AZ HIPAA Medicaid Consortium

Sept 17, 2003
2:00 PM to 4:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:

ADHS/BHS
CJ Major
Lee Cisney
Brian Heise
Thomas Browning
Jerri Gray

AHCCCS
Patti Goodwin
Michelle Dillon
Kyra Westlake
Bruce Jameson
MaryKay McDaniel
Huong Vo
Linda Stubblefield
Tom Forbes
Brent Ratterree
Carrie Stamos
Deborah Burrell
Mary Langan
Dan Lippert
Nancy Mischung
Frank Straka
Dennis Koch
Mariaelena Ugarte
Jim McManus

AmeriChoice
Jim Drab
RamKumar Manakal
David Wormell

APIPA
Chuck Reveneu
Lucy Markov

Care 1st Arizona
Terry Harden
Herb Woo
Bill Hobbs

CIGNA
No Rep signed in

DES
Crystal Rodgers
Marcella Gonzalez
David Gardner
Stan Hime
Aidan Frazier
Major Williams

Evercare Select
Bill Klassy
Vicki Johnson

HCA
Paul Benson
Ethan Schweppe

HCSD
No Rep Signed in.

I.H.S.
No Rep Signed in.

MCP & Schaller Anderson
Michael Fletcher
Cathy Jackson-Smith
Anne Romer
Joginder Singh
Art Schenkman

Maricopa Health Plan
Rebecca Wininger
Rob Mayer

Pinal LTC
Susan Murphy

PHP
Greg Lucas
JoAnn Ward

PHS
Mark Hart

UFC
Kathy Oestreich
John Valentino
Eric Nichols

Verizon
Marsha Solomon

Yavapai County
David Soderberg

1. Project Schedule Update (Lori Petre)

We will be concentrating on the Encounter dates as we go forward.

2. Implementation Update/Follow-up (Nancy Mischung)

Everything is on schedule as indicated three weeks ago.

3. Invoking Contingencies (Lori Petre)

Short term and Long Term decisions were received from everyone. There will be one final opportunity to change/validate that decision next week.
Action Item: Next Wednesday we will send out another email to make sure that we captured what you elected.

We will have individual conversations with the plans that have indicated to stay on proprietary. We will discuss timelines, and high-level action steps; we will need to monitor what will be done.

4. Follow-up Items (Lori Petre/Nancy Mischung/Brent Ratterree)

Q: Were the Pima Scenario test cases generated?
A: Per DMS, as of Friday we have keyed cases.
Action Item: This will be checked.
Result: Checked – issue with entry, will be re-ran.

Q: When does testing end?
A: All testing ends today, with the possible exception of those plans that have chosen a contingency.
We are running the scenario-based month-end today.

When we receive problem reports on particular situations we will continue to track and will discuss how we will handle those reports.

Q: What about the scenarios that cause problems?
A: We need to receive them as Problem reports or email stating what the problem is.

Q: How are you going to get multiple actions on one member? Are we going to get one maintenance code for each change rather than many changes at one?
A: For the 834 that is correct.

For those who have not elected to go 10/1:
There is a document in your package that includes what we will need signed stating that you are taking the contingency and what your timeline is.

Q: Does it matter who signs the letter?
A: As long as it is someone who is responsible for the Contingency.

FYI: We are going forward implementing our 837 Inbound for 10/16, we have certified 7 providers.

Co-Pay (Kelly Gerard):

We have been sending daily files; we are wrapping up our testing now.
Q: Do you get co-pays for LTC?
A: You will get a 0 value, since they are exempted from the co-pay process at this time.

Q: For the providers that we (health plan) work with, are they supposed to get the co pay info from the health plan or the State?
A: The health plan.

Local Codes (Brent Ratterree)

We were using an older UB manual and recently discovered a new one and had to change a few revenue codes. See Crosswalk handout.

Q: Where the revenue codes not going to 4 digits?
A: They are on UB02; we are currently 0 filling the front-end digit.

The other significant change is that bill types can end in an alpha character.
Bill type can be an alpha/numeric field.

There is no grace period for these Local codes and they will be terminated 9/30.
The HCPCS have a grace period till 12/31.

Q: Is there a crosswalk to the 'A' bill type value?
A: The UB manual is what is used since this is new.
The manual is clear on what each of the values mean. Review the manual to see the values.

Whatever the provider sends to you as a claim is what is best sent and then can be processed, or pended as an encounter.
These changes also need to be communicated to your providers.

Q: For late charges, how are we going to refer the old claim?
Action Item: This is one that we are working on to layout along with the denial codes.

Q: If a UB is sent with the wrong code and wrong bill type, it pends, can AHCCCS change it?
A: Denial is the only option and would need to be corrected with the provider as of 10/1

Data Certification (Brent Ratterree):

According to the BBA we have concurrent Data Certification. We rely on encounter data heavily.
Our short-term solution is attached with instructions and a form.
Fax to # 602 417-4725

Submit this with the appropriate signatures.

We will take the fax form and compare this to the file you have transmitted to the server; if it matches the file will be processed.
If not you will be contacted.

Q: Whom do you contact for the discrepancy
A: The current encounter contact that we have today.

Q: Is there a target for the electronic option?
A: Yes, January.

You may email us who your encounter contact is, and we will verify that is what we have.
If you have any questions or problems you may also contact either Peggy Brown, or Esther Hunt.

This certification is needed for November processing beginning October 4th.
On the certification you will list the plan number and encounter file name.

We are currently doing this for the encounter data only.

Q: What is a reasonable response time?
A: A couple of days.

Q: Does this include MIPS?
A: No, this is not technically an MCO relationship.

At this point in time the only method is fax.
The fax machine we are using store in memory many documents, you should not run into too many busy signals.

Q: Could we email rather than fax?
A: No, we are trying to avoid having your request not attended to if that person is out of the office. We will man the fax number; therefore your request should not go unattended.

Acknowledgements (Lori Petre/ Dennis Koch):

We do receive a daily spreadsheet of 997 that are processed and if any issues exist this spreadsheet will be sent.
We are currently testing out the process.

Q: Will you accept the 997s with a tilde or carriage return?
A: Yes

One has to do with the transmission and another with the EDI.

Q: Where do we place 997s?
A: There is a specific folder for you to place those in.
Action Item: We will send the folder name/path to everyone, again.

Co-Pay handout is for your reference, this was previously sent via email.

5. Testing Status (Lori Petre):

Officially 834/820 testing ends today. We are evaluating your go-live decisions for 10/1, once we confirm next week they will be published.

Any other possible testing will be addressed under the contingency conversation for the 834/820.

Encounters (MaryKay McDaniels):

Handout given is NCPDP changes that are in process. There are conversations between CMS and NCPDP in regard to the NCPDP transaction.
The bigger problem is that there is no way to recognize co-pays, deductible, and coinsurance on NCPDP transaction. A solution that has come up is a way to be able to utilize the NCPDP transaction, it is not clean but it works. It is a change to the way we use this transaction.

Another handout in the package is a Glossary for NCPDP information.

NCPDP is different from the regular X12, it does not contain ISA segment or GS segment.

We talked about how to acknowledge this. We tried using the 997 and it does not work.

NCPDP has their own acknowledgement; it is not AHCCCS intention to acknowledge each claim that comes through, which is how NCPDP works.

We have talked and looked at simplifying a way, can we do a 997 for an NCPDP?

There is short response at the front that is a NCPDP response saying that we received the file and the file is clean. It passed through Mercator into our backend system. We will not be able to tell you out of Mercator what it paid or how it paid.

Q: Does the response simulate a TA1?
A: Yes, it says I received your header and trailer, but not which one is the problem. We were hoping to develop a way to be able to tell you were it is wrong. If we reject the entire file it would be nice to tell you where it is wrong.

Q: How about the 997?
A: We would like to send a 997 but the control numbers are not there to build the 997. We cannot send the control number blank since you need to know what file we are referring to.

Q: What about the proprietary?
A: It does not fit either.

The NCPDP is different from X12, which we cannot put it in X12 or put it in what we have now.

Health plan-We are using the entire response file.
Health plan Suggestion – Strip the file and send back what is wrong, then if the agreed assumption is to send the entire file again we will do so.

Health plan – This goes against what NCPDP does. NCPDP sends in one claim in and one claim back.

Suggestion: You can send the batch number, and the claim number.
A: We are talking about wrapping the 1.1 batch header and trailer record around the response segment, but only using the high-level header response.
A: Yes, with the claim number.
Suggestion: If you use the message segments can there be a negative acknowledgement, one batch header, trailer, message, claim identified and preferable an error message number we could reference.

Q: From and error message number perspective, whose error message?
A: AHCCCS'

A: There are error messages we could use in the segment.
There are 300 or so messages.

AHCCCS can tell us which messages are to be used for which scenarios.

This issue has been on the table since the beginning of the mapping workgroups.

Action Item: Issue has been raised again from a Health plans' perspective of getting the 5.1 to AHCCCS; this is an issue for at least two of the health plans.

Request: Could we possibly get the minutes out sooner, preferably by next week?

Q: Health Plan - who would be validating/certifying the NCPDP Transaction?
A: Claredi does not certify NCPDP. So far there is no one certifying the NCPDP 5.1.
Q: Whom will AHCCCS use?
Action Item: AHCCCS will need to follow-up on this item.

Action Item: MaryKay will compile what we have discussed into a flow and attempt to send it out before next consortium meeting.

Result from Brent: Patsy from NCPDP told me that WebMD is validating 5.1 transactions and that we may be able to obtain a 5.1 claims file from WebMD or Texas Medicaid
In addition I have attached NCPDP's v5.x question & response document (see Version5Questions.pdf).

Discussing the other handout. Changes that were made with NCPDP and what they are doing. This is specific to the COB segment. The first page is representative of the actual data. The piece that has come up is the Other Payer amount, a 99 qualifier. The first occurrence of the 99 qualifier is the deductible, second occurrence of the 99 qualifier is coinsurance and the third is co-pay.
If there isn't a coinsurance and deductible but there is co-pay we will still need those first two occurrences (known as loops or counts in NCPDP).

Q: Are the two lower loops required?
A: If there was a deductible or a coinsurance collected or a co pay, the answer would be yes. If not then they are optional.

Q: Do you have a sample?
A: Not yet, PBMs stated they are not doing this yet so they could not provide a sample.
Suggestion: You may contact, Truxler at Advance PCS, email…..., he could get you a sample.

If you get one sample then we can all agree upon a standard NCPDP initiator.
We run into the issue that what one person thinks is standard another does not.

Issue: For some of the health plans there are issues getting information from the PBMs, not knowing if they could get the data in 5.1 from the PBM, and second issue is the timeframes conversation may be better had with the technical people doing this.
A: Since the PBMs are a covered entity and AHCCCS and HPs are covered entities then what is requested must be done.
A: We have put PBM on notice, Pima and us
The best we can do is get something from the PBM and just forward to AHCCCS. All the activities that go along with a transaction would not happen.

A: The 997 cannot be used as an acknowledgment for this transaction.
A: The response PBM is looking at is real time mode.

If we get an NCPDP file in and we cannot process, AHCCCS needs to notify the PBM or HP what was not right. We cannot use 824, 997 was not built for this, what can we do?
A: Worst case scenario between HP and PBM state we captured your file. And when you pass it to AHCCCS, we can acknowledge that we either have it or not.

If the 997 is not going to work as an overview, we can discuss this some more.

Q: Is the mapping work that we did not being used?
A: Brent had a conversation with the PBM last week saying they could tweak their program to provide this file.

There is always tweaking in this whole development phase.

We have the mapping docs from the workgroup that the programmers can get started with.

If you start this early on and follow the IG you are almost there.

Q: File rejection for NCPDP?
A: The pharmacy industry will provide data that is pretty clean. In the 5.1 version.

We can offer some individual health plan meetings to those who may wish to discuss items.

Q: Lets discuss U277?
I compared this new trans to the existing one. In the existing one it is Julian on the header record. Process date 8 characters.
This is on the supplemental file.

Q: Can we keep this the way it is now? Julian date.
Q: Is the health plans CRN the patient acct #?
A: Now it is your document control number, the patient acct# you will be able to see on a regular 277.
Patient control # is only patient control #, which is providers acct # on that patient. And only that can be used in that field for HIPAA format.

Brent: If anyone is planning on transmitting HIPPA like files in January, a new name will be used for those files.

Q: Do we retain the same address for the server on the proprietary files?
A: Yes.

Next meeting is October 8th.

Meeting adjourned.