

Date: Fri, Jul 11, 2003

Subject: Weekly DHS Provider Communication: Business Rules

Attached is a draft of the DHS Proposed Business Rules for these transactions - 835, 820, 834 - that many of you helped us shape at our recent work session. We said that we would get this draft out to you this week.

Please review these draft rules and get your comments or questions back to me by next Friday, July 18. You can do this via email or give me a call. Thanks so much!

Trish Neiworth
DHS HIPAA Communication Officer
503-945-5859
MMIS Project
503-378-2101, ext 363
trish.neiworth@state.or.us



DEPARTMENT OF HUMAN SERVICES PROPOSED BUSINESS RULES: 835, 820, 834

Background

DHS has increased its dialogue with its trading partners and has pursued a collaborative approach to developing business rules around its system limitations. The current MMIS system is a 30-year-old mainframe-based operation that has been modified almost continuously in response to changing business processes and legal requirements. Because of this, DHS is somewhat limited in what more it can modify in its current system and maintain operations.

Previously, DHS held a work session to develop business rules for the 837 inpatient transactions. DHS in conjunction with its business partners narrowed the scope of the MMIS enhancement needed to only 837 institutional claims. The solution means that trading partners will be able to send in all HIPAA complaint transactions up to 999 lines (institutional claims) and the dollar amount per line can exceed \$99,999.99 up to 18 characters. DHS is creating a process to "roll up" transactions exceeding line limits.

DHS held an additional work session with its trading partners on June 18, 2003 to determine the need for business rules on three other HIPAA EDI payment transactions. At the meeting, the group agreed on the following business rules pertaining to the 835, 820, and 834 transactions. The proposed business rules from the work session are as follows:

835 – Payment

Transaction Purpose

The 835 transactions will be used by OMAP for sending explanations of benefits (EOB) related to the adjudication of a claim(s) received the previous week to the health care provider(s). Payments from OMAP will be by a paper check.

Proposed Business Rules

1. Payments and RA's will be sent separately
2. Same rules for FFS and Encounter transactions
3. 837 rollup claims will have detail at the rollup level. 837 over 28-line claims that can not be processed by the new rollup program will be rolled up manually. The submitter will be notified as to how the claim was rolled up and what information will appear on the associated 835.
4. Loop 2000 – provider summary will **not** be used
5. DHS will not fully populate all claim segment loops. The number of loop repeats was specified in the 835 Data Mapping Requirements document.
6. 835 transactions will go to the organization designated by the provider/electronic submitter.
7. An 835 transaction will be sent for each 837 transaction
8. Paper in – Paper out policy (if it is submitted in paper format, it will be sent out in paper format). This also implies that DHS will have an "Electronic In – Electronic Out" policy.



DEPARTMENT OF HUMAN SERVICES PROPOSED BUSINESS RULES: 835, 820, 834

9. DHS will maintain and display at a secure, designated FTP site eight consecutive weeks of the 835 transaction files, Split/Roll Report, History Pend File and Test Reports.

820 – Remittance Advice

Transaction Purpose:

The 820 transactions for Remittance Advice are for the purpose of reporting payroll deducted insurance premiums. The premium can be associated with health care, individual life, disability and/or property and casualty contracts.

It can be used to initiate an electronic payment with the associated remittance details, or send the payment and remittance details separately to the receiver. The payment can be either electronic or paper check. When payment and remittance information are sent separately, the 820 transaction has provided a method for associating the two.

This transaction will be used to send notification of capitation payments to Prepaid Health Plans (PHP). The paper check will continue to be produced and mailed through OMAP'S weekly remittance advice process.

Proposed Business Rules

1. Paper checks will continue to be handled via regular payment process.
2. Table 2 Organization Summary will **not** be used.
3. Files will be date stamped and retained
4. Include all adjustments

834 – Benefit Enrollment and Maintenance

Transaction Purpose

This transaction is used to transfer enrollment information from the payer/sponsor (DHS) of the insurance coverage to a payee (Prepaid Health Plan). The 834 transaction will be used to provide updates (weekly – new and closed) and full file refresh (monthly – new, closed and ongoing).

OMAP enrolls and/or disenrolls clients into managed health care plans using numerous criteria. These examples include benefit packages, program eligibility, geographic area, availability of health care plan, etc. Once enrollment is made, an "enrollee" file is sent weekly to the plans listing new clients, and clients no longer in the plan. Once a month, the plans will get a total refresh of new, closed and ongoing clients.

Proposed Business Rules

1. Provide weekly updates and full monthly refresh information.



**DEPARTMENT OF HUMAN SERVICES
PROPOSED BUSINESS RULES: 835, 820, 834**

2. Excluded data will be included in segment 2300.
3. 834 transactions will contain **only** enrollment information.
4. Include 820 adjustments in this.

Transition Process

DHS will accept non-compliant electronic transactions up to 2:00 p.m. on September 25, 2003. All electronically submitted claims after that date must be HIPAA compliant. The Bulletin Board will close and cease operationally after claim processing on September 25, 2003, to allow DHS sufficient time to process, pay, adjudicate or deny claims.

Fee For Service Process

DHS will process FFS suspended claims up to October 10, 2003. If claims have not adjudicated by that date, DHS will deny all remaining FFS claims. FFS providers will receive a Remittance Advice identifying those claims. DHS will continue to accept FFS paper claims. Paper submissions are affected by medical code changes.

Encounter Process – Pre-HIPAA Data

Encounter claims submitted September 22-25, 2003, will receive the current weekly Status file, which displays MMIS processing of claims that week in the “B” portion and outstanding historical pends in the “P” portion. On September 28, 2003, all outstanding pended claims will be deposited in a new History Pend File. The History Pend File will maintain the same format as the current history portion of the Status File.

Encounter Process - HIPAA Format Data

Encounter claims submitted on an 837 will receive an 835 displaying MMIS processing of claims that week. Pended claims in the 835 will be displayed in the History Pend File the following week. Encounter HIPAA and Pre-HIPAA pended claims will reside in one History Pend File.

Next Steps

DHS will finalize the proposed business rules with provider input, by July 30, 2003.

DHS has not yet determined how it will handle adjustments to the 820/834 for “retro” checks. As soon as this information is available it will be shared with the managed care plans.

Another work session will be held, on the Inquiry Transactions. (270, 271, 276, 277, 278). DHS will schedule and host this work session July 26, from 1-4 p.m.

Transition to the new system, Sept. 25, 2003. HIPAA Compliant: Oct. 16, 2003.