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MoHealthNet

PROVIDER BULLETIN

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HIPAA and CORE Phase I and II System Enhancements

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HIPAA/CORE PHASE I AND II CHANGES

In order to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA) and Committee on Operating Rules for Information Exchange (CORE) Phase I and II Operating Rules for Eligibility and Claim Status, the following system improvements will be implemented on April 14, 2013 to enhance claims and transaction processing.

- New Other Payer attachment on pharmacy claims through eMOMED
- D.0 batch response changes
- New HCIdea prescriber validation database for pharmacy claims
- 837I facility type changes
- CORE Phase I and II
  - Data content
  - AAA error reporting
  - Availability
  - Web services

eMOMED PHARMACY CLAIM OTHER PAYER ATTACHMENT

Adding an Other Payer attachment to the eMOMED pharmacy claim will enable the MO HealthNet Division (MHD) to collect the same detailed coordination of benefit (COB) information that is currently received on National Council for Prescription Drug Programs (NCPDP) transactions. Users will be allowed to enter up to 9 Other Payer attachments to the

pharmacy claim screen when the Other Coverage Code (OCC) is 2, 3 or 4. When a user selects OCC 2, 3, or 4 they will be required to fill out the Other Payer attachment. The following fields will be added to the eMOMED pharmacy claim screen:

- Other Payer Coverage Type – Determines the order in which the claim was paid by other payers and is a required field.
- Other Payer ID Qualifier – Required when Other Payer ID field is populated.
- Other Payer ID – Determines the ID of prior payers and is not a required field.
- Other Payer Date – The date prior payer processed the claim and is not a required field.
- Other Payer Amount Paid Qualifier – Indicates the type of payment made by a prior payer. This field will be a required field if other payer amount paid is populated for the corresponding occurrence and will have a drop down list with valid values.
    - Only the Other Payer Amount Paid Qualifier value of 07-Drug Benefit will be used to determine the Third Party Liability (TPL) amount that will be considered for payment.
- Other Payer Amount Paid - Indicates the amount paid by a prior payer. This is a required field if the OCC 2 or 4 is populated.
- Other Payer Reject Code –Indicate the reason the prior payer did not pay the claim. Up to 5 reject codes can be entered. This field will be required field if the OCC 3 is populated.
- Patient Responsibility Amount Qualifier – The type of patient responsibility amount returned by prior payer. This is required if Other Payer Patient Responsibility Amount is populated.
    - Only the Patient Responsibility Amount Qualifier value of 06-Patient Pay Amount will be considered for payment.
- Patient Responsibility Amount – Indicates the patient responsibility amount returned by prior payer. This will be required when at least one occurrence of 2 or 4 in the OCC.

D.0 BATCH RESPONSE

The NCPDP D.0 batch translator will no longer reject the entire batch if there is an error in any transaction within the batch. Only transactions within the detailed record that have issues and/or errors will be rejected. Remaining error free transactions within the same detail record and error free transactions in other detailed records of the batch will be accepted and processed. If the batch Header or Trailer records have issues and/or errors, the entire batch will be rejected. Compound claims will have a single combined response for all the ingredients that are part of the compound drug.

HCIdea PRESCRIBER DATABASE

MHD has contracted with NCPCP to obtain their HCIdea prescriber database. This will allow MHD to accept and validate NPIs in the prescribing physician field. The addition of the HCIdea prescriber database will help with claims adjudication, validating prescribers, drug utilization review and surveillance.

837 INSTITUTIONAL CLAIMS FACILITY TYPE CODE CHANGES

Facility Type Codes (the second and third digits of the Type of Bill Code) identify where services were performed. Facility Type Codes determine the claim type that will be

generated. For example, Facility Type Code 11 will generate an inpatient hospital claim with a Type of Bill 111, the first digit of the Type of Bill is a leading zero.

- For outpatient claims, MHD will begin generating an outpatient claim denial for any claim that contains Facility Type Codes that are not covered under MHD policy. A claim denial will now serve to alert the provider that a non-covered Facility Type Code has been submitted. There will be no changes to how MHD generates home health or inpatient claims.
- Facility Type Code 66 will be added to the MHD covered list of codes for generating a nursing home claim. Facility Type Codes 24, 25, 26, 27, and 29 will be removed from the list of covered codes for generating nursing home claims because these facility types are no longer covered under MHD policy. With this implementation, nursing home claims will be generated if MHD covered Facility Type Codes 21, 22, 23, 28, 65, or 66 are received on an 837I Institutional Claim.
- Facility Type Codes 72, 73, and 79 will be added to the MHD covered list of codes for generating outpatient claims. With this implementation, outpatient claims will be generated if MHD covered Facility Type Codes 13, 14, 71, 72, 73, 79, 81, 82, or 85 are received on an 837I Institutional Claim.
- The following Facility Type Codes will be added to the MHD covered list of codes for generating Medicare/Medicaid crossover claims.
  - Medicare UB-04 Part A Institutional and Part C Institutional
    - 65 code for nursing home crossover
    - 66 code for nursing home crossover
    - 86 code for nursing home crossover
  - Medicare UB-04 Part B Professional and Part C Professional
    - 43 code for outpatient crossover
    - 77 code for outpatient crossover
    - 78 code for outpatient crossover
    - 79 code for outpatient crossover
    - 84 code for outpatient crossover
    - 89 code for outpatient crossover

Facility Type Codes 17, 27, and 51 will be removed from the MHD covered list of codes for creating Medicare UB-04 Part A Institutional and Part C Institutional Crossover claims. Facility Type Code 24 will be removed from the MHD covered list of codes for creating Medicare UB-04 Part B Professional and Medicare UB-04 Part C Professional Crossover claims.

CORE OPERATING RULES PHASE I AND PHASE II

All HIPAA-covered entities are required to adopt the Council for Affordable Quality Healthcare's (CAQH) CORE Phase I and II Operating Rules for Eligibility and Claim Status. MHD will implement system changes to correspond with the operating rules April 14, 2013. For more information about the CORE operating rules, visit www.caqh.org.

CORE: DATA CONTENT CHANGES FOR PARTICIPANT ELIGIBILITY REQUEST & ELIGIBILITY RESPONSE TRANSACTIONS

Effective April 14, 2013 the following changes will be made for eligibility requests and responses:

- For a generic inquiry (Service Type = 30), the eligibility response will now include Eligibility Benefit Segments for each of the required service types required by CORE. See column "Service Type Codes Required for a Generic Inquiry" in the table below.
- MHD will support explicit eligibility inquiry requests for the CORE required service types. See column "Service Type Codes Required for an Explicit Inquiry" in the table below.
- Patient financial responsibility information for copayment will be reported by sending an Eligibility Benefit Segment with a value of "B - Copayment" on the eligibility response. If it is not a service type for which CORE mandates the reporting of patient financial responsibility information or if copayment can only be determined based on claim information, a copayment eligibility segment will not be sent. Patient financial responsibility information will only be returned for service type codes marked 'Mandatory' in the table below.

CORE Service Type Code Table

Service Type Codes	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Return Patient Financial Responsibility Information
1 Medical Care	Y	Y	**Discretionary**
2 Surgical		Y	Mandatory
4 Diagnostic X-Ray		Y	Mandatory
5 Diagnostic Lab		Y	Mandatory
6 Radiation Therapy		Y	Mandatory
7 Anesthesia		Y	Mandatory
8 Surgical Assistance		Y	Mandatory
12 Durable Medical Equipment Purchase		Y	Mandatory
13 Ambulatory Service Center Facility		Y	Mandatory
18 Durable Medical Equipment Rental		Y	Mandatory
20 Second Surgical Opinion		Y	Mandatory
30 Health Benefit Plan Coverage	Y	Y	Mandatory
33 Chiropractic	Y	Y	Mandatory
35 Dental Care	Y	Y	**Discretionary**
40 Oral Surgery		Y	Mandatory
42 Home Health Care		Y	Mandatory
45 Hospice		Y	Mandatory
47 Hospital	Y	Y	Mandatory
48 Hospital - Inpatient	Y	Y	Mandatory
50 Hospital - Outpatient	Y	Y	Mandatory
51 Hospital - Emergency Accident		Y	Mandatory
52 Hospital - Emergency Medical		Y	Mandatory
53 Hospital - Ambulatory Surgical		Y	Mandatory
62 MRI/CAT Scan		Y	Mandatory
65 Newborn Care		Y	Mandatory
68 Well Baby Care		Y	Mandatory
73 Diagnostic Medical		Y	Mandatory
76 Dialysis		Y	Mandatory
78 Chemotherapy		Y	Mandatory

Service Type Codes	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Return Patient Financial Responsibility Information
80 Immunizations		Y	Mandatory
81 Routine Physical		Y	Mandatory
82 Family Planning		Y	Mandatory
86 Emergency Services	Y	Y	Mandatory
88 Pharmacy	Y	Y	**Discretionary**
93 Podiatry		Y	Mandatory
98 Professional (Physician) Visit - Office	Y	Y	Mandatory
99 Professional (Physician) Visit - Inpatient		Y	Mandatory
A0 Professional (Physician) Visit - Outpatient		Y	Mandatory
A3 Professional (Physician) Visit - Home		Y	Mandatory
A6 Psychotherapy		Y	**Discretionary**
A7 Psychiatric - Inpatient		Y	**Discretionary**
A8 Psychiatric - Outpatient		Y	**Discretionary**
AD Occupational Therapy		Y	Mandatory
AE Physical Medicine		Y	Mandatory
AF Speech Therapy		Y	Mandatory
AG Skilled Nursing Care		Y	Mandatory
AI Substance Abuse		Y	**Discretionary**
AL Vision (Optometry)	Y	Y	**Discretionary**
BG Cardiac Rehabilitation		Y	Mandatory
BH Pediatric		Y	Mandatory
MH Mental Health	Y	Y	**Discretionary**
UC Urgent Care	Y	Y	Mandatory

- Up to 45 EB segments will be sent on the eligibility response whenever applicable. **Eligibility requests with a large date span run the risk of receiving incomplete responses; therefore, MHD recommends that requests be limited to no more than two months at a time.**
- Providers may request a benefit coverage date 12 months in the past or up to the end of the current month in increments of two months span of time. If an eligibility request is submitted outside of this time period on an eligibility request, the request will be rejected with Reject Reason Code ”62 – Date of Service Not Within Allowable Inquiry Period”.
- Authentication, Authorization and Accounting (AAA) Error reporting defines a standard way to report errors that caused the system to be unable to respond to the eligibility request. Up to four AAA error codes will be reported on the eligibility response whenever applicable. Code values can be found in the Accredited Standards Committee (ASC) X12 version 5010 standard 270/271 Eligibility Request implementation guide located at http://store.x12.org/store/.
- Name Normalization will be applied to the Last Name field submitted on an eligibility request. During an eligibility search for a participant using the Last Name, First Name and Date of Birth, the system will remove the following character strings when they are preceded by a space, comma, or forward slash and followed by a space or at the end of the data element: JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV and ESQ.

CORE: WEB SERVICE CONNECTIVITY FOR ELIGIBILITY AND CLAIM STATUS REQUESTS

Beginning June 1, 2013, Wipro may be contacted to initiate Web Services Connectivity as an alternative option for submission of Eligibility (270/271) and Claim Status (276/277) transactions. Real-time and Batch requests will be supported. If interested in setting up a web services connection, please contact the Wipro Infocrossing Help Desk at 573/635-3559. The Wipro Help Desk will then work with your technical staff or those that submit on your behalf to begin a process of establishing the new connection between the Trading Partner and Wipro. Information will need to be shared between both parties and tests will be requested before production files may be transmitted.

CORE: ELIGIBILITY AND CLAIMS STATUS REQUEST AVAILABILITY

Beginning April 14, 2013, MHD will publish system downtimes for eligibility and claim status requests on the MHD provider web site at http://dss.mo.gov/mhd/providers/. Non-routine downtime will be published on eMOMED at least one week in advance. MHD will notify providers of unscheduled downtimes on eMOMED.

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