

## **Weekly Trading Partner Communication**

### **08/29/03**

This week we want to provide you with some information about the DHS Service Continuation Plan as well as highlight an issue regarding the 837D Transaction. Your feedback on both of these issues is greatly appreciated.

### **DHS Service Continuation Plan**

The goal of the DHS Service Continuation Plan is to:

1. Outline the DHS approach to HIPAA compliance for each transaction;
2. Provide guidance to DHS trading partners regarding alternative ways to continue services to clients and maintain cash flow; and
3. Provide an opportunity for DHS and the trading partner community to collaboratively address HIPAA challenges while actively working toward compliance.

Attached you will find the DHS Service Continuation Plan in draft form. It defines how DHS and its partners will conduct its EDI business as we work toward HIPAA compliance.

Please review this document thoroughly. DHS developed this draft using information gathered from our numerous interactions with the trading partner community regarding contingency planning. We hope this draft will answer some of your current questions, as well as raise others that will ultimately better prepare us for compliance.

Our goal is to receive your comments and suggestions by close of business September 5, then incorporate them into the DHS Service Continuation Plan and distribute Version 1.0 in the September 12 weekly email.

Please send your comments and suggestions should be directed to Jarred Clark, DHS HIPAA Transactions & Code Sets Project Manager.

DHS appreciates your suggestions and ideas in our effort toward HIPAA compliance.

### **837D Transaction**

Also attached to this week's email, you will find a document that outlines an issue DHS is trying to resolve with its dental trading partners. As suggested in the last OMAP Contractors meeting, we wanted to review this issue in a weekly email message to solicit your review and comments, rather than hold a special meeting on the topic.

If this issue applies to your organization, please review the attached document and provide comments directly to Nancy Buck, OMAP HIPAA Coordinator by the close of business September 5. We will evaluate the responses we receive, report back to the contractors group and work quickly to come to a consensus on a solution.

## **DHS HIPAA Transactions & Code Sets Project**

### **837 Dental Claim Transaction Over 28-line**

August 19, 2003

#### **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 can be modified in its current system and continue to maintain operations.

Previously, DHS held a work session to develop business rules for the 837 in-patient transaction. DHS, in conjunction with its trading partners, narrowed the scope of the MMIS enhancement needed to only 837 institutional in-patient claims. The solution means that trading partners will be able to send in all HIPAA compliant transactions up to 999 lines (institutional in-patient 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 teleconferences with trading partners on July 7, 2003 and again on July 17, 2003 to discuss how to handle Dental Claims (837 D) that are over 28-lines. These meetings served as a follow-up to a work session that DHS held with its trading partners on the handling of over 28-line in-patient claims. Whereas, in-patient claims lend themselves to being rolled up into fewer than 28-lines, the nature of dental claims will not allow the same methodology. Dental claims require that tooth surfaces and procedure codes maintain their identity in order for the claim to be adjudicated. Any roll up methodology would lose this identity and could result in a roll up being adjudicated differently by DHS. The only solution that would continue to maintain the integrity of the claim editing process would be splitting an over 28-line claim into two or more claims. However, DHS estimates that given its current work load and focus on HIPAA implementation it will not be able to complete this work by the October 16, 2003 compliance deadline.

#### **Interim Options available for 837 Dental Claims Over 28-lines**

1. Continue the current practice. Submitters should split the claim into two or more claims.
2. Claims submitted over 28-lines can be truncated, paying only up to the 28<sup>th</sup> line.
3. DHS or Providers can look for roll up methodology for example: X-rays rolled up into the same line.
4. For encounters, DHS could pay up to 28-lines and provide a separate file that captures the truncated encounter data beyond the 28-lines.
5. Fee for service claims over 28-lines may be submitted on paper.

#### **DHS Compliance Action Plan**

DHS will work with the trading partner community to develop the appropriate business rules for a HIPAA compliant solution related to the 837 Dental Claims that are over 28-lines. Currently DHS is projecting that the HIPAA compliant solution will be available in the second quarter of 2004.

**OREGON  
DEPARTMENT OF HUMAN RESOURCES**

**HIPAA  
Transactions & Code Sets  
Service Continuation Plan**

**August 2003**

**Version 1.0**

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<b>Version Number</b>	<b>Creation Date</b>	<b>Comments</b>
<b>0.1</b>	<b>Aug 15, 2003</b>	<b>Initial internal draft</b>
<b>0.2</b>	<b>Aug 18, 2003</b>	<b>Second internal draft</b>
<b>0.3</b>	<b>Aug 21, 2003</b>	<b>Third internal draft</b>
<b>0.4</b>	<b>Sep 2, 2003</b>	<b>Fourth internal draft</b>
<b>1.0</b>	<b>Sep 12, 2003</b>	<b>Version 1.0 distributed in 9/12 message.</b>

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## 1. Introduction

Over the past two years, DHS has worked diligently toward HIPAA compliance. As we get closer and closer to October 16, 2003, it is clear that not everyone will be compliant. As with all major systems projects, the implementation of HIPAA includes some unknowns and risks that can delay implementation. These include risks related to technical problems that may exist, and possible delays in completing design or development tasks on time. Possible problems in the implementation approach may manifest themselves during testing, and there is also the possibility that some trading partners may not be able to comply with the new standards by the required implementation date. If any such risks delay implementation of one or more transaction standards, the DHS cannot afford to stop receiving, sending or processing electronic transactions. DHS must have available alternatives that support health care delivery to members while complying with HIPAA to the maximum extent possible.

The DHS Service Continuation Plan is intended to communicate to trading partners how DHS plans to achieve HIPAA compliance and provides guidance for trading partners to follow in the event that compliance is not possible by October 16, 2003.

### **The DHS Service Continuation Plan Goals include:**

1. Working collaboratively through outreach and testing;
2. Ensuring clients are served and access to health care is maintained; and
3. Maintaining cash flow to trading partners.

### **Service Continuation Plan Scope**

The DHS Service Continuation Plan specifically addresses and is limited to HIPAA Transactions and Code Sets. General business risks are addressed in other state planning documents including business continuity plans, which deal with possible events such as major hardware or structural losses and plans for notifying and mobilizing key personnel to deal with these events.

### **Service Continuation Plan Concepts**

The DHS Service Continuation Plan recognizes the risks associated with HIPAA Transactions and Code Sets development, and identifies the "Service Continuation" alternatives that provide possible interim solutions to delays in implementation. These can be thought of as "fall back" positions that allow DHS and its trading partners to fulfill their primary missions while moving as quickly as possible to full compliance. "Service Continuation" alternatives were developed with input from both DHS operational and technical staff regarding the feasibility of possible options as well as members of the Oregon HIPAA Forum representing the trading partner community.

Each "Service Continuation" alternative identified has been assessed to evaluate and document its potential advantages and disadvantages. Specific elements for each "Service Continuation" alternative have been identified and include the following:

#### **Transaction Compliance Approach Description**

The description of the transaction compliance approach provides a high level summary of the DHS implementation plan for each standard transaction.

#### **"Service Continuation" Alternative Description**

The description of the alternative provides a high level summary of how it would support a continuation of business functions if a particular standard transaction were not implemented on time.

**Status**

The status of the alternative defines it as available, implemented or unavailable. The alternative would remain available as long as it is feasible to implement from a business and technical standpoint. After the need for the alternative has passed, the alternative is rejected as infeasible, or the alternative can no longer be implemented due to business or technical limitations, or the alternative is unavailable.

**Start Date/Complete Date**

If an alternative were implemented, it would have a start date when it becomes operational, and an expected completion date to indicate when it should be complete or no longer necessary.

**Compliance Action Plan**

When an alternative is implemented an action plan(s) will be developed describing actions that will be undertaken to resolve the delay, who will be responsible for the actions and when resolution is expected. The action plan(s) will then be tracked to assure that the problem is resolved and implementation can proceed. (Detailed Compliance Action Plans will be developed independently of this document and may be specific to individual trading partners.)

The DHS Service Continuation Plan uses the above elements to develop alternatives to the standard HIPAA Transaction and Code Sets implementation schedule. Each transaction set was analyzed to identify which alternative actions are available if the primary plan for complying with HIPAA cannot be implemented. The plan documents steps required for each alternative, and the duration of each available alternative. In some cases, the alternatives identified are not feasible. The alternative may be too costly or difficult to implement, or may not be effective in meeting business requirements. These are identified with a status of unavailable. Those that are considered feasible have a status of available, or of implemented if they have been put into effect.

The following sections describe the DHS plan for HIPAA Compliance and the alternatives that are available and necessary to maintain both access to health care and cash flow.

**Note:** This document is intended to communicate service continuation alternatives. It is likely that as we get closer to the compliance date and continue to work through compliance issues and through collaboration with trading partners that this document will be updated to reflect ongoing compliance efforts.

## 2. Transactions and Code Sets Data Transmission

<b>Transaction Compliance Approach Description</b>	The Oregon DHS MMIS has an extensive and proven capability for the transmission of data to MCOs, providers and other trading partners. Nevertheless, the implementation of HIPAA compliant formats for electronic interchange of health care data represents a significant change in the stream of mechanisms for delivering data with a unique potential for disruption of transmission services. In particular this may impact the distribution of data to trading partners via the file transfer protocol process (FSTP) using secure shell (SSH) technology for encryption during the first days of HIPAA production implementation. For example, even a small change to a parameter setting in the programs that govern the complex of software "firewalls," routing equipment, data servers and operating system software has the potential for disrupting a trading partners ability to retrieve data processed by the MMIS. In some cases the re-establishment of this ability may require the cooperative efforts of trading partner and MMIS technical staffs. Typically these types of issues can be resolved expeditiously. However, in the event that service is disrupted for a number of Trading Partners, the time to resolve issues for all trading partners may result in a service outage.
<b>Service Continuation Alternative Description</b>	To deal with this risk, the DHS will provide for a contingency to create and distribute data files in a HIPAA compliant format on CD-ROM media for the short period of time anticipated to be necessary to remediate data transmission and/or system connectivity problems.
<b>Status</b>	<b>Unavailable</b>
<b>Start Date/Complete Date</b>	Upon emergency and until resolution
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 12/31/03.

### 3. 837P Claim Transaction – Fee-For-Service

<b>Transaction Compliance Approach Description</b>	<p>Currently, MMIS uses the NSF (National Standard Format) and ADA specifications for accepting claims. NSF 1.0 is used for accepting the CMS (formerly HCFA 1500) NSF claims; the 1500/CMS 1500 will be replaced with the 837 professional claim specification. The Oregon MMIS will transition to use of the 837P format by 9/2/2003.</p> <p>The MMIS processes a significant volume of claims each month, a significant portion of which are submitted electronically. This makes it imperative that there be an orderly transition from the NSF formats to the HIPAA formats, so as not to disrupt the flow of payments to providers and to minimize manual handling of claims during a period of severe budgetary constraints for Oregon DHS and its trading partners.</p> <p>There are two situations that may affect implementation of the 837P transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 837P claims transaction as planned</li> <li>• One or more fee-for-service providers are not ready to send the 837P claim transaction as planned.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>DHS trading partners should continue using the CMS 1500 Claim until business-to-business for the 837P has been completed and a controlled transition for each trading partner is agreed to.</p> <p>The trigger date for invoking this option should give trading partners at least 30 days notice that they will need to continue submitting in the pre-HIPAA formats. Implementation of this option should involve minimal additional effort by applications staffs, since this option simply involves continuing use of existing systems and procedures.</p>
<b>Status</b>	<b>Available</b>
<b>Start Date/Target Completion Date</b>	10/16/03 to 12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 12/31/03.

#### 4. 837D Claim Transaction – Fee-For-Service

<b>Transaction Compliance Approach Description</b>	<p>MMIS has the capability of accepting dental claims using a modified version of the CMS 1500 (NSF 1.0). Dental claims are submitted to MMIS using the CMS 1500/NSF format. The Oregon MMIS will transition to use of the 837D format by 9/2/2003.</p> <p>The MMIS processes a significant volume of claims each month, a significant portion of which are submitted electronically. This makes it imperative that there be an orderly transition from the NSF formats to the HIPAA formats, so as not to disrupt the flow of payments to providers and to minimize manual handling of claims during a period of severe budgetary constraints for the Oregon DHS and its trading partners.</p> <p>There are two situations that may affect plans for implementing the 837 transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 837D claims transaction as planned</li> <li>• One or more fee-for-service providers are not ready to send the 837D claim transaction as planned.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>DHS trading partners should continue using the CMS 1500 Claim until business-to-business for the 837D has been completed and a controlled transition is agreed to.</p> <p>The trigger date for invoking this option should give trading partners at least 30 days notice that they will need to continue submitting in the pre-HIPAA formats. Implementation of this option should involve minimal additional effort by applications staffs, since this option simply involves continuing use of existing systems and procedures.</p>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 to 12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 12/31/03.

## 5. 837I Claim Transaction – Fee-For-Service

<b>Transaction Compliance Approach Description</b>	<p>The 837I health care claim transaction will be used to transmit claims for payment for services provided by authorized institutions to Oregon Medicaid clients. MMIS has the capability of accepting institutional claims in the UB92 claims Version 5 and 6 formats. The 837I will replace those formats. Oregon MMIS will transition to use of the 837I format by 9/2/03.</p> <p>The MMIS processes a significant volume of claims each month, a significant portion of which are submitted electronically. This makes it imperative that there be an orderly transition from the NSF formats to the HIPAA formats, so as not to disrupt the flow of payments to providers and to minimize manual handling of claims during a period of severe budgetary constraints for the Oregon DHS and its trading partners.</p> <p>There are two situations that may affect plans for implementing the 837I transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 837I claims transaction as planned;</li> <li>• One or more fee-for-service providers are not ready to send the 837I claim transaction as planned.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>DHS trading partners should continue using the UB 92 format until business-to-business for the 837I has been completed and a controlled transition is agreed to.</p> <p>The trigger date for invoking this option should give trading partners at least 30 days notice that they will need to continue submitting in the pre-HIPAA formats. Implementation of this option should involve minimal additional effort by applications staffs, since this option simply involves continuing use of existing systems and procedures.</p>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 to 12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 12/31/03.

**6. 837 P Claims Transaction – Managed Care Encounter**

<b>Transaction Compliance Approach Description</b>	<p>Currently, MMIS uses proprietary formats for submission of CMS (formerly HCFA 1500) NSF and UB92 encounter data.</p> <p>The 837P health care encounter transaction will be used by MCOs to submit encounters to the DHS. Oregon DHS will transition to use of the 837P format by 10/6/2003.</p> <p>Encounters are records of medical services (or visits) rendered by OMAP registered providers to members enrolled with an OMAP approved MCO on the date of service. Submission of encounter data by MCOs is a mandated requirement of the OMAP program. Encounter data is used for management and analytic purposes including:</p> <p>Evaluation of health care quality, evaluation of MCO performance, development of capitation rates, Fee-For-Service rate setting, determination of disproportionate share compensation for hospitals serving low income members and payment of reinsurance to applicable MCOs.</p> <p>MCOs must submit encounters to OMAP within 180 days from the date of service. This reporting requirement gives OMAP and the MCOs considerable flexibility with dealing with HIPAA implementation risks and contingencies -- within limits.</p> <p>There are two situations that may affect implementation plans of the 837P encounter transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 837P encounter transaction as planned;</li> <li>• One or more MCOs is not ready to send the 837P encounter transaction as planned.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>Alternatives for dealing with 837P encounter transaction include:</p> <p>DHS suspension of submission requirements</p>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 to 12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis.

## 7. 837D Claims Transaction – Managed Care Encounter

<b>Transaction Compliance Approach Description</b>	<p>Currently, MMIS uses proprietary formats for submission of CMS (formerly HCFA 1500) NSF and UB92 encounter data.</p> <p>The 837D health care encounter transaction will be used by MCOs to submit encounters to the DHS. Oregon DHS will transition to use of the 837D format by 10/6/2003.</p> <p>Encounters are records of medical services (or visits) rendered by OMAP registered providers to members enrolled with an OMAP approved MCO on the date of service. Submission of encounter data by MCOs is a mandated requirement of the OMAP program. Encounter data is used for management and analytic purposes including:</p> <p>Evaluation of health care quality, evaluation of MCO performance, development of capitation rates, Fee-For-Service rate setting, determination of disproportionate share compensation for hospitals serving low income members and payment of reinsurance to applicable MCOs.</p> <p>MCOs must submit encounters to OMAP within 180 days from the date of service. This reporting requirement gives OMAP and the MCOs considerable flexibility with dealing with HIPAA implementation risks and contingencies -- within limits.</p> <p>There are two situations that may affect implementation plans of the 837D encounter transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 837D encounter transaction as planned;</li> <li>• One or more MCOs is not ready to send the 837D encounter transaction as planned.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>Alternatives for dealing with 837D encounter transaction include: DHS suspension of submission requirement.</p>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 to 12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis.

**8. 837 I Claims Transaction – Managed Care Encounter**

<b>Transaction Compliance Approach Description</b>	<p>Currently, MMIS uses proprietary formats for submission of CMS (formerly HCFA 1500) NSF and UB92 encounter data.</p> <p>The 837I health care encounter transaction will be used by MCOs to submit encounters to the DHS. Oregon DHS will transition to use of the 837I format by 10/6/2003.</p> <p>Encounters are records of medical services (or visits) rendered by OMAP registered providers to members enrolled with an OMAP approved MCO on the date of service. Submission of encounter data by MCOs is a mandated requirement of the OMAP program. Encounter data is used for management and analytic purposes including:</p> <p>Evaluation of health care quality, evaluation of MCO performance, development of capitation rates, Fee-For-Service rate setting, determination of disproportionate share compensation for hospitals serving low income members and payment of reinsurance to applicable MCOs.</p> <p>MCOs must submit encounters to OMAP within 180 days of the date of service. This reporting requirement gives OMAP and the MCOs considerable flexibility with dealing with HIPAA implementation risks and contingencies -- within limits.</p> <p>There are two situations that may affect implementation plans of the 837I encounter transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 837I encounter transaction as planned;</li> <li>• One or more MCOs is not ready to send the 837I encounter transaction as planned.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>Alternatives for dealing with 837I encounter transaction include: DHS suspension of submission requirements.</p>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 to 12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis.

## 9. 835 Claims Remittance Transaction

<b>Transaction Compliance Approach Description</b>	<p>The 835 health care claim payment advice will be used by MMIS to send remittance information to providers. This will include information on denied claims. Information for claim payments that providers can use to reconcile their accounts and claim adjudication status. The Oregon MMIS will transition to use of the 835 format by 9/1/2003.</p>
<b>Service Continuation Alternative Description</b>	<p>Currently MMIS use proprietary systems for transmitting remittance information on claims. These systems communicate information on paid claims, adjusted claims, denied claims, voided claims, pended claims and claims in process. Payments are transmitted separately from the remittance advice. With respect to Prepaid Health Plans, the Remittance Advice file contains information on the adjudication status of claims submitted.</p> <p>There are two situations that may affect implementation plans for implementing the 835 remittance transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to send the 835 remittance transaction as planned;</li> <li>• One or more managed care organization or Fee-For-Service providers not ready to receive the 835 remittance transaction as planned.</li> </ul> <p>Six contingencies have been identified for dealing with 835 transaction risks:</p> <ul style="list-style-type: none"> <li>• Continue pre-HIPAA electronic remittance (FFS);</li> <li>• Supply providers with paper remittances (FFS) (<b>upon request</b>);</li> <li>• Use the 835 remittance transaction and continue pre-HIPAA electronic remittance for Fee-For-service (FFS);</li> <li>• Use the 835 remittance transaction and revert to paper remittances for non-compliant providers (FFS);</li> <li>• Continue MCO pre-HIPAA status file (MCO);</li> <li>• Use the 835-remittance transaction and create a status history file (previously pended data) for MCOs (MCO).</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/1/03 – 12/31/03
<b>Corrective Action Plan (CAP)</b>	<p>The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 12/31/03.</p>

**10. 820 Capitation/Premium Payment Transaction**

<b>Transaction Compliance Approach Description</b>	The 820 transaction communicates capitation payments to MCOs, and any adjustments or corrections to those payments. This information is currently communicated on a proprietary roster and data files provided to the MCOs. Oregon MMIS will transition to use of the 820 format by 10/1/03.
<b>Service Continuation Alternative Description</b>	<p>There are two possible situations/risks that could prevent the 820 transactions from being implemented according to plan:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to send the 820 transaction as planned;</li> <li>• One or more MCOs are not ready to receive the 820 transaction as planned.</li> </ul> <p>The trigger date for invoking this option should give trading partners at least 30 days notice that DHS will need to continue submitting in the pre-HIPAA formats. Implementation of this option should involve minimal additional effort by applications staffs, since this option simply involves continuing use of existing systems and procedures.</p> <p>The following alternatives apply to the 820:</p> <ul style="list-style-type: none"> <li>• Continue pre-HIPAA roster/capitation interfaces for all MCOs;</li> <li>• Provide MCOs with paper rosters (<b>upon request</b>);</li> <li>• Use the 820 transaction for compliant MCOs and continue pre-HIPAA interfaces for non-compliant MCOs;</li> <li>• Use the 820 transaction for compliant MCOs and provide non-compliant MCOs with hardcopy remittance summaries.</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 –12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 12/31/03.

**11. 834 Benefit Enrollment and Maintenance Transaction**

<b>Transaction Compliance Approach Description</b>	<p>The 834 transaction provides enrollment information to MCOs. This information is currently communicated to the MCOs on a proprietary roster and data files. Oregon MMIS will transition to use of the 834 format by 10/6/03.</p> <p>Daily rosters currently produced by MMIS provide MCOs with essential information on enrollment additions, terminations and changes. In addition a monthly roster provides data on all enrolled members, enabling MCOs to audit their data and account for payments. Timely receipt and processing of the rosters is essential to provide timely availability of medical services to OHP members. Currently, this need for timely information is provided to the MCOs through electronic roster files and supplements.</p>
<b>Service Continuation Alternative Description</b>	<p>There are two possible situations/risks that could prevent the 834 transaction from being implemented according to plan:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to send the 834 transaction as planned;</li> <li>• One or more MCOs are not ready to receive the 834 transaction as planned</li> </ul> <p>The trigger date for invoking this option should give trading partners at least 30 days notice that they will need to continue submitting in the pre-HIPAA formats. Implementation of this option should involve minimal additional effort by applications staffs, since this option simply involves continuing use of existing systems and procedures.</p> <p>Three alternatives have been identified for dealing with 834 transaction risks:</p> <ul style="list-style-type: none"> <li>• Continue pre-HIPAA roster interfaces for all MCOs;</li> <li>• Provide MCOs with paper rosters (<b>upon request</b>);</li> <li>• Use the 834 transaction for compliant MCOs and continue pre-HIPAA interfaces for non-compliant MCOs.</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 –12/31/03
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 12/31/03.

**12. 270 Eligibility Verification**

<b>Transaction Compliance Approach Description</b>	The 270 transaction would be used by external entities to request eligibility and enrollment information regarding OHP members. Oregon MMIS will transition to use of the 270 Eligibility Verification Transaction by 12/1/03.
<b>Service Continuation Alternative Description</b>	<p>The DHS already has a number of methods for responding to requests for eligibility verification. Those mechanisms for eligibility verification include:</p> <ul style="list-style-type: none"> <li>• Verification by contacting the OMAP, via telephone</li> <li>• Automated Voice Response System (AVRS)</li> <li>• On-line Eligibility Verification Access via Direct Connection</li> <li>• First Health Services Eligibility Verification</li> <li>• Via Electronic Eligibility Verification Vendors (EEVS)</li> </ul> <p>All of these current sources of information will continue to exist after HIPAA Transactions and Code Sets implementation. Ultimately, existing transaction mechanisms will be modified to ensure that their content is HIPAA compliant.</p> <p>In addition, the DHS must provide an inquiry and response mechanism that is compliant with HIPAA 270/271 requirements. A batch process that is currently under development has been designed to meet this HIPAA requirement, and should be in production by December 1, 2003.</p> <p>There are two possible situations/risks that could prevent the 270/271 transactions from being implemented according to plan:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 270-batch transaction as planned.</li> <li>• One or more providers are not ready to send the 270-batch transaction as planned.</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 – 4/30/04
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 4/30/04.

### 13. 271 Eligibility Response Transactions

<b>Transaction Compliance Approach Description</b>	The 271 transaction would be used by external entities to request eligibility and enrollment information regarding OHP members. Oregon MMIS will transition to use of the 271 Eligibility Verification Transaction by 12/1/03.
<b>Service Continuation Alternative Description</b>	<p>The DHS already has a number of methods for responding to requests for eligibility verification. Those mechanisms for eligibility verification include:</p> <ul style="list-style-type: none"> <li>• Verification by contacting the OMAP, via telephone</li> <li>• Automated Voice Response System (AVRS)</li> <li>• On-line Eligibility Verification Access via Direct Connection</li> <li>• First Health Services Eligibility Verification</li> <li>• Via Electronic Eligibility Verification Vendors (EEVS)</li> </ul> <p>All of these current sources of information will continue to exist after HIPAA Transactions and Code Sets implementation. Ultimately, existing transaction mechanisms will be modified to ensure that their content is HIPAA compliant.</p> <p>In addition, the DHS must provide an inquiry and response mechanism that is compliant with HIPAA 270/271 requirements. A batch process that is currently under development has been designed to meet this HIPAA requirement, and should be in production by December 1, 2003.</p> <p>There are two possible situations/risks that could prevent the 270/271 transactions from being implemented according to plan:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to send the 271-batch transaction as planned.</li> <li>• One or more providers are not ready to receive the 271-batch transaction as planned.</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 – 4/30/04
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 4/30/04.

**14. 276 Claim Status Transactions**

<b>Transaction Compliance Approach Description</b>	<p>MMIS would use the paired 276/277 health care claim status request and response transaction to receive and respond to requests for claim status information. Providers would use the 276 transaction to submit batch file requests for claim status information, which would be accepted by MMIS. Oregon MMIS will transition to use of the 276 Claim Status Transaction by 12/1/03.</p> <p>Currently, the MMIS has several mechanisms for receiving and responding to claim status requests. These mechanisms will remain in place after implementation of the 276/277 transaction. OMAP has the following means for receiving claim status requests:</p> <ul style="list-style-type: none"> <li>• Via phone by the claims processing unit; or</li> <li>• Via fax by the claims processing unit; or</li> <li>• Via OMAP OLM Screens.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>There are two situations that may affect implementation plans for the 276/277 transactions:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 276-claim status inquiry (Batch) transaction as planned;</li> <li>• One or more providers not ready to send the 276 status (Batch) transaction.</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 – 4/30/04
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 4/30/04.

**15. 277 Claim Response Transactions**

<b>Transaction Compliance Approach Description</b>	<p>MMIS would use the paired 276/277 health care claim status request and response transaction to receive and respond to requests for claim status information. DHS would use the 277 transaction to respond to requests for claim status information, which would be accepted by MMIS. Oregon MMIS will transition to use of the 277 Claim Status Transaction by 12/1/03.</p> <p>Currently, the MMIS has several mechanisms for responding to claim status requests. These mechanisms will remain in place after implementation of the 276/277 transaction.</p> <p>OMAP has the following means for responding to claim requests:</p> <ul style="list-style-type: none"> <li>• Via phone the claims processing unit; or</li> <li>• Via fax by the claims processing unit; or</li> <li>• Via the OMAP OLM Screens for inquiry.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>There are two situations that may affect implementation plans for the 277 transactions:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to send the 277-claim status response (Batch) transaction as planned;</li> <li>• One or more providers not ready to receive the 276 status (Batch) transaction.</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 –4/30/04
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 4/30/04.

**16. 278 Prior Authorization**

<b>Transaction Compliance Approach Description</b>	<p>The 278 health care services review information transaction is designed for the exchange of information between providers and reviewing entities. Oregon MMIS will transition to use of the 278 Prior Authorization by 12/1/03. The business events it is intended to cover include:</p> <ul style="list-style-type: none"> <li>• Admission certification review request and associated response;</li> <li>• Health care services certification review request and associated response;</li> <li>• Extend certification review request and associated response.</li> </ul>
<b>Service Continuation Alternative Description</b>	<p>OMAP already has a number of methods for communicating requests for prior authorization, which are required in many circumstances where services are provided to Fee-For-Service members such as:</p> <ul style="list-style-type: none"> <li>• Via phone or;</li> <li>• Via fax the PA to the TEDS/Medical Unit to request authorization.</li> </ul> <p>The 278 transaction would supplement and not replace existing capabilities to obtain prior authorizations by giving providers the ability to submit batch files of requests to MMIS and receive batch file responses to those transactions.</p> <p>There is one situation that may affect implementation plans for the 278 prior authorization transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to receive the 278 (prior authorization) transaction.</li> </ul> <p>Two contingencies have been identified for dealing with 278 prior authorization transaction:</p> <ul style="list-style-type: none"> <li>• Continue pre-HIPAA prior authorization mechanisms.</li> <li>• Accept 278 prior authorization transaction and give hardcopy response.</li> </ul>
<b>Status</b>	<b>Available</b>
<b>Start Date/Complete Date</b>	10/16/03 –4/31/04
<b>Corrective Action Plan (CAP)</b>	The CAP will be developed on a case-by-case basis with a goal of completing all trading partner transitions by 4/30/04.

**17. 277U Encounter Status Transaction**

<b>Transaction Compliance Approach Description</b>	The 277U unsolicited status transaction can be used to report on the adjudication status of MMIS encounters. Oregon MMIS will transition to use of the 277U Encounter Transaction at a date to be determined.
<b>Service Continuation Alternative Description</b>	<p>There are two situations that may affect implementation plans for the 277U encounter status transaction:</p> <ul style="list-style-type: none"> <li>• MMIS is not ready to send the 277U transaction;</li> <li>• One or more MCOs is not ready to receive the 277U transaction.</li> </ul> <p>Contingencies for dealing with 277U encounter status risks:</p> <ul style="list-style-type: none"> <li>• To be determined. DHS is in the process of researching this transaction and will need to work with trading partners to develop the appropriate business rules.</li> </ul>
<b>Status</b>	<b>Not Available</b>
<b>Start Date/Complete Date</b>	TBD
<b>Corrective Action Plan (CAP)</b>	TBD