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CMS TO HOST CONFERENCE

The Centers for Medicare & Medicaid Services will host the 2002 National Medicaid HIPAA and MMIS Conference from April 22 – April 25, 2002 in Hunt Valley, Maryland. The State of Maryland, Department of Health and Mental Hygiene, is the host for the MMIS portion of the conference.

The conference will be set in a workshop environment and participants will bring back knowledge and content that is extremely relevant and timely to their respective organizations. The conference offers two venues that are thematically based on critical Medicaid systems issues. Tools and methods will be shared to assist States' efforts to become HIPAA-compliant, and collaborate on a national level. The agenda includes topics of national interest, State interests, and sessions demonstrating the newest version of CMS's Medicaid HIPAA Compliant Concept

Model (MHCCM). In addition, CMS's A-Team will conduct training and education workshops on gauging the HIPAA readiness of one's organization and addressing HIPAA transition issues.

The Medicaid Systems Technical Advisory Group (S-TAG), the National Medicaid EDI HIPAA (NMEH) Workgroup, the Private Sector Technology Group (PS-TG), and the State of Maryland have assisted CMS in developing portions of the agenda to broaden the participation by all those who make up the "enterprise" that administer and operate the Medicaid program. Webcasts of select sessions from this conference will be made available by kaisernetwork.org, a free service of the Kaiser Family Foundation, after 5:00 p.m. ET, Monday, April 22. The webcasts, transcripts, and related resources can be found at http://w.kaisernetwork.org/healthcast/hipaa/22apr02. ☼

The X12 Process, in Layman's Terms

By Robert C. Pozniak, New York State Department of Health

I'd like to try and provide a simplified explanation of the X12 standards maintenance process by comparing it to buying/designing a car. Think of X12 as the transportation industry, X12N as GM and HIPAA transactions as Chevrolet.

We're interested in getting a Remitta Model (835) but want some changes from what's available on the dealer lot. First we ask for an exterior color of forest green with a tan leather interior (DSMO Fast Track). Dealer says okay I don't have one but I can get one in with that color scheme fairly quickly (Addenda to the original transaction).

We also decide we would like front wheel drive for better traction in bad weather. However, the current design of the vehicle cannot accommodate a transaxle, so if we really want that, we'll have to wait for the next model re-design (our DSMO request for a claiming address on the 835).

In addition, we want an ABS braking system for safety (payer-to-payer post payment recovery). We're told the Remitta doesn't currently come with ABS. Although the ABS-only change could be accommodated fairly easily, if we want to also add front wheel drive (claiming address), the entire design team will need to be assigned to that project (X12 Data Maintenance). Then there won't be resources or incentive to make the changes for the ABS brakes and we'll have to wait for the complete model re-design.

Well, we think about the choices and considering we have a 4 wheel drive SUV for bad weather conditions, (270/271 to provide a claiming address) maybe we don't really need to have front wheel drive. Also, all wheel drive is mandated in a couple of years anyway (National Plan ID).

So the choice is front wheel drive with ABS brakes, but we'll have to wait, or try to get the ABS brakes now and rely on the SUV (270/271) until the next model cycle with all wheel drive (National Plan ID). ☼

Implementation Guide Selection

At first glance, it appears as though the transaction rule is definitive on which Implementation Guide (IG) must be used (institutional or professional) when submitting claims. However, as covered entities have opened discussions with trading partners, it has become clear that there is much variation today and that the final rule is not specific. For example, ambulatory surgical centers are being asked to bill with both a UB-92/institutional and a HCFA-1500/professional billing form for the same service depending on the payer. In a like manner, hospitals, many types of specialties, and dentists (particularly oral surgeons) are faced with a similar problem. It is an issue for providers because it causes them to maintain two or more separate billing platforms, thus increasing their administrative overhead.

WEDI/SNIP, with support from the National Uniform Billing Committee (NUBC) and the National Uniform Claims Committee (NUCC), has decided to develop a philosophy for standardization of IG selection. This philosophy will serve as a starting point for reaching industry consensus for standardization in the future.

The first step is to document whether or not there is a problem for providers. Jan Root and Ruth Tucci-Kaufhold are co-chairing a white paper workgroup at WEDI/SNIP. The group is polling the industry through a survey on the current billing practices, so the it can document the areas

in the health care industry where payers are asking for different billing forms/transactions for identical services. The workgroup will use the survey responses as input to the development of the IG Selection white paper.

There are two versions of the survey - one for payers and one for providers. The survey takes about 15 minutes or so to complete. Both versions and a cover letter can be found at:
http://snip.wedi.org/public/articles/Coverletter2.doc
http://snip.wedi.org/public/articles/ServicestoIG_V2_PAYER.xls
http://snip.wedi.org/public/articles/ServicestoIG_V2_PROVIDER.xls
They ask that the survey be completed by June 2002, and emailed to Jan Root (janroot@uhin.com). The group will share the results with the NMEH LISTSERV. Results will only be reported in aggregated form.

The NMEH has discovered in its fact-finding, that there is variation in billing format requirements from state to state. All Medicaid Agencies will want to complete the survey because full collaborative participation in standards development is key to meeting each individual state's Medicaid business needs. The resultant white paper will lead to a gradual transition to a new standard for IG selection. ☼

Claims Adjudication with No Local Codes

A great paper describing the local codes process is available on our Web site at: www.hcfa.gov/medicaid/hipaa/adminsim/ (click on Medicaid Local Codes). Once that process is complete how will State Medicaid Agencies move from using local codes in their claims processing systems to use of HIPAA compliant standard HCPCS codes? No

providers will be allowed to report local codes anywhere on the HIPAA compliant ASC X12 837 claims transactions. States must be able to use the standard data elements and codes found in the standard transaction to adjudicate their claims. As described in reports of the NMEH local code effort, states submitted many thousands of codes that will result in only a few hundred new standard HCPCS available for use. How will states, who may have many hundreds of local codes today, be able to price claims correctly with so few national codes?

Do a Crosswalk

The answer is that there are a number of other fields on the standard claim that can be used to derive all the intelligence currently imbedded in the local codes. Using those allowable codes and data elements in the new format, a state agency will find that it can create a crosswalk from each single local code to a set of fields and other codes that can be used to calculate the same payment amount.

Among the fields on the professional ASC X12 837 that contain information states currently imbed in local codes are: HCPCS modifier codes, units, place of service codes, pregnancy indicator, special program indicator and provider taxonomy codes. The institutional claim also has condition codes, occurrence codes, and value codes can be used to map local codes. Where the data does NOT exist in the 837, claims attachments may be a viable option. The NMEH expects to publish some guidance shortly, in a data base documenting their analysis of the local codes submitted by each state. This analysis may assist states in their mapping effort, by pointing to the codes and fields recommended by the NMEH workgroup.

Decide What to Do with Unmappable Codes

There will be some exceptions. Not every payment in every fee

schedule in every single state will be able to be crosswalked this way. If a state has a policy that is different from most other states, the local code subworkgroup may have chosen to exclude associated codes from consideration when requesting new national HCPCS codes. This was necessary to complete the enormous task of completing those code requests critical handling the bulk of Medicaid business in time to meet the HIPAA compliance deadline.

States may submit individual applications directly to the HCPCS committee requesting additional codes. They must have a very strong justification, and still may not be approved if they do not have wide applicability, or the committee does not feel they meet the other criteria for HCPCS code set inclusion. States should consider a fallback position for reimbursing those services. They may want modify their pricing policies to take advantage of code standardization.

Produce Pricing Guidance for Providers

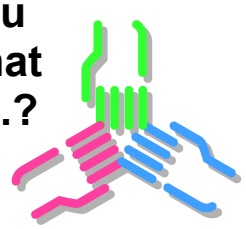
Once a state has mapped its local codes to the standard HCPCS and other data available in the claim, it is imperative to advise the provider community how to code the standard claims to receive the same payments for the services they claim today. Provider practice management software vendors, medical office staff and clearinghouses must have plenty of lead time to retool their systems and procedures without adverse impact on their cash flow as they transition to use of HIPAA formats. States might want to write easy to understand crosswalks charts for providers, with headings such as: Current procedure code, HCPCS, Modifier, Units, POS, etc.

Modify the Medicaid Claims Payment Process

Each state has its own HIPAA implementation plan. Some are re-coding the payment algorithms in the MMIS to use the HIPAA standard data fields and codes. Others may to put the maps into their translators and generate their old local codes to go into a minimally changed MMIS for claims processing. It is up to each state to determine where and how to apply the crosswalks they create.

There is still much work to be done by each state to bring their systems into compliance, but with the help of the NMEH Local Code subworkgroup and the assistance available via the LISTSERV, what once seemed like an impossible task is achievable. ☼

Did You Know that NMEH. . .?



The National Medicaid Electronic Data Interchange (EDI) HIPAA workgroup, or **NMEH**, (pronounced Nè-mee) is not concerned with local codes alone. While NMEH's Local Codes subworkgroup has received kudos for its work to standardize the Medicaid local codes, the NMEH itself is an umbrella workgroup consisting of over a dozen subworkgroups that do much, much more!

Claims Attachments
Dental
Eligibility
Explanation of Benefits
Local Codes
Bundling School Based Services
Durable Medical Equipment (DME)
Prior Authorization (PA)
HIPAA Integration & Transition
Provider Taxonomy
Security/Privacy
Third Party Liability (TPL)/ Coordination of Benefits
Designated Standards Maintenance Organization (DSMO)

You can check their contacts, status reports, and their meeting schedules at http://www.hcfa.gov/medicaid/hipaa/adminsim/nmehcont.pdf.

NMEH holds conference calls on the second and fourth Wednesdays of each month and the minutes are posted to the NMEH list serve. On these calls, all the subworkgroup chairs describe current activities and issues. Also, National Association of State Medicaid Director (NASMD) representatives to the various standards development organizations give meeting reports, and the NMEH members who work on Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI/SNIP) committees provide announcements on new drafts of SNIP white papers and solicit Medicaid information.

Recently, Unisys donated phone conferencing services for these calls. As a result, the problem of too few ports, and quirky service are thankfully over. These calls and the minutes are invaluable for those who wish to stay up to date on Medicaid HIPAA issues.☼

DME Codes Under Development

By Fran Crystal, CMS

With HIPAA looming on the not too distant horizon, and mandated elimination of the local codes used by states to report medical reimbursement just around the corner, the NMEH and CMS are actively working to make sure that the most vulnerable citizens will not experience any interruption of service once HIPAA is implemented. Through its Local Code sub-workgroups, NMEH is addressing the issue of how states will correctly pay for medical equipment, supplies, and services once local codes disappear.

One of the most daunting local code issues facing states is Durable Medical Equipment Prosthetic, Orthotics, and Supplies (DMEPOS). National HCPCS codes, whenever possible, have historically reported services, procedures, medical equipment, and supplies in a generic fashion. Local codes were developed by individual states to report services and equipment that had not yet been codified by Level I and II HCPCS codes, or to represent each state's unique payment and reporting system. Compounding the problem is the fact that local DMEPOS codes are more disparate than other category codes, and the definition of national HCPCS codes are often too generic or too specific to meet the unique needs of Medicaid.

Under the leadership of NMEH Workgroup chair Diane Davidson and DMEPOS sub-workgroup leader Barb Hollerung, over 5000 DMEPOS local codes were collected from states. Through NMEH collaboration, states, CMS and representatives of the DMEPOS industry have achieved greater understanding of the real issues surrounding DMEPOS coding, and a fuller appreciation for the need to follow the national HCPCS code submission process.

Several representatives of the manufacturing industry have stepped forward to offer their assistance identifying coding gaps and, as members of the NMEH DMEPOS sub-workgroup, are now working with the manufacturers of IV and parental nutrition, mobility equipment, orthotics, prosthetics, and diabetic supplies. The list of 5000 local DMEPOS codes originally submitted by states has been reduced by removing those codes that fall under the categories currently being addressed by the industry representatives. Through the hard work of Barb Hollerung, many of the remaining codes have been cross-walked to an existing national code. Established codes with descriptions that require modification in order to be usable by Medicaid are being identified and modification requests will be submitted to the CMS HCPCS Workgroup. Medicaid covered services and products not currently included in the HCPCS code structure are also being identified, and additional codes will be requested

through the National Medicaid HCPCS code process. Additionally, DMEPOS experts from NMEH member states are actively involved in identifying gaps in the coding structure that present problems for many of the states.

It is expected that the first set of DMEPOS codes will be submitted by April 1, 2002. While every effort is being made to accomplish these tasks in time for inclusion in the 2003 HCPCS Update, it will not be possible to submit and review every new code or code modification request in time. Therefore, the bulk of the code requests will be carried over into the 2004 update work process. CMS will continue to work closely with NMEH to provide assistance whenever it is needed, and the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is available to provide guidance on the proper use of HCPCS codes. ☼

Draft Addenda to the X12 Implementation Guides

Since publication of the Final Transactions Rule, the industry found a number of limitations in the versions of the Implementation Guides that were named, and using a DSMO fast track process to address these limitations, X12N created Draft Addenda for the Implementation Guides named in the final rule. (The Addenda documents can be downloaded from http://www.wpc-edi.com/hipaa/addenda.)

Because the May 2000 versions of certain ASC X12 Implementation Guides were named in a Final Rule, these Draft Addenda must go through the federal rule making process before they can replace the existing ones originally named. At the recommendation of the NCVHS, HHS plans to publish a Notice of Proposed Rule Making (NPRM), referred to as "the Addenda NPRM" which will propose adoption of the addenda as the federally mandated standard.

Once the proposed rule is published, there will be a 30 day comment period, after which the department, (in consultation with the DSMOs for technical expertise), must evaluate the comments. To make the process as speedy as possible, X12 has decided that of the technical comments referred to them by HHS, only those comments related specifically to the modifications noted in the Draft Addenda will be considered at this time. All other comments referred to X12 will be evaluated for future versions of the standards.

The required implementation date for the addenda will be specified in the final rule adopting the addenda. The revised standards (with Addenda) will replace the standards previously named on the specified implementation date. The Secretary will propose a 6-month implementation timeframe. At this time, HHS is unable to estimate a specific NPRM publication date to guarantee that the final rule can be published in time for implementation by October 2003.

State Medicaid Agencies, as all other HIPAA covered entities, are currently conducting risk analyses to decide whether to implement costly systems constructs that will no longer be required when the Addenda are mandated in a final rule. ☼

Updated Provider Taxonomy Code List Now Available Online

NUCC has been maintaining the Provider Taxonomy code list for awhile now, but had not published any new codes since the takeover. They have contracted with

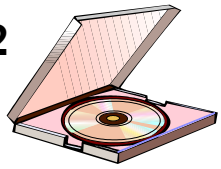
Washington Publishing (WPC) to publish the list on their Web site and supply an on-line code request and review process. Everything is now up and running on the WPC Web site. Go directly to the new Codes page, http://www.wpc-edi.com/codes/ and log in, the taxonomy code list is up to date. WPC is working on an electronic download capability (for a nominal fee) using a simple X12 841 transaction format. It should be available soon. There will also be a PDF format available for download. ☼

HCPCS Committee Approves Medicaid Level of Care Modifiers

States have long sought a way to use national coding for waiver services claims. The HCPCS committee recently announced a decision that will make it much easier to represent services by level of care. In its request for 13 Level of Care modifiers, the NMEH bundled school based services group indicated that "level of care refers to distinctions in various factors associated with service delivery, including but not limited to, a determination of level of care need, clinical intensity of services, classification, specialty facility type/need, case mix, and/or amount of patient supervision required." Such modifiers would not be limited to use with school based services claims, but could also be applied to a variety of other Medicaid State plan and waiver benefits. For example, they could be used in "applying pricing methodologies, conducting service utilization review, budgeting, and monitoring access."

David Greenberg of CMS stated on a February 27, 2002 NMEH conference call that the CMS HCPCS Workgroup has approved 13 Medicaid Level of Care HCPCS modifiers, with an effective date of July 1, 2002. They may only be used by State Medicaid programs and will be defined by each state. Note that CMS has received and is reviewing additional code requests submitted by the NMEH waiver services workgroup. ☼

MHCCM Version 2.2 Released



Version 2.2 of the Medicaid HIPAA Compliant Concept Model (MHCCM) was released in February. The MHCCM contains three parts:

- The Enterprise view is a pictorial view of the data flows between Medicaid Agencies and all their business partners, clearinghouses, providers, patients, other state agencies, banks, etc. It goes on to show which of the flows of information are affected by the HIPAA transactions and code set regulation. Version 2.2 improvements include new information about SCHIP, and some HIPAA impact updates.

- An Operations view of Medicaid business functions, such as program administration, program management, and program oversight, with lots of drill-downs to more granular business functions, depicting HIPAA's impact on each. Version 2.2 adds more details on HIPAA's impact at the higher levels, and more detail in the business functions of Eligibility determination and verification, and of Enrollment.

- Lastly, the Toolkit contains such items as crosswalks, white papers, presentations, the statutes and regulations, project planning, URLs to code sets specifications and DSMOs and other informational sights. Revisions include:

-Privacy Rule information and analytic tools

-More White Papers

-A whole new section of updates on NMEH activities.

The MHCCM can be viewed on the web at www.mhccm.org. It is not downloadable. If you would like a copy that you can customize for your own operations and load on your PC or office network, you may request a copy by e-mailing Karen Leshko at kleshko@cms.hhs.gov. Include your U.S. Postal Service mailing address. ☼

Ask the HIPAA Wizard

Q. In December, Congress passed the Administrative Simplification Compliance Act (ASCA) which extended the deadline for HIPAA compliance. In order for HIPAA covered entities (such as State Medicaid Agencies, their managed care plans and providers) to delay HIPAA compliance until October 16, 2003, each must submit a compliance extension form describing its implementation project plan. (See www.cms.gov/HIPAA/). Will CMS be releasing a list of all entities that request an extension? What is the best way to track this should CMS decide they can not release the information?

A. CMS will not be posting a list of all the entities that apply for extensions. However, keep in mind that if you are ready and your trading partners are not, you do not have to file an extension plan. You may continue to do business with your trading partners using non-compliant formats until they are compliant, or until 10/16/2003, whichever comes first.

You will have to negotiate a transition schedule and test with all your providers and other trading partners. Those communications are probably the most accurate way to track when trading partners will be ready.

Q. Wes Rishel (Gartner Group) in his keynote speech to the 2002 MMIS conference in August, said, “finalizing the guides would be a slow process”. If so, how do we map confidently without a viable road map?

A. You build flexibility into MMIS systems. Modularize; use object technology and other architectures that were developed to support our ever evolving health care environment (even without HIPAA.) Vendors should propose solutions with built-in flexibility. States should endeavor to conserve taxpayer dollars by heeding the long term cost benefits of moving toward modern IT architectures.

Q. Is a Medicaid Agency allowed to not comply with a standard via trading partner agreement?

A. No. This is clearly stated in the final rule.

Q. Do states have to use the 834 enrollment transaction to enroll Medicaid beneficiaries in MCOs?

A. Yes. The preamble states: “A State Medicaid program is acting as a sponsor and is excepted from the HIPAA standard requirements only when purchasing coverage for its employees. The State Medicaid program is not acting as a sponsor when enrolling Medicaid recipients in contracted managed care health plans, and thus is not excepted from the law.”

Q. Is CMS giving 90% money to states that purchase translators?

A. The rules for determining federal matching dollars have not changed for HIPAA. Translators are generally leased software, and, as such,

would be reimbursed at the 75% rate. Check with your regional office if your state thinks it has special circumstances that warrant a different match rate.

Q. What is HCFA/CMS position regarding the government owned clearinghouse/translator, Logicon?

A. States are free to explore all solutions. If you find that this one is the best for your state, say so in your Advanced Planning document (APD). Your Regional Office (RO) will evaluate it the same way CMS evaluates all APDs. Your approval from the RO can be copied and forwarded to DOD, to serve as the assurance they need from CMS to proceed.

Q. What will happen with paper claims that have data content different from the 837?

A. For the time being, states will have to build a system to deal with the fact that they are different. Two options are:

a. You may want to issue clarifying instructions to you paper submitters to try to minimize the differences. You should get some guidance from the ASPIRE project sponsored by WEDI and AFEHCT and endorsed by the NUBC and NUCC.

b. NUBC and NUCC, who are responsible for the paper forms and instruction manuals, are aware of the problem, and plan to bring them in synch in the long run. They will start with the final reports from the ASPIRE project. If you would like to offer input, please contact the project lead, (Kathryn Schulten) through WEDI.

Q. Will MSIS or the 2082 be impacted or changed because of HIPAA?

A. The general commitment in CMS is to eventually receive compliant national data to realize the cost savings and information quality improvements inherent in HIPAA. As state replace their MMIS' with compliant systems, CMS wants to take advantage of that. No official announcement has been made. CMS is still discussing ways to reach this goal with minimum impact to the states.

Q. Why do the requests for new HCPCS codes from the NMEH local code subworkgroup include environmental services and non-medical transportation?

A. HIPAA does not preclude states from continuing to use local codes for non-medical services such as environmental modifications. However, states may seek HCPCS codes for certain non-medical services anyway for administrative simplicity. The standard (including standard codes) is required only when billing for health services between covered entities. If the services are not defined, under HIPAA, as health services, the standard is not required. That even means that the regulation does not require the use of the ASC X12 837 at all. However, Medicaid Agencies might choose to agree with their providers to use the 837 and standard codes for simplicity. ☼

HIPAA Web Sites

National Medicaid Sites:
www.mhccm.org (The Medicaid HIPAA Compliant Concept Model)
http://www.hcfa.gov/medicaid/hipaa/adminsim/ (Medicaid HIPAA Admin Simplification home page, white papers, conference notes, news)
http://www.hcfa.gov/medicaid/hipaa/adminsim/hipaapls.htm (Previous and current issues of "Medicaid HIPAA Plus")

HIPAA laws, regulations, and FAQs
http://aspe.hhs.gov/admnsimp (Text of Administrative Simplification law and regulations)

http://www.cms.hhs.gov/hipaa/ (Model Compliance Plan for Implementation Extension)

Advisory Groups and Industry Collaboration:

http://www.ncvhs.hhs.gov/ (National Committee on Vital and Health Statistics)
http://www.wedi.org/ (Workgroup for Electronic Data Interchange)
http://www.wedi.org/snip/ (WEDI Strategic National Implementation Process (SNIP))

DSMOs

www.x12.org-select the Insurance, X12N, subcommittee file
http://www.hl7.org (Health Level7)
http://www.ncpdp.org (National Council for Prescription Drug Programs)
www.ada.org (American Dental Association)
www.nubc.org (National Uniform Billing Committee)
www.nucc.org (National Uniform Claims Committee)

Guides, Maps, Tutorials

www.wpc-edi.com (X12N version 4010 transaction implementation guides)
www.hcfa.gov/medicare/edi/edi.htm (Medicare Electronic Data Interchange)
www.hcfa.gov/medicare/edi/hipaadoc.htm (Map of Medicare National Standard Format to X12837 Professional Claim Transaction, Version 4010-HIPAA Standard)
http://aspe.hhs.gov/datacncl (HHS Data Council)
www.ushik.org (Data Registry; searchable database containing all data elements defined in HIPAA implementation guides)
http://www.nahdo.org/project/837%20101%20Tutorial.htm (X12 Tutorial)
http://www.nahdo.org/project/Adopting%20Standards%20for%20Encounter%20Data%20Systems.htm (X12 change process Tutorial)

NOTE: This document is located on the Web at:
http://www.hcfa.gov/medicaid/hipaa/adminsim/hipaapls.htm ☼

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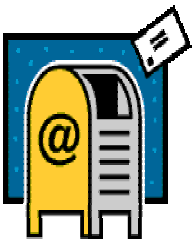

Please send comments or questions regarding this issue of Medicaid HIPAA Plus to Sheila Frank at Sfrank1@cms.hhs.gov or to Karen Leshko at Kleshko@cms.hhs.gov. ☼