Dept. of Health & Mental Hygiene
Office of Planning & Development
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Inside this Issue

DHMH Encounter Data Update

MCO Meetings

DHMH and CHPDM would like to extend our appreciation for the time each MCO spent in March to meet with us to discuss issues of mutual concern. We received a number of useful suggestions in these meetings; some will be implemented soon, as reflected by other articles in this newsletter.

We are considering another meeting within the next six months for which the MCOs will draft the agenda. Let us know what you think.

Periodically over the last several years, MCOs have been provided with lists of CPT/ HCPCS codes accepted by MMISII.

A new production report has been requested which will provide updates of this information every six months, at least until HIPAA implementation. We hope to forward the first of these updates to you by email in compressed Excel format within the next month.

New Remit File Fields

DHMH has received suggestions for the addition of fields to the medical and institutional remit layouts. These additional fields would potentially assist MCOs in problem-solving fatal errors. In addition, fields were suggested that could be deleted from the current layout that are not useful and would allow the necessary bytes to accommodate the requested additions.

Pages 4 of this newsletter reflects these proposed changes. Please review this information and let us know if you see any problems. Within the next two weeks, a letter will be sent to MCO senior managers requesting sign-off on these changes. We need to have the consensus of all 6 MCOs before the changes can be made.

Encounter Data Programming Changes

As of April 18 2002, encounter data processing logic now allows all traditionally outpatient revenue codes accepted by MMISII to appear on hospital inpatient encounters. This allows hospitals and MCOs to comply with the HSCRC "72 Hour Rule." This rule requires that any service provided by the hospital or subsidiary within 72 hours of an admission must be reported on the inpatient UB 92 bill. A revised list of accepted revenue codes will be forwarded to each MCO soon.

Also, programming changes are underway to allow the following provider types on UB 92 outpatient encounter formats:

39- ambulatory surgicenters
61-dialysis
10-labs, medical
60- diagnostic facilities, other
32-clinic, drug abuse (methadone)

We hope to have these changes in production within the next month.

HIPAA UPDATE

Nationwide, it is acknowledged that HIPAA will fundamentally change how health care is provided, managed, and paid for in the United States. Maryland Medical Care Programs are not an exception. The planning and implementation of the Administrative Simplification titles under HIPAA have major impact on all aspects of the Medicaid program, in terms of staff and technical resources necessary to analyze and change operations and systems.

The HIPAA mandate to eliminate local codes has created a monumental task for all Medicaid programs. It first required the aggregation of all of the states' local codes, yielding over 30,000. This list has been worked and the final result was a list of approximately 500 codes and modifiers. These codes are in the process of being reviewed and approved on a national level. Once approved, the Maryland Medical Care Program must weave them into our existing system to replace the local codes previously used.

HIPAA Timeframe

On December 27, 2001, HR3323 was signed into law. This bill allows covered entities to apply for an extension to the compliance dates for transactions and code sets. This is done by submitting a written plan to the Department of Health and Human Service (DHHS) by October 16, 2002. The request must include a plan that shows the covered entity will be able to begin testing by April 2003. The Maryland Medical Care Program plans to file for the extension to implement standard transactions. The extension has no impact on the requirements for compliance with the Privacy standards, which remain April 14, 2003.

HIPAA Transactions

The Medical Care Program will be eliminating the use of all local codes and will only process paper claims using the HCFA 1500, UB 92 and ADA dental claims forms. The current claims process for the MCOs will change to the HIPAA standard Premium Payment 820 transactions. All encounter data (except Pharmacy) will need to be submitted on the HIPAA 837 transaction. MCOs will receive enrollment information on the HIPAA 834, through our contractor, Concera (Benova).

Testing

HR 3323 requires that testing for HIPAA begin by April 2003. MCOs will have to be able to convert claims and encounters processed by the MCO before the implementation date to the HIPAA standard. Both the MCOs and the Medical Care Programs must have their transactions tested by an outside vendor before that date. This testing applies to the transactions submitted by the MCO to the Medical Care Program and from the Program or its business associate to the MCO. We will be providing more information regarding the level of testing required in future communications.

"Even if I knew that tomorrow the world would go to pieces, I would still plant my apple tree. "
- Martin Luther King, Jr.

SUGGESTED REMIT FILE LAYOUT CHANGES

The following is a composite of the additions and deletions to the remit file layouts that have been suggested by MCOs. All fields in left columns will be deleted. Brackets indicate contiguous fields that will replaced by fields in right column. Added fields will appear in the new layout contiguously and in the order indicated. Fields in the left column not enclosed by brackets will be converted to filler. If you have any comments regarding these proposed changes, please contact Claudia Lamm at (410) 767-5150. If none are received, this document will be included in a letter to MCO senior managers requesting sign-off. Thank you.

HCFA 1500

FIELDS TO BE DELETED

Field Name	Position/ Size
Date Paid	121-128
Allowed Charge Source	148
Charged Amount	149-156
Allowed Charge	157-164 (8)
Total Charged	165-173 (9)
Coinsurance	174-180 (7)
	(24)
Total Paid	187-195
Third Party Amount	198-206
Deductible	209-214

FIELDS TO BE ADDED

Field Name	Size
Diagnosis Code (ICD-9)	5
Diagnosis Code2 (ICD-9)	5
Diagnosis Code3 (ICD-9)	5
Diagnosis Code4 (ICD-9)	5
	(20)

UB 92

FIELDS TO BE DELETED

Field Name	Position/Size
Date Paid	130-137
Allowed Charge Source	154
Charged Amount	155-162
Allowed Charge	163-170 (8)
Total Charged	171-179 (9)
Coinsurance	180-186 (7)
Total Paid	193-201 (9)
Third Party Amount	202-210 (9)
HCPCS Procedure	211-215 (5)
Deductible	216-223 (6)
	(53)
Filler	(23)

FIELDS TO BE ADDED

Field Name	Position
Proc Code (ICD-9 Surg)	5
Date of Surgery	8
Procedure Code 2 (ICD-9 Surg)	5
Date of Surgery 2	8
Procedure Code 3 (ICD-9 Surg)	5
Date of Surgery 3	8
Procedure Code 4 (ICD-9 Surg)	5
Date of Surgery 4	8
	(52)
Diagnosis Code (ICD-9)	5
Diagnosis Code 2 (ICD-9)	5
Diagnosis Code 3 (ICD-9)	5
Diagnosis Code 4 (ICD-9)	5
	(20)