



CMS 2011

Medicare Crossover Updates and Medicaid PIE

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Agenda

- CMS Updates
- HIPAA 5010
- Mass Adjustment
- Future Initiatives
- Medicaid Payer Initiated Eligibility (PIE)

Slide 2

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Crossover claims fee:

- .40 cents per claim
- Adjustments/Mass Adjustments included

** BCBSA and AHIP revisiting with CMS to exclude adjustments from the .40 fee

The Blue Cross and Blue Shield Association is an association of independently licensed Blue Cross and Blue Shield companies.

2011 CMS Updates (cont.)

- **NGS Issue (Dec 2010 – Jan 2011)**

- National Government Services

- News: Crossover Claims Rejecting with H45138

COBVA February 11, 2011: CMS alerting all COBA trading partners that the Part A shared system (FISS) recently installed a fix (FS6265) to correct a problem that had surfaced in late December 2010. The issue was that there were many instances where a Part A provider was creating the same information in loop 2310E (Service Facility Name) as was created at the 2010AA or 2010AB level. In accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 837 Institutional Guide for version 4010A1, loop 2310E is only to be created when the facility address differs from that reflected in the 2010AA or 2010AB. Despite the inappropriate billing practices of the providers on their incoming claims to Medicare, FISS had not been mapping out the duplicate 2310E loop on outbound COB claims sent to the COB Contractor (COBC) until approximately December 21, 2010. The COBC has been rejecting incoming claims that had the same information reflected in the 2310E as was contained in either the 2010AA or 2010AB since that time. Approximately 300,000 claims were impacted by this problem.

- POA change

Through feedback received from its Medicare contractor crossover representatives, the Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits Agreement (COBA) team has learned that, effective January 3, 2011, CMS implemented a change to no longer accept present on admission (POA) indicator '1' when billed via Direct Data Entry (DDE) billed Part A claims. As per CMS CR 5679, POA indicator 1 denotes "exempt from POA reporting, which is the equivalent of entering a blank value on incoming Uniform Billing (UB)-04 hard copy claims." The CMS COBA team believes that this decision was made in anticipation of the upcoming Health Insurance Portability and Accountability (HIPAA) 5010 requirements that will apply to all entities within 12 months of the implementation of CR 7024.

HIPAA 5010 COBC Update

- CMS began testing the pre-Errata 5010 COB 837 institutional and professional claims with a small subset of all COBA trading partners on September 27, 2010.
- As of February 1, 2011, a total of 140 core entities (211 lines of business), including BCBS plans, TPAs, and 6 Medicaid State Agencies, were testing HIPAA 5010 COB with the COBC.
- CMS's goal is to have 75% of all COBA trading partners testing HIPAA 5010 COB by July 1st.

HIPAA 5010 COBC Update (cont.)

- CMS released its initial COBA HIPAA 5010 COB 837 Institutional (I) and Professional (P) Crossover Claims Companion Guide for use by all COBA trading partners on March 25, 2010.
- CMS updated its COB Companion Guide to include all 5010 Errata changes and other needed revisions on December 30, 2010.
- CMS conveyed the revised Companion Guide to COBA trading partners via COBVA e-mail broadcast on January 7, 2011.

HIPAA 5010 COBC Update (cont.)

- During January 2011, CMS created a new HIPAA 5010 COB section on its COBA web site for easy reference by external entities.
 - The URL for the new site is:
http://www.cms.gov/COBAgreement/40_HIPAA_5010.asp#TopOfPage
- COBA trading partners may reference CMS's revised HIPAA 5010 COB Companion Guide as a downloads document on the site at:
<http://www.cms.gov/COBAgreement/Downloads/5010GuideV312302010.pdf>

HIPAA 5010 COBC – Excepts from Companion Guide

- Possible strategy for determining Medicare's allowed amount in the absence of AMT*B6 and AMT*AAE segments as required by HIPAA 5010:
 - Take Medicare's paid amount in 2320 AMT qualified by "D," and add all CAS*PR segments (i.e., Part B deductible, Part B co-insurance, Part B blood deductible if indicated, outpatient psychiatric reduction, and late filing penalty if reflected).
 - **IMPORTANT:** For non-assigned Medicare claims, do not include PR*45 (limiting charge) as part of your formula for deriving Medicare's allowed amount. All other CAS PR adjustments, just discussed, may be added to Medicare's paid amount to determine Medicare's allowed amount.

HIPAA 5010 COBC – Excepts from Companion Guide (cont.)

- AMT segments denoting Medicare Part A and Medicare Part B Trust Fund amounts are eliminated with HIPAA 5010.
 - Upon request, CMS can provide a listing of institutional and facility types of bills (TOBs) that fall under each Medicare trust fund.
- POA Indicator values have changed. Values now are limited to N, U, W, & Y (or can be blank).
- POA Indicator values now have their own placement within the 2300 HI portion of the 837 institutional claim.

HIPAA 5010 COBC – Excepts from Companion Guide (cont.)

- Secondary Provider Reference Identifier Segments are limited just to 2010AA REF.
 - Values will be limited to EIN/Tax ID for 837-I claims and to EIN/Tax ID or solo practitioner's SSN for 837-P claims. (NOTE: To the extent the physician's EIN is available, as per PECOS, Medicare will send this out on its 837 professional COB claims.)
- For 837I 5010 claims, 2300 QTY-01 and QTY-02 segments are now eliminated.

HIPAA 5010 COBC – Excepts from Companion Guide (cont.)

- Medicare will now reflect institutional day counts for covered, non-covered, co-insurance, and life-time reserve (LTR) days within the 2300 HI as follows:
 - 2300*HI*BE
 - 2300*HI01-2 with the applicable value of:
 - 80 (for covered days)
 - 81 (for non-covered days)
 - 82 (for co-insurance days)
 - 83 (for LTR days)
 - 2300*HI01-5 will reflect the actual day count associated with the qualifier in 2300*HI01-2.

HIPAA 5010 COBC – Errata Changes

- Effective April 4, 2011, claim version numbers changed to 005010X223A2 for 837I claims and to 005010X222A1 for 837-P claims.
- Admission Type Code now required for 837I claims.
 - CMS will gap-fill with value 9 (“Information Not Available”) as needed when converting incoming 4010A1 to 5010 Errata 837I COB claims.
- N401, N402, and N403 address elements are now situational within loops 2010BA, 2330A, and 2330B (applicable to both 837I and 837P).

HIPAA 5010 COBC – Errata Changes (cont.)

- Loop 2430 SVD becomes situational, which effectively aligns the requirements for this “composite” with those already effective for HIPAA 4010A1 claims.
- This change eliminates a huge barrier to HIPAA 5010 837 institutional claim trading partner testing that was introduced likely unintentionally by the pre-Errata Technical Report Version 3 (TR-3).

Additional HIPAA 5010 COB Information

- Effective April 4, 2011, CMS will be adding a 23rd byte claim adjustment indicator to the BHT03 identifier within its 4010A1 and 5010 COB claims. Possible values for the new 23rd BHT03 position will be as follows:
 - O—original claims
 - P—Affordable Care Act (ACA)/Other Congressional imperative mass adjustments (NOTE: Will not be applicable to DMEPOS claims, which are unaffected by ACA pricing changes.)
 - M—Non-ACA mass adjustments tied to Medicare Physician Fee Schedule (MFPS)
 - S—Mass adjustment claims—all others
 - R—Recovery audit claims (RAC) adjustment claims
 - A—Routine adjustment claims, not previously classified

Additional HIPAA 5010 COB Information (cont)

- Down-versioning (HIPAA 5010 to 4010A1)
facts you should know:
 - HIPAA 4010A1 down-versioned (or “skinny”) COB claims will reflect a singular AMT*B6 amount; all other AMT segments that normally appear on 837 4010A1 claims will be omitted. (NOTE: This satisfies HIPAA compliance requirements.)
 - If a provider submits a 5010 Errata version claim to Medicare that contains both a 2010AA and a 2010AB loop, will both loops be created within the 4010A1 down-versioned/skinny COB claim?
 - Unfortunately, the Medicare shared systems will only be able to create the 2010AA loop and related N3 and N4 segment address information.

Additional HIPAA 5010 COB Information (cont)

- Some additional 2010AA and 2010AB loop considerations
 - Remember, under 4010A1, the 2010AA and 2010AB loops often contain different provider entities, with the differences between the loops not being limited just to address elements.
 - By contrast, under HIPAA 5010, providers should only be creating a 2010AB loop if their payment (Pay-to) address differs from their physical or billing (Bill-to) address.

SPECIAL NOTE: Also, importantly, unlike HIPAA 4010A1, the 2010AA N301 segment within the HIPAA 5010 claim cannot not contain a P. O. Box; only a physical delivery address may be reflected.

NCPDP D.0 COB Testing

- CMS is planning to begin testing NCPDP D.0 batch COB claims with interested COBA trading partners in April 2011.
- CMS's NCPDP D.0 COB/Crossover Companion Guide was issued in early February 2011 via COBVA broadcast.
- The NCPDP D.0 COB/Crossover Companion Guide may be located on the CMS web site by going to the following URL and referencing download documents:

http://www.cms.gov/COBAgreement/40_HIPAA_5010.asp#TopOfPage

Mass Adjustments

- During the last two months of CY 2010 and in January 2011, CMS's Medicare contractors were addressing provider reopening requests and creating adjustment claims for Part B claims with DOS January 1 thru May 31, 2010.
 - These claims were originally processed under the neutral MPFS prior to the June 2010 MPFS with + 2.2% update.
- Medicare is now in the midst of mass adjusting numerous claims retroactively to January 2010, as required by ACA legislation.

Mass Adjustments (cont.)

- These adjustments, which are applicable to Part A and Part B services, and not to DMEPOS, are needed due to pricing changes specified within numerous ACA provisions.
- Medicare is, and will be, mass adjusting these claims gradually over time, to account for systems capacity considerations.

Mass Adjustments (cont.)

- ACA mass adjustments may be identified with “U” in final position of 837I claim’s Document Control Number (DCN); value “MP” will be reflected in 2300 NTE02, with NTE01=ADD, of 837 professional claims. (CR6973)
- Additional identifiers for ACA mass adjustments will be available in April 2011.
- CMS will continue to update all COBA trading partners about this issue via COBVA e-mail broadcasts.

ICD-10

- Limited effect upon COBA version 5010 crossover claims, which can support ICD-9 and ICD-10 codes.
- Currently, CMS is planning to ensure that ICD-9 and ICD-10 codes cannot appear within the same individual claim.
 - CMS's Medicare contractors will not accept individual claims that contain both codes as part of a combined date of service billing (i.e., services billed before and after October 1, 2013).
 - Providers/physicians/suppliers will be required to bill claims with service dates prior to October 1, 2013, using ICD-9 codes; and they will be required to bill claims with ICD-10 codes if the service dates are October 1, 2013, and after.

Future Initiatives (cont.)

- ICD-10 (cont.)
CMS is currently formulating its Medicare Secondary Payer (MSP) ICD-10 requirements, including the future internal mapping of ICD- 9 to ICD-10 codes within “active” MSP non-group health plan auxiliary records housed at the Common Working File (CWF).
- HPID- National Health Plan ID
Regulation not yet finalized
Possible implementation date (Oct 2012?)
NM109- COBA ID will be replaced with HPID
EX: NM1*40*2*ANTHEM CONNECTICUT*****46*30001~
Will you need the COBA ID to be displayed in another field/segment? REF*

CMS Medicaid Payer Initiated Eligibility (PIE)

- Medicaid Reclamation Introduction:

The Medicaid Program is considered the payer of last resort by Federal statute (42 U.S.C. 1396a(25), 1396b(d)(2) and 1396b(0)). Therefore, state Medicaid programs are required to recover any payments made on claims for which commercial or other health insurance is identified. When Medicaid discovers they have processed and paid for services rendered to a patient who has an active Blue Cross Blue Shield health plan, Medicaid will request reimbursement.

CMS Medicaid Payer Initiated Eligibility (PIE)

Section 6035 of the Deficit Reduction Act of 2005 (DRA) provides a tool for States to use in order to identify when Medicaid recipients have other health insurance coverage. The DRA requires health insurers to provide States with eligibility and coverage information that will enable State Medicaid agencies to determine the existence of third party coverage for Medicaid recipients. Eligibility and coverage data are to be exchanged in a manner prescribed by the Secretary of the Department of Health and Human Services (HHS).

CMS Medicaid Payer Initiated Eligibility (PIE)

- CMS letter June 2010 - SMDL # 10-011

Letter announced recommended transmission formats for sharing eligibility and benefit information between the State, or its agent, and health plans. These recommended formats will serve as a tool to enable States to comply with the DRA data exchange requirements. The transmission formats are:

- Payer Initiated Eligibility/Benefit (PIE) Transaction
- Accredited Standards Committee (ASC) X12 270/271 Health Care Eligibility/Benefit Inquiry and Response Standard Transactions (“270/271 Transactions”)

**CMS is seeking formal approval for the use of these formats through the Paperwork Reduction Act. In the meanwhile, we strongly recommend that States begin using these formats. One major concern is that plans avoid the need to provide data in a variety of different formats in order to accommodate multiple States’ requirements.

CMS Medicaid Payer Initiated Eligibility (PIE)

- October 2010 - CMS had initiated the Paperwork Reduction Act (PRA) submittal process to the Office of Management and Budget (OMB) for approval of the Payer Initiated Eligibility/Benefit (PIE) transaction. The PRA approval process typically takes 6 - 9 months. At the conclusion of that process, the PIE transaction will become the approved standard for electronic data interchange (EDI) transactions between Medicaid agencies (or their contractors) and plans.
- It is important to note, however, that other formats are permissible to use in States having existing agreements with plans. CMS will permit States and plans to adopt, or continue to use, proprietary formats to share eligibility information, provided that both parties agree to its use. In the event that either party decides to discontinue use of a proprietary format, the PIE transaction must be used.

CMS Medicaid Payer Initiated Eligibility (PIE)

- Documents attached on your Flash Drive



6-21-2010 CMS PIE
Letter



PIE FAQs



Layout specific
details



PIE Comp Guide

Questions?

