Corrections to the minutes should be directed to NpiConsortiumCoordinator@azahcccs.gov.