MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-36

Distribution: All Providers

Issued: September 1, 2011

Subject: Health Insurance Portability and Accountability Act (HIPAA) 5010/National Council for Prescription Drug Programs (NCPDP) D.0 Implementation and Business-to-Business (B2B) Testing

Effective: As Indicated

Programs Affected: Medicaid, Adult Benefits Waiver, Children's Special Health Care Services (CSHCS), Children's Waiver, Maternity Outpatient Medical Services (MOMS), MIChoice Waiver, Plan First!, and other Health Care Programs administered by MDCH

The purpose of this bulletin is to provide updated information regarding the Michigan Department of Community Health's (MDCH) continued progress with its HIPAA 5010 implementation plan and the importance of our trading partners to participate in the B2B testing process. As stated in Medical Services Administration (MSA) Bulletin 10-54, the transition to HIPAA X12 version 5010 and NCPDP version D.0 will have a significant impact on payers and providers (both Fee-for-Service [FFS] and Medicaid Health Plans).

IMPACT TO ALL TRADING PARTNERS

Effective January 1, 2012, all trading partners must submit electronic healthcare transactions using the HIPAA 5010/NCPDP D.0 transaction formats. (Trading partners include: providers, clearinghouses, billing agents, vendors, and health plans.)

MDCH will be implementing the following new 5010/NCPDP D.0 formats and end the exchange of current 4010A1/NCPDP 5.1 formats January 1, 2012:

- 270/271 Eligibility Inquiry and Response
- 276/277 Health Care Claim Status Request and Response
- 278 Health Care Services – Request Authorization
- 820 Premium Payments
- 834 Health Plan Enrollment
- 835 Health Care Claim Payment/Remittance Advice
- 837 Health Care Claims/Encounters (Institutional, Professional and Dental)
- TA1/999 Acknowledgements
- NCPDP Pharmacy Encounters
- NCPDP Pharmacy FFS Claims

With the adoption of the 5010/NCPDP D.0 standards, trading partners must be prepared to accept the new formats and will need to modify their systems to correctly display and transmit new or changed data.

In addition, they will need to be able to complete the following:

- Use the 276 Claim Inquiry transactions to receive statuses for claims that MDCH has previously reported through unsolicited (277U) claim status transactions (applies to FFS providers only).

- Adjust claims or encounters submitted and adjudicated under 4010A1/NCPDP 5.1 while using the data configuration required for 5010/NCPDP D.0.
- Submit pharmacy encounters under the NCPDP D.0 standard (applies to pharmacy managed care providers only).
- Incorporate new or revised MDCH Companion Guides created due to 5010/NCPDP D.0 implementation changes.

NCPDP D.0 PHARMACY FFS TESTING PROCESS AND DUAL STRATEGY

The MDCH Pharmacy Benefits Manager (Magellan Medicaid Administration, Inc.) is planning a pharmacy FFS dual processing strategy as early as October 1, 2011. During the dual processing period, pharmacies may submit claims either in the current NCPDP version 5.1 or in the new D.0 format. Effective January 1, 2012, FFS pharmacy providers will be required to cutover completely to D.0.

Magellan Medicaid Administration, Inc. is instructing all FFS pharmacy providers to monitor the pharmacy website at https://michigan.fhsc.com for NCPDP D.0 migration announcements including details related to B2B testing instructions, contact information, and related documentation (e.g. updated pharmacy payer specifications and pharmacy claims processing manual). B2B testing for NCPDP pharmacy encounters will be part of the MDCH testing plan.

MDCH 5010/NCPDP D.0 IMPLEMENTATION PLAN B2B TESTING

MDCH is well into its readiness plan for the implementation of the 5010/NCPDP D.0 standards. As stated above, Community Health Automated Medicaid Processing System (CHAMPS) will only accept transactions using the new standards starting on January 1, 2012. **The current 4010A1/NCPDP 5.1 formats will be accepted until this date, prior to the direct cutover to 5010/NCPDP D.0.** The readiness plan includes the newly revised companion guides, posted to the MDCH website, along with the development of a comprehensive trading partner testing timeline.

B2B testing is now available for all trading partners through the Ramp Manager testing website at https://sites.edifecs.com/?michigan. All trading partners must test and be certified through the MDCH two-stage B2B testing process in order to successfully submit 5010/NCPDP D.0 transactions to CHAMPS. Due to the implementation of all HIPAA Type 1 and Type 2 validation edits, it is critical that all HIPAA-covered entities participate with this testing initiative. These validation changes include the requirement of reporting the nine-digit zip code.

The MDCH two–stage B2B testing approach includes a Stage 1 integrity testing along with Stage 2 testing performed using the CHAMPS B2B environment. Stage 1 integrity testing through the use of Ramp Manager will verify syntactical and structural correctness of inbound transactions (e.g. 270, 276, 278, 837, NCPDP) submitted to CHAMPS. Stage 2 testing will test the processing of inbound and generation of outbound 5010 transactions in CHAMPS. Outbound transactions, such as the 835, 820, and 834 transactions will be produced on a scheduled basis. For further clarification, please contact the following e-mail address: MDCH-B2B-Testing@michigan.gov.

SUMMARY OF 5010 CHANGES BY TRANSACTION

The new electronic transactions offer efficiencies in claim filings and inquiries. These improvements include new guidelines for consistent use of data across all transactions, modification to physical components such as segments and new data elements, and the elimination of redundant and unnecessary data content. The following summary represents a few significant changes affecting transactions submitted to MDCH:

270/271 – ELIGIBILITY INQUIRY AND RESPONSE

The size of the 271 transaction has increased to supply more detailed eligibility information including the use of service type codes to provide a high-level description of beneficiary covered benefits. Both 270/271 transactions will be implemented in both batch and real time modes.

276/277 – HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

The 277 Unsolicited Response for suspended claims will be discontinued on January 1, 2012. **In order to receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned.** Participating within the B2B testing process for the 276/277 formats is highly encouraged. Providers will continue to receive information on suspended claims via the CHAMPS claims inquiry screens.

278 – HEALTH CARE SERVICES – REQUEST AUTHORIZATION

The 278 transaction has added new segments for key patient conditions to be entered including related DME information. In addition, the PWK segment can be used when referring to an attachment for documentation.

820 – HEALTH PLAN PREMIUM PAYMENTS

More elements/segments/loops have been added to payment information affecting balancing and the overall size of the transaction. CHAMPS will now send detailed information for Organization level payments.

834 – HEALTH PLAN ENROLLMENT

The additional elements/segments/loops provide more detailed benefit enrollment data including Coordination of Benefits (COB) information.

835 – HEALTH CARE CLAIM PAYMENT/REMITTANCE ADVICE

The 835 transaction contains only paid and denied health care claims. The claims status has clearer guidance to report how a claim was adjudicated including mass adjustments initiated by MDCH. The CAS code used for Medicaid Bad Debt will be discontinued.

837 - HEALTH CARE CLAIMS/ENCOUNTERS

Dental 837 Health Claim:

1) Loop 2300 HI – Health Care Diagnosis Code – The appropriate diagnosis code is required to be reported for all oral/maxillofacial surgery and/or anesthesiology services.
2) Loop 2400 DPT - Treatment Start Date and Treatment Completion Date – For Medicaid, reimbursement for root canal therapy, complete and partial dentures, and laboratory-processed crowns completed within 30 days after beneficiary loss of eligibility:
    - Services must have been started prior to the change and/or loss of eligibility (Treatment Start Date is required within loop 2400 DPT).
    - Services must be completed within 30 days of change and/or loss of eligibility (Treatment Completion Date is required within loop 2400 DPT).
3) Loop 2430 SVD/SVD05 – Quantity – The quantity for dental code D0230 – (Intraoral periapical each additional) is required for proper claim adjudication.

Professional 837 Health Claim:

1) Loop 2410 LIN and REF – For billing physician administered drugs, only one repeat is allowed within the LIN Segment used to report the supplemental National Drug Code (NDC) information along with the HCPCS code. For compound drugs with multiple NDCs, the same HCPCS code must be repeated on multiple service line loops allowing each NDC to be reported. For the REF segment, the prescription number must be reported on each service line to link this service together as one compound drug.

Institutional 837 Health Claim:

1) Loop 2300 QTY - For Long Term Care (LTC) providers, the Covered, Non-Covered, Co-Ins and Lifetime Reserve Days loops/segments currently reported in the 4010 are being eliminated. The appropriate value codes (80 – 83) must be reported instead within the 2300 Health Insurance (HI) portion of the 837 institutional claim (e.g. 2300 HI* [denoting value code] and 2300 HI01-2 [value code 80 – 83].
2) Loop 2320 CAS – MDCH requires providers to use the HIPAA mandated Claims Adjustment Reason Codes to report other payer adjudication information. For LTC providers, this use of CAS segments must replace the current reporting of value codes when appropriate.

TA1/999 – ACKNOWLEDGEMENTS

MDCH will be using the 999 acknowledgement transaction. The 999 acknowledgement is designed to report only on conformance against a Technical Report Type 3 (TR3) and can report both transaction errors and standard syntax errors. The 997 transaction will be discontinued effective January 1, 2012.

NCPDP PHARMACY ENCOUNTERS

Managed Care Organizations will need to format and submit encounters under the NCPDP D.0 and 1.2 Batch standards.

CHANGES TO CLAIMS DIRECT DATA ENTRY (DDE)

To comply with the HIPAA 5010 transactions revisions, specific changes have also been implemented for the CHAMPS online DDE for claim submission. MDCH will be offering a DDE training course to provide users with the understanding of how these changes affect both the entry and/or adjustments of claims for each of the three invoice types (institutional, professional, and dental). Further information regarding these training sessions will be available to providers via the MDCH 5010 webpage.

ADDITIONAL INFORMATION

To download the X12 version of the HIPAA 5010 electronic transactions or TR3s and related Errata documents, please refer to the Washington Publishing Company website at www.wpc-edi.com. In addition, MDCH has created an informational webpage at www.michigan.gov/5010icd10 to assist providers with the planned 5010 implementation. The website provides information to assist in the transition process and includes 5010 Companion Guides and instructions for 5010 testing.

NCPDP compliant transactions require the use of the NCPDP Telecommunication Standard Implementation Version D.0, dated August 7, 2010. This implementation guide is available for download from the NCPDP website at www.ncpdp.org/standards_purchase.aspx. Access to the implementation guide requires an NCPDP membership. For FFS pharmacy providers, B2B test instructions for the NCPDP format are available at the Magellan Medicaid Administration Inc. website at https://michigan.fhsc.com .

Providers are encouraged to check both the MDCH and Magellan informational websites often to obtain up-to-date information.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

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Medical Services Administration
P.O. Box 30479
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Or
E-mail: ruhnof@michigan.gov

Comments received will be considered for revisions to the bulletin.

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration