

To: EDI Providers Group
Date: Thu, Jul 31, 2003
Subject: Weekly providers communication

We have several items to share with you this week. Thank you all for your input and suggestions to the business rules for the 835, 820 and 834 transactions. Attached are the final business rules as a result of your input. They will be posted at: www.dhs.state.or.us/admin/hipaa

Some personnel changes are also occurring in the DHS HIPAA Project Office over the next few weeks that you should be aware of.

DHS HIPAA Project Manager Steve Caputo will be leaving his post as of July 31, 2003. DHS HIPAA Technical Lead Jarred Clark will be assuming Caputo's duties as Project Manager as of that date. Steve Schafer is being loaned to DHS from the Department of Administrative Services to provide project oversight.

DHS HIPAA Communication Officer Trish Neiworth will be concluding her work on the project as of Aug. 7, 2003. Clark will become your key communication point of contact during this transition period. He can be reached at: 503-947-5378 or at jarred.e.clark@state.or.us

Rick Howard, of OMAP, and Fariborz Pakseresht, DHS Deputy Chief Administrative Officer, will also continue to be available to the trading partner community if you have any questions or issues.

DHS remains committed to continuing the partnership it has built with you - our trading partners - on the HIPAA project. We have been able to work through some difficult issues in the past few months and your willingness to work with us on these challenges has made all the difference. DHS looks forward to being able to build on this positive working relationship, as a model for its future dealings with all of you.

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 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 current system limitations. The DHS 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 transaction. DHS in conjunction with its business partners narrowed the scope of the MMIS enhancement needed to 837 institutional inpatient claims only. 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 and in some cases split detail lines that exceed the dollar limitation.

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 business rules from the work session are as follows:

835 – Remittance Advice

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. OMAP will send in payments separately in the form of a paper check. The 835 transaction will **not** be used as a pre-authorization transaction.

Business Rules

1. Payments and the 835 Remittance Advice will be sent separately. DHS will place the electronic 835 in the submitter’s electronic mailbox.
2. DHS will attempt to have similar rules for FFS and Encounter transactions. For example, there are differences between what amounts to a zero dollar 835 (or 835 paid through a cap payment) and a FFS claims payment (non-capitated). MMIS will also maintain different edits for FFS and Encounter claims.
3. 837 rollup claims will have detail at the rollup level. Any 837 institutional over 28-line inpatient claim -- 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. DHS will **not** be splitting claims as a general rule. Claims lines would be split, only if the line exceeds \$99,999.99. See the business rules for over 28-line claims.
4. Loop 2000 – provider summary will **not** be used



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5. DHS will **not** fully populate all claim segment loops. The number of loop repeats was specified in the 835 Data Mapping Requirements document. See below:

CLM - Claim Date segment under 2100 loop – HIPAA has 4 repeats and OMAP uses maximum of 2 repeats. If DATE-CLM-SERV-BEG = DATE-CLM-SERV-END, use DATE/TIME qualifier = 232 for claim statement period start.

If the two input dates are different, use DATE/TIME qualifier 232 and 233 for claim statement period start and end.

CAS - Claim Adjustment segment of 2100 loop – HIPAA has 99 repeats and OMAP uses maximum of two repeats. There is a maximum of six adjustment trios on each repeat.

Create one adjustment loop for each exiting Claim adjustment Code group on the flat file and create one adjustment trio where adjustment amount (AMT-ADJ-REAS) each occurrence on file is greater than zero. Include adjustment reason code (OMP-CLM-ADJ-RSN-CD), but omit unit/quantity.

DTM - Service Date segment under 2110 loop – HIPAA has 3 repeats and OMAP uses maximum of 2 repeats. If DATE-PROC-SERV-BEG = DATE-PROC-SERV-END, use DATE/TIME qualifier 472 for Single Date service. If the two dates are different, use DATE/TIME qualifier 150 and 151 for service period start and end.

CAS - Service Adjustment segment under 2110 loop – HIPAA has 99 repeats and OMAP uses maximum of two repeats. There are six adjustment trios on each repeat. Apply same rules for CAS Claim Adjustment Segment here.

LQ - Health Care remark codes segment under 2110 loop – HIPAA has 99 repeats and OMAP uses maximum of 12 repeats. Map each existing code on the flat file to a new LQ segment.

PLB Provider Adjustment under Summary - create one Provider adjustment segment for each existing 'T835-9999' record. HIPAA has five of the adjustment trio, and OMAP only uses one, but omit PLB03-2 Provider Adjustment identifier.



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6. 835 transactions will go to the organization designated by the provider/electronic submitter.
7. An 835 transaction will be sent for each weekly processing and/or payment cycle.
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. DHS will do electronic adjustments, as needed. A trading partner that chooses to send some claims in electronically must send in all its claims electronically. The DHS processing has separate tracks for paper claims and electronic claims. The design does **not** allow an 835 to be sent out for a paper claim.
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. The 835 will contain all information related to MMIS processing of claims for the week. MCOs do not have to use the history PEND file to obtain a complete set of pended data. As a courtesy, DHS will continue reporting the History PEND report (one week lag), should the MCO wish to use it for the purpose of gathering all pended claims from one report.

820 – Premium Payment

Transaction Purpose:

The 820 transactions for Premium Payments 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.

Business Rules

1. Paper checks will continue to be handled via regular payment process.
2. Table 2 Organization Summary will **not** be used. The RMR -- Organization Summary Remittance Detail loop is required.
3. Files will be date stamped and retained
4. Include all adjustments



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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 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 PHP listing new clients, and clients no longer in the plan. Once a month, the PHP will get a total refresh of new, closed and ongoing clients.

Business Rules

1. Provide weekly updates and full monthly refresh information.
2. Excluded data will be included in segment 2300.
3. 834 transactions will contain **only** PHP enrollment information.
4. Include 820 adjustments in this.

Next Steps

1. DHS will develop companion guides for the 835, 820, and 834 transactions based upon the above Business Rules. The companion guides will be circulated to DHS trading partners prior to being finalized.
2. DHS will create a document that outlines its approach for the transition from Legacy operations to EDI/HIPAA operations.
3. DHS will provide information on how adjustments will be handled as soon as it is available.