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HIPAA 2 Implementation of X12 v5010 and NCPDP vD.0

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HIPAA 2 IMPLEMENTATION OF X12 VERSION 5010 AND NCPDP VERSION D.0

In order to comply with the Health Insurance Portability and Accountability Act (HIPAA) mandatory standards, effective January 1, 2012, MO HealthNet will require Accredited Standards Committee (ASC) X12 version 5010 standards for electronic health care transactions and National Council for Prescription Drug Programs (NCPDP) version D.0 transactions.

Providers exchanging transactions with MO HealthNet need to review the X12 v5010 implementation guide adopted under HIPAA located at <http://store.x12.org> and the NCPDP vD.0 implementation guide located at ncdpd.org. Providers should also view Missouri specific changes pertaining to the new X12 v5010 and NCPDP vD.0 formatted transactions in the MO HealthNet companion guides located at <http://manuals.momed.com/manuals/edb.jsp>.

TRANSITION TO 5010/D.0 FOR BATCH TRANSACTIONS

Providers who submit batch files through FTP/NDM or the eMOMED.com "File Management" link will be required to send v5010 or vD.0 transactions beginning January 1, 2012.

TRANSITION TO 5010/D.0 FOR PAPER & EMOMED SUBMISSIONS

X12 v5010 and NCPDP vD.0 policies and guidelines will apply to all claim submission methods, including claims submitted by paper or keyed into eMOMED claim forms. MO HealthNet has developed a schedule to transition from 4010/5.1 version claims to 5010/D.0 version claims. Data elements on 5010 or D.0 version claims must be compliant with ASC X12 and NCPDP D.0 implementation guidelines.

Paper Claims

All paper claims received through December 30, 2011 will be entered and processed as 4010 or 5.1 version claims. All paper claims received on or after December 31, 2011 will be entered and processed as 5010 or D.0 version claims.

Non-Batch eMOMED Claims

Claims keyed individually into the eMOMED claim entry system on or before December 17, 2011 will be processed as 4010 or 5.1 claims. Claims keyed on or after December 18, 2011 will be processed as 5010 or D.0 claims. eMOMED changes listed below will take effect on December 18, 2011.

CHANGES TO EMOMED CLAIM FORMS

Medical Claim Form Changes:

1. The Header Allowed Amount field in the TPL information has been removed.
2. Prescription number has been expanded from 7 to 12 characters.
3. The valid value list for Service Facility Location has been updated to reflect 5010 values. FA – Facility, LI – Independent Lab, and TL – Testing Lab options will be removed from the drop down list on the claim forms. The only valid value will be 77 – Service Location.
4. The referring provider Taxonomy Code field is no longer available. A taxonomy code is no longer required for the Referring Provider NPI field.
5. The valid value list for Place of Service has been updated.

Inpatient Claim Form Changes:

1. The Header Allowed Amount field in the TPL information has been removed.
2. The other provider Taxonomy Code fields are no longer available. A taxonomy code is no longer required for the Other Provider NPI fields.

Outpatient Claim Form Changes:

1. The Header Allowed Amount field in the TPL information has been removed.
2. Prescription number has been expanded from 7 to 12 characters.
3. The Procedure Code and corresponding Date fields have been removed. Surgical procedure codes can no longer be reported in the header. Instructions for reporting surgical procedures are explained below.
4. The other (admitting) provider Taxonomy Code fields are no longer available. A taxonomy code is no longer required for the Other Provider NPI field.

Dental Claim Form Changes:

1. The Header Allowed Amount field in the TPL information has been removed.

Pharmacy Claim Form Changes:

1. A new field called Patient Residence has been added. The drop down list has been updated to utilize D.0 valid values.
2. Prescription Number has been expanded from 7 to 12 characters.
3. The list of valid values for Other Coverage Code has been changed. For claims billed to MO HealthNet as primary payer OCC 00 or 01 will be allowed. For claims billed where MO HealthNet is not the primary payer, OCC 02, 03, or 04 will be allowed for these TPL claims.
 - a. NOTE: When copying or replacing v5.1 claims, this field will be blank and the user will input the value.
4. The Unit Dose Indicator field was renamed Special Packaging Indicator. The drop down list has been updated to utilize D.0 valid values.
5. A new field called Patient Responsibility Amount field has been added. This amount reflects the participant's responsibility per the private insurance company (prior payer to Medicaid).
6. The Other Payer Amount Paid field name has changed to Other Coverage Amount (Drug Benefit). This is the amount the other payer paid for the drug benefit.
7. The Participant Location field was renamed Place of Service. The drop down list has been updated to utilize D.0 valid values.
 - a. NOTE: When copying or replacing v5.1 claims, this field will be blank and the user will input the value.
8. The valid value list for Patient Location has been updated.

CHANGES TO EMOMED ELIGIBILITY REQUEST & RESPONSE**Eligibility Request Changes:**

1. There will be no format changes to the Eligibility Request form; however, 5010 version data elements will be required.

Eligibility Response Changes:

1. 5010 version data elements will be utilized.
2. Monetary Amount will display the participant's total month's spenddown amount when applicable.
3. For nursing home providers, the Monetary Amount will display the nursing home surplus/liability amount.

CHANGES TO REMITTANCE ADVICES**Printable Remittance Advice (RA) Changes:**

1. There will be no format changes to the printable RA; however, 5010 version data elements will be utilized.

835 Remittance Advice Changes:

1. 5010 version data elements will be utilized.
2. The PLB segment will be incorporated to report any balance forwarding information.
3. ICN of the original claim will be reported in the Payer Claim Control Number [CLP07] field for a claim that has been replaced or voided.
4. ASC X12 5010 guidelines require provider bank information be sent in the BPR segment if providers receive payment through EFT. This requirement to include BPR

segment information will cause a delay in transmission of provider 835s. The expected delay is two days after financial cycle runs.

REPORTING SURGICAL PROCEDURES ON 5010 OUTPATIENT CLAIMS

For 5010 version paper, eMOMED, and 837I transaction outpatient claims, surgical procedures performed in the outpatient hospital or Rural Health Clinic (RHC) setting must be reported on the detail line of the claim with the appropriate surgical revenue code. For X12 v4010 claims, surgical procedures performed in the outpatient hospital or RHC setting are reported with the CPT code at the header level of the claim in the Principle Procedure and Other Procedure field(s). The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (5010 837I Implementation Guide) stipulates that CPT procedure codes are not to be reported in the Principle Procedure and Other Procedure fields. To comply with this requirement, all ASC X12 v5010 outpatient hospital and RHC claims, regardless of date of service, must have the surgical CPT procedure code(s) reported on the line detail using the appropriate surgical revenue code.

Additional reimbursement will not be made on the lines with the surgical CPT codes. These lines are for reporting purposes only and will receive Claim Adjustment Reason Code 234, "This procedure is not paid separately", and Remittance Advice Remark Code N365, "This procedure code is not payable. It is for reporting/information purposes only". The charge amount for the surgical procedure must be zero (\$0.00). If the claim detail line for the surgical CPT has a charge greater than zero (\$0.00), the line will be denied. Charges for the surgical procedure are to continue to be reported under the appropriate facility revenue code with any other appropriate facility charges. This change applies to all 5010 version outpatient hospital and RHC claims submitted by an electronic transaction, eMOMED, or by a paper UB-04 (CMS 1450) Claim Form.

NCPDP VERSION D.0 IMPLEMENTATION CHANGES

Coordination of Benefits (COB) Claims Processing

With the implementation of NCPDP vD.0, MO HealthNet will begin using the Government Coordination of Benefits (COB) methodology to process Third Party Liability (TPL) claims for both the Fee-For-Service (FFS) and MoRx programs.

1. Other Payer Patient Responsibility Amount - The NCPDP v5.1 term Co-Pay/Co-insurance has been changed to Patient Responsibility Amount in NCPDP vD.0. The Government COB method requires providers to submit the Other Payer Amount Paid [431-DV] **AND** the Other Payer-Patient Responsibility Amount [352-NQ], even in cases when the amount is zero (\$0.00). Using this method allows MO HealthNet to reimburse claims based on the lower of Other Payer Paid Amount or Other Payer-Patient Responsibility amount calculations.
2. Benefit Stage Amount - Benefit Stage Amount [394-MW] repetitions are required when a prior payer is a Medicare Drug Insurance plan. The Benefit Stage Amount is the amount of the claim allocated to the Medicare (TrOOP) stage identified by the benefit stage qualifier, and allows MO HealthNet to identify the stage of benefit for the participant.

3. Other Coverage Codes – Only the Other Coverage Codes (OCC) 02, 03, and 04 will be allowed for TPL claims. For claims billed to MO HealthNet as primary payer OCC 00 or 01 will be allowed. For claims billed where MO HealthNet is not the primary payer, OCC 02, 03, or 04 will be allowed for these TPL claims.

Code	Description
00	Not Specified by patient
01	No other coverage
02	Other Coverage exists-payment collected
03	Other Coverage billed-claim not covered
04	Other Coverage exists-payment not collected

4. Patient Pay Amount Qualifier – For FFS TPL claims, when payment is based on the Other Payer-Patient Responsibility Amount, only the Patient Pay Amount qualifier [351-NP] value of 06 will be accepted by MO HealthNet. All other Patient Pay Amount qualifiers will be denied. For MoRx claims, values 01, 02, 03, 04, 05, 07, 08, 09, 10, 11, 12, or 13 will be accepted – 06 from any prior payer will deny. This field is used to indicate the provider is submitting the amount reported by a prior payer as the patient’s responsibility.
5. Other Payer Amount Paid Qualifier - Only the Other Payer Amount Paid Qualifier value 07 [342-HC] will be accepted. This indicator signifies when the dollar amount paid by the other payer has been paid as part of the drug benefit plan.

MO HealthNet will no longer allow providers to submit a 02 in the Eligibility Clarification Code [309-C9] to bypass TPL edits.

LONG-TERM CARE DISPENSING FEE

In NCPDP vD.0 the qualifications for determining the controlled dose long-term care prescription fee differential will be based on Patient Residence [384-4X], values 02 or 03 and Special Packaging Indicator [429-DT], values 03 or 04.

Patient Residence	
Code	Description
02	Skilled Nursing Facility
03	Nursing Facility

Special Packaging Indicator	
Code	Description
03	Pharmacy Unit Dose
04	Custom Packaging

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the red or white card.

Provider Communications Hotline
573-751-2896

RES C I N D E X
see Vol. 34, No.