AHCCCS 5010 834 Consortium

Tuesday, May 25, 2010
10:00 A.M.

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

Facilitator: Lori Petre

Handouts: Agenda and Handouts were electronically provided prior to the Consortium

Attendees: Teleconference attendees are shown with an *

Abrazo Health/PHP
Christine Cheesman*
Shanthi Jayapal*
Liz Liska
Veronica Rivera*
James Ten Eyck
JoAnn Ward*

ADES
Leo Booth*
David Gardner
David Gonzales
Stacey Hill
Donna Schneider
Steve Wheeler

ADHS
Kevin Gibson
Dimiter Pekin
Paula Rendfeld
Susan Ross
Terri Speaks

AETNA/Schaller Anderson/MCP
Todd Cassel
Maurice Hill
Cathy Jackson-Smith*
Walter Janzen
Angelica Perea*
Vicki Sosa*

AHCCCS
Cindy Altman
Kathy Bezon
Deborah Burrell

Kelly Gerard
Midia Giliana
Zina Horrell
Ester Hunt
Dennis Koch
Dora Lambert*
Asia Lennear
John Murray
Jacqueline McElroy
Alicia Perez
Brent Ratterree
Daniel Saunders
Rhonda Zollars

Bridgeway/Centene
Antonio Estrada
Peter Durso*
John Juff
Keith Lueking*
Jessica Silver*
Carrie Skiig-Boutajrit
Susan Stout

Care 1st Arizona
Margie Alexander
Susan Cordier
Kathy Thurman

Cochise Health Sys
Marcia Goerdt
Barbara Jones
Paula Saroff
Susan Speicher

Iasis Healthcare/HCA

Mary Boyd
Jaime Perikly
Jesse Perlmutter
Rozalinda Pili
Mike Sisson

Pima Health Systems
Mark Hart
Fred Payne
Alan Tiano

Pinal County
Cheryl Davis
Jennifer Schwarz

Scan Healthplan
Liza Crowson*
Jim Hasey
Sharon Hawn
Patrick Maloney*
Julie Shannon
Theo Tran*
Vicki Wright*

UHC/APIPA
Debra Alix
Carolyn Anderson*
Helen Bronski*
Beverly Duffy
Nancy Mischung
Karen Saelens
Sean Stepp
Jane Upton

UPH/UFC/MHP

Kim Bolton*
Alexis Megeath
Kathy Steiner*

Yavapai County
Becky Ducharme*
Jean Willis*

Arizona Technical Consortium
Tuesday, May 25, 2010 – 10:00 A.M. – 11: 30 A.M.

OPENING REMARKS   Lori Petre

Lori Petre began the meeting by explaining the change in administration related to these meetings, Carol is no longer with the Agency and Mac Williams will be taking over the administrative coordination of the meetings. Meeting materials for future meetings will not be emailed; they will be on the Web or FTP server. Lori went on to state that in the future she would like meeting invitation replies by a certain period of time if attendees wanted to attend telephonically, to ensure we can allocate lines accordingly and necessary information can be distributed. Also, may try changing attendance sheets, so Lori asked attendees to please bear with us through the transition.

OVERALL STATUS UPDATES   Lori Petre

The Agenda today is more diverse: in addition to 5010 topics, we are going to talk about Co-pays and Adult Benefit changes. Lori stated that these meetings are to talk about what attendees would like to talk about, so your feedback on agenda items is appreciated.

Housekeeping items: Meeting invitations and materials, please keep us advised of any changes to staff from your organizations.

Timelines: Reviewed the current HIPAA project timeline including the optional trading partner implementation dates for the 820, 834 based upon the feedback we received from the plans. If you have any comments or concerns, please let us know. We will be implementing the 5010 code for the 834 and 820 transactions for 10/1/2010, but will continue to support those trading partners who are not yet ready, under the 4010a until one of the option dates as elected by each plan.

We may do something similar for 837 encounters; however, there is limited leeway in this schedule. October 1, 2011 we have targeted for implementation and by law, everything must be in place January 2012.

Lori emphasized that sharing dates on our intended implementation such as the 270/271 that we exchange with providers are supplied as an FYI for plans. In a future meeting we would like to take a little time to share how we are actually addressing each of these transactions, to share our lessons learned, etc. As a note, thus far the 270/271 has been the most difficult of these.

There are a lot of different 277s; in the past, we only used the 277U. The 277CA replaced the 277U and the 277PSI and replaced the current Encounter Pend filed. For claims, we will also use the 277PSI for pends.

AHCCCS did not implement the 276/277 and 278 when we implemented 4010, so these are new development and will be implemented to make us fully compliant.

✉…email comments regarding overall 5010 status to lori.petre@azahcccs.gov.

ERRATA   Mary Kay McDaniel

Mary Kay stated the document that she sent late this morning was a document put together from an organization in the Northwest. This is the mandate transactions, the 3rd column is the HIPAA ERRATA and should be using now. The new set is things that are coming through and expect it to be adopted in June at the X12 conference.

Many of these changes were as a result of our comments/requests. For example, we are not currently using an address section; that change was made to require this. Also, changes made to 270/271.

Mary Kay alluded to the fact that there will be a lot of future legislative mandates.

824 transaction or 999, you may want to rethink, due to some clarifications coming.

If you have not looked at claims attachments, now is the time to do so as that legislation is coming up right behind the acknowledgment. Acknowledgment model is from WEDI and will probably be the one in the legislative language.

Changes are coming. One of the largest is the CMS enforcement of HIPAA compliance. CMS has started to come to the table to work more closely with the standards bodies on these issues. Look at the civil monetary penalties and what willful disregard means to you.

The current school of thought is for legislative transactions (new versions) going every two years. You may be developing 4010 to 5010, but the next version of transactions is already in progress. Will it be 2 year turn around for all transactions? Probably not, timelines will be much tighter. Payers need to look for ways to upgrade the transactions timely and efficiently.

Section 10109 of the legislation adds a new code set. There will be a standard "cross-walk" between ICD-9 and ICD-10 (and any future versions). It will be created by the industry and there will only be one for specific purposes and you will use it.

Also, expanding reporting that states must do for claim fraud. Service addresses are going to become very important. Provider relations will become very important. Provider transactions that are being looked at today will be a standard format for provider registration. More than likely will regulate with Medicare as the leading body. You will probably see that this transaction will become mandate by 2016.

Eligibility transaction between hospital provider and health plans. There is a HIT group working on this, see http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=2004&PageID=18540. From a Medicaid perspective will be doing in real time. The HIT workgroup is looking at the core standards.

Lori asked if there was a standard definition for the ERRATA, what they can include, etc. …? The ERRATA should be only clarification and additions. They are an option defined for X12. No addition of new screens. There was an issue in the Addenda extending out a character set.

Mary Kay advised that Medicare has information on sources for the ERRATA on the Web that will be sent out.

Mary Kay explained some of the resources and technical documentation is available on the Web at www.cms.gov. For example, the institutional and professional spreadsheets will be helpful.

On the WPC site, whenever you purchase the original 5010 Transactions, there will be no cost for updates.

All documents are listed in the WPC registry and there is no one place to find documents and resources. Mary Kay has a handy way to locate these that she will also share.

Implementation guide – registration for every transaction in X12, there is a legend (first word). If you do not purchase X12 standards themselves, you do not get the guide to codes. Mary Kay will talk to the standards setting group to see if she can get those pieces out of standards. Receive option list of addenda and ERRATA.

✉…email comments regarding ERRATA to ahcccshipaaworkgroup@azahcccs.gov

OVERALL STATUS UPDATES (con't)   Lori Petre

820 and 834: Lori stated that she has sent out two notifications of updates of "crib sheets" and the examples. We will continue to maintain as needed. We have not made other changes. Companion document will be available in the next couple weeks. Lori advised will not probably give as much detail as the crib sheets, which will also be trying to incorporate into them long term.

Concept of what a Companion Document is, as well as its name, has been changed. There are now two documents:

TI (Transaction information): and will have much of the substance specific to the individual trading partner requirements.

And the CCI document which has the information about connectivity, setting up as trading partner, etc.

You will have draft documentation when you start testing each transaction. Daniel showed the drafts on screen and briefly described them. Lori advised that we (AHCCCS) will continue to finalize as appropriate. Further, we will have some additional information on 834 which deals with what you can expect (i.e., the crib sheets) that we plan to try and embed into the documents.

There are similar concepts for 837. Lori advised that we will have a draft of those documents shortly also.

The exact date 834 and 820 files will be available and specific testing requirements for these transactions are still being finalized. We were delayed a bit due to Cap Rollover and Risk Adjustment. Test files are expected to be available in late June, early July. Per Dennis, test files will not be quite parallel to Production, as we use a simulated Production environment for testing. However, we will try to build in a process that if a specific scenario doesn't exist, we will try to build and accommodate it in a test file for you.

HIPAA STATUS REPORTING   Lori Petre

In regards to the Health Plan Milestone tracking for the 5010 project, due on the 15th of the month. Thank you to everyone for your initial submissions. Lori will schedule ongoing one-half hour time slots for each plan for conference calls to discuss status as well as any plan specific issues, questions or concerns, probably do right after the 15th of the month so that attendees will have their most current information available. Lori asked that anyone having any questions or concerns advise her.

Mark Hart from Pima commented that they thought some things on the status report were redundant. Lori stated feedback like this is very helpful on both the format and other things that may not have been asked.

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

CO-PAYS   Lori Petre

There have been a lot of e-mails regarding co-pays over the past several months. Lori stated that there were three (3) different co-pay populations: (i) TMA; (ii) Nominals (options), and (iii) TWGs . The TMA are the new co-pay group; Nominal's (optional) have existed for some time, but we've made some changes to their actual services to which co-pay applies; and the TWGs are one of the original co-pay groups, but they had been under a court injunction which was lifted in April. The TWG co-pay services differ from those for the TMA and Nominals, but we were not able to make any changes to this group in the related Rule.

The plans have expressed some concerns about how eligible co-pay members will be identified. For the health plans, we have tried to make the identification of the co-pay eligible members as easy as possible. All member level exceptions are considered and are including in the co-pays assigned to the individual member, so the plans don't have to do this. Every enrolled member will have a co-pay level. Co-pay levels may be "0" or in any of the 3 categories (TMA, Nominal or TWG) as appropriate to the member's age, eligibility type, and other factors.   There have been some questions about the 5% cap for TMAs and what the plans will need to do when someone hits 5%, there will be no co-pay and we will change the member's individual co-pay level to prospectively (the first of the following month) to reflect this.

TWG and TMA co-pays are mandatory. If the provider cannot collect the co-pay, he can deny the service to the member and the plan can deduct the appropriate co-pay amount from the provider's payment, even if the provider did not choose to collect it.

Co-pays don't apply to the FFS population.

Lori and Rodd (Mas) have talked about a managed care manual to incorporate those billing-related rules such as co-pays that would not be reflected in the FFS Provider Billing Manual.

 Because not everyone will be ready for 5010, we will also provide co-pay level information on the 4010a. However, the current co-pay $ amount fields will be removed.

Bi-monthly you will receive two new Reference extracts. One will be for the new table that will provide the specific co-pay eligible services for each population and how to qualify them. The second will provide an extract of all diagnosis and NDC codes flagged as Family Planning Services.

✉…email comments regarding Co-Pays to lori.petre@azahcccs.gov.

Encounter reporting requirements were added to ensure mandated co-pay amounts were included on submitted encounters.

Mary Kay asked if co-pays were expected at the header or line levels. Lori advised that for 1500s, they should be at the line and for UBs, at the header. We will include this in the instructions.

It should be noted that co-pays only apply to Recipient's age, 19 or older, not to be confused with Adult Benefit limits which apply to adults 21 and over.

There have also been some questions about how to identify co-pay eligible services, which the provided Draft Co-Pay Services matrix and related new Reference tables should address. The Draft Co-Pay Services matrix was reviewed in the meeting. If you have any additional questions, please let us know.

Some items of note:

Office Visits: How to ID is by service code, as indicated in the table. Exceptions: if pregnancy or family planning related are identified by diagnosis as also indicated in the matrix.

Form Type 1500: Diagnosis are at the line.

Pharmacy: Fairly straightforward; family planning related services are identified at the individual code level as are brand vs. generic designation.

Family planning related services are exempt for all service types and populations.

Surgery Outpatient: Has three (3) different criteria that can qualify as outlined in the matrix. This is looking for outpatient surgeries which are non-emergent or elective.

TWG Non-emergency use of the ER: This will be largely self-reported by the hospital; however, some suggested criteria are also outlined in the matrix.

Nominals: Will also be in the table. Qualifiers are generally the same as the TMA.

Question from the telephone: Are all co-pays going to be in new location on the current 834? As previously noted, the co-pay level , as demonstrated in the examples, will be present on the 834, but the current co-pay amounts fields will be removed.

Lori advised that the new tables will be included in the plans' regular bi-monthly reference extracts in the Sharepoint information folder.

✉…email comments regarding Co-Pays to lori.petre@azahcccs.gov.

Benefit Limits: There will also be an e-mail sent out shortly confirming this information and asking for your feedback. There are a couple of updates to the metrics as presented that will be included. Lori hoped to send out later today or in the next day or two.

Lori went on to state that most of the benefit limits would be reflected as age limits on the applicable HCPCS/CPT codes as noted on the matrix.

Adults are defined as those members aged 21 and older.

If a member has QMB dual Medicare coverage, benefits are not generally limited as long as Medicare is the primary payer.

Everything has been moved from July 1 to October 1 as far as effective dates.

Lori then went through the chart showing the specific benefit changes:

Emergency Dental Services: Separate code list attached. Some things will be covered under transplants only for adults.

Podiatrist: This eliminates a provider type from use by adults. We have a new edit that will ensure if a claim or encounter is received for a date of service on or after 10/1/10 that the member not be age 21, or older.

Well Exams: We are expecting a few additional diagnosis codes to be added. Lori will obtain updates from Dr. Leib.

Transplants will be handled through Reinsurance process.

Physical Therapy: There was no detail presented in this version of the matrix, but will be included in the updated version that will be distributed this week.

Bariatric surgery: If this is implemented, it will be through policy.

ER: Two (2) urban counties (Pima and Maricopa). AHCCCS does not expect this benefit to go forward.

There are a few more benefit areas which were not specifically addressed in the legislation that Dr. Leib is looking at for possible future consideration.

The proposed code lists also went to the CEOs and Medical Directors at the plans.

Question was asked: when will final come out? Lori hoped soon, but sending out drafts for every to look at.

QUESTIONS   Mary Kay McDaniel and Lori Petre

Lori asked for topics for the June meeting; however, may not be ready to discuss things in June, perhaps July.

There being no further questions, Lori advised that everything would be posted to the Website.

The Meeting adjourned at 11:30 a.m.

Corrections to the minutes should be directed to Mac Williams at mac.williams@azahcccs.gov.