Administrative Uniformity Committee

Streamlining Health Care Administrative Transactions in Minnesota

AUC OPERATIONS COMMITTEE AGENDA

2:00 p.m. – 4:00 p.m., Tuesday, December 13, 2016

TIES Event Center, Hamline Room

1644 Larpenteur Avenue West, Falcon Heights, MN 55108

Note: The TIES Event Center is on the western end of the TIES complex on the corner of Larpenteur and Snelling avenues, close to the state fair grounds and the St. Paul campus of the University of Minnesota. Free parking is available in the lot immediately adjacent to the event center, on the south side of Larpenteur, about ½ block west of the Snelling/Larpenteur intersection.

Teleconference line: 1-712-832-8300 Participant passcode: 337213

*Note: Please place your phone on mute you do not wish to be heard. (Press the mute button on your phone or press *6 to mute/unmute your line.) Please do not place your phone on hold.*

WebEx instructions:

1. To start the WebEx session, go to: https://health-state-mn-ustraining.webex.com
2. Under "Attend a Session," click "Live Sessions"
3. Click on the session for "AUC Operations"
4. Provide your name, email address, and the following password: Ops2010! (Note: The password is case sensitive and the exclamation mark at the end is part of the password.)
5. Click "Join now"

Key Meeting Objectives:

- Year-end review and planning for 2017

Please see agenda on the next page

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Agenda

1. Meeting to order – Tony Rinkenberger, co-chair
2. Anti-trust statement: http://www.health.state.mn.us/auc/pdfs/antitrust.pdf
3. Introductions - Please e-mail your attendance to health.auc@state.mn.us
4. Approve minutes of previous meeting (minutes will be emailed under separate cover)
5. Review and discussion
    a. Reminder re. member responsibilities, preparations for 2017
    b. Provider AUC co-chair for 2017
    c. AUC Website – records retention, appearance, accessibility
    d. Companion guide and TAG updates
    e. 2016 in review
    f. Looking ahead to 2017
6. Other Business

Next Meeting: 2:00 p.m. – 4:00 p.m., March 14, 2016 (In-person & Teleconference/WebEx)
TIES Event Center, 1644 Larpenteur Avenue West, Falcon Heights, MN 55108

AUC Operations

Regular Quarterly Meeting

December 13, 2016

Meeting Agenda
December 13, 2016

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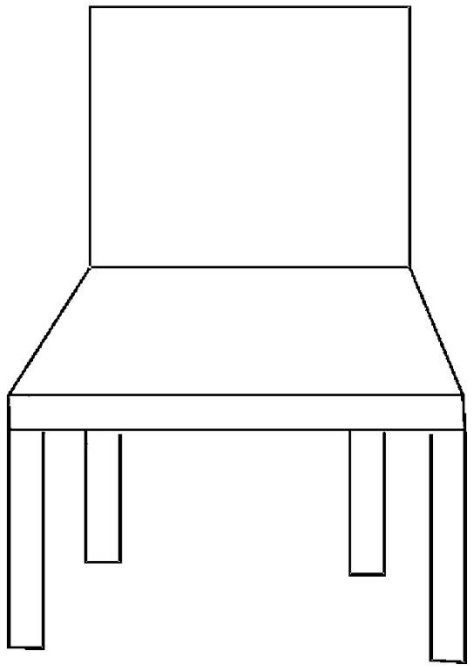
http://rlv.zcache.com/time_to_shift_gears_gears_brain_stationery-r5ff82bea116e450c8acc2c48c2c85168_vg6ke_8byvr_324.jpg

Reminder re. member responsibilities, preparations for 2017

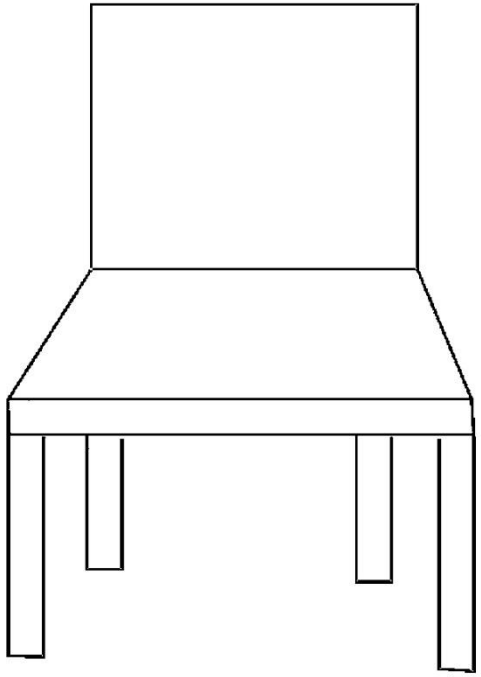
- Assigning primary/secondary representatives
- Attendance
- TAG representation
- Updating contact information

Provider AUC co-chair for 2017

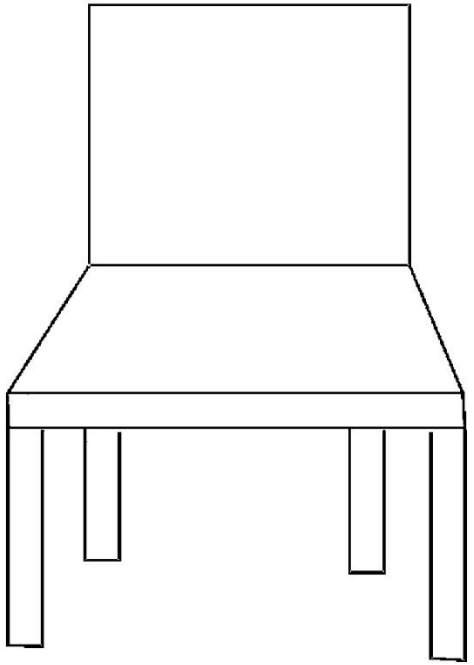
Incoming co-chair (2017)
Dave Andersen
Payer



Current co-chair (2016)
Tony Rinkenberger
Provider



Immediate past co-chairs (2015)
Ann Hale, Cherie Nauha
Payer



AUC Website – records retention, appearance, accessibility

http://www.health.state.mn.us/auc/forms.htm

Forms

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Administrative Uniformity Committee

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Administrative Simplification

- Forms
- MN Uniform Companion Guides (Rules)
- Best Practices
- Coding
- FAQs
- Links
- MN Department of Health
- ICD-10
- HIX Grace Period Notifications
- SBARs

Forms

This form was recently developed and approved by the AUC for requesting PA for Home Health Services covered by a health plan or a county-based purchasing plan. The form is NOT to be used for DHS FFS Home Health Services or for PCA services and is to be used ONLY for Home Health Services.	
	**Single, Uniform Home Care Prior Authorization (PA) Form** (PDF)

The three forms below should be sent to the appropriate **payer** (Do Not Send to the MN Department of Health or the AUC)	
	**Claims Attachment Cover Sheet** (DOC) **Instructions** (PDF) **AUC Payer Contact Information** (PDF) for faxing claims attachments
	**Claims Appeal Request Form** (DOC) **Instructions** (PDF) **AUC Payer Contact Information** (PDF) for faxing appeals forms This Form is to be used when a provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.
	**UFEF/Prescription Drug PA Request Form** (PDF) The form is intended primarily for use by prescribers, or those designated and authorized to act on behalf of prescribers, to: 1. Request an exception to a prescription drug formulary. 2. Request a prior authorization (PA) for a prescription drug.
	**Minnesota's Universal Outpatient Mental Health/Chemical Health Authorization Form** (PDF)

Most Viewed

Claims Forms

* Attachment Cover Sheet

(Instructions-pdf)

* Appeal Request Form (Instructions-pdf)
* Payer Contact Info (pdf)

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Subscribe to AUC updates

Adobe Acrobat Reader to view PDF files (free download from Adobe website)

- **Vendor Alert - June 2008** (PDF)
- **Payer Alert - January 2008** (PDF)
- **Provider Alert - December 2007** (PDF)

Accomplishments/Updates

- **2011 July-December** (PDF)
- **2011 January-June** (PDF)
- **2010 Summer** (PDF)
- **2009 Accomplishments** (PDF)
- **2009 3rd Quarter Update** (PDF)
- **2009 2nd Quarter Update** (PDF)
- **2008 3rd Quarter Update** (PDF)
- **2008 2nd Quarter Update** (PDF)
- **2008 1st Quarter Update** (PDF)
- **2006 1st and 2nd Quarter Update** (PDF)
- **2005 3rd and 4th Quarter Update** (PDF)
- **2005 1st and 2nd Quarter Update** (PDF)
- 2004 Year End Update
- 2003 3rd and 4th Quarter Update
- 2003 1st and 2nd Quarter Update
- 2002 2nd and 3rd Quarter Update
- 2002 1st Quarter Update

Paper Claim Manuals

- **Minnesota CMS 1500 Manual** (PDF) (effective 11/2006)
- **MN Standards for the Use of the ADA 20006 Dental Claim Form** (PDF) (effective 2/28/2007)
- **MN Standards for the Use of the Uniform 2007 Paper**

Inactive TAGs

- Ambulatory Payment Classifications/Ambulatory Patient Groups (APC/APG)Work Group (Complete)
- Anesthesia TAG (Complete)
- Communications TAG (Complete)
- Communications and Marketing TAG Revised as Communication/Membership/Policy TAG
- Complaint Reporting TAG (Complete)
- Data Definitions TAG Revised as Claims DD TAG
- Dental Manual TAG (Complete)
- Explanation of Benefits/Remittance Advice (EOB/REMIT) Work Group Revised as EOB Remit TAG
- HIPAA Education TAG (Complete)
- Health Plan Identifier/Other Entity Identifier
- ID Card TAG (Complete)
- LTC TAG (Complete)
- Membership/Policy/Procedure TAG Revised as Communication/Membership/Policy TAG
- Communications/Membership/Policy
- Mental Health TAG (Complete)
- Policy/Procedure TAG
- Prompt Pay TAG (Complete)
- State HCPCS Committee Revised as Medical Code TAG
- Strategic Steering
- Two Digit Program Code

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- ICD-10
- HIX Grace Period Notifications
- SBARs

Anesthesia TAG

Activation Date of TAG: October 1996

Inactivation Date of TAG: January 1997

Mission Statement:

- Task Force will seek to separate submission of billing data from payment practices in making its recommendations.
- Task force will make recommendations on achieving simplification and uniformity in the submission of anesthesia bills.

Accomplishments:

- Recommendations for billing anesthesia services were presented to the AUC in a report. After the TAG incorporated discussion of timelines and costs for compliance, the recommendations were accepted by the AUC. The process for incorporating the recommendations into the CMS 1500 Manual have been discussed and implemented by the Data Definitions TAG.

Return to Activities Page

Most Viewed

Claims Forms

* Attachment Cover Sheet

(Instructions-pdf)

* Appeal Request Form (Instructions-pdf)

* Payer Contact Info (pdf)

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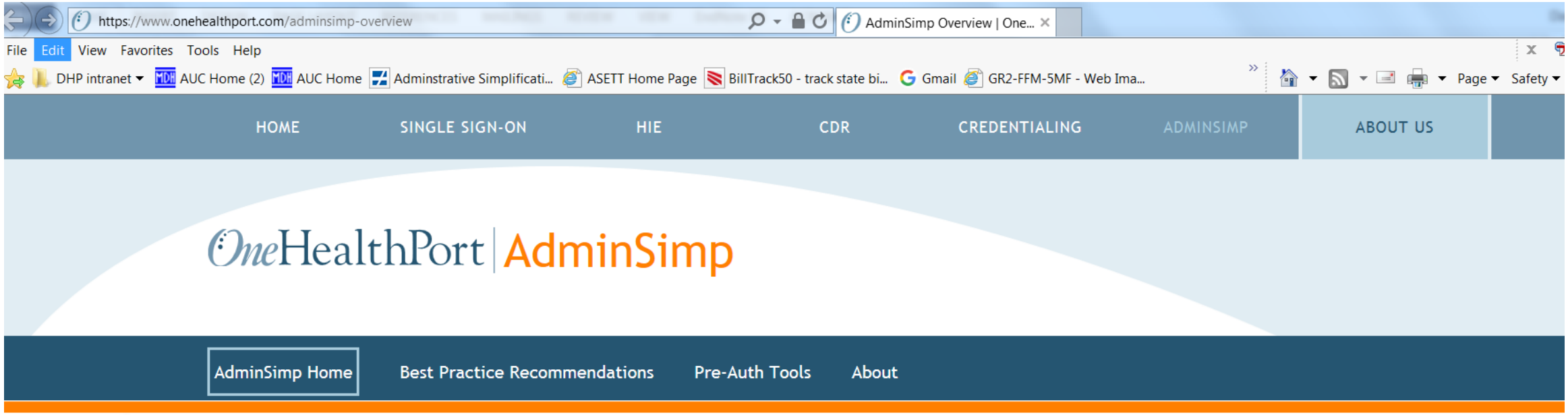
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BillTrack50 - track state bi...
Gmail
GR2-FFM-5MF - Web Ima...
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Safety
HOME
SINGLE SIGN-ON
HIE
CDR
CREDENTIALING
ADMINSIMP
ABOUT US
OneHealthPort | AdminSimp
AdminSimp Home
Best Practice Recommendations
Pre-Auth Tools
About
Best Practice Recommendations
The AdminSimp solutions delivered by OneHealthPort are known as Best Practice Recommendations (BPR). A BPR is a better way to get things done that's pragmatic and works for everyone. View a list of all BPR's and their related documents.
Pre-Auth Tools
OneHealthPort is working with the Pre-Auth Workgroup to develop a search tool designed to help providers quickly locate specific pre-service information on a payer website. The initial version of the pre-service search tool is expected in late 2016.
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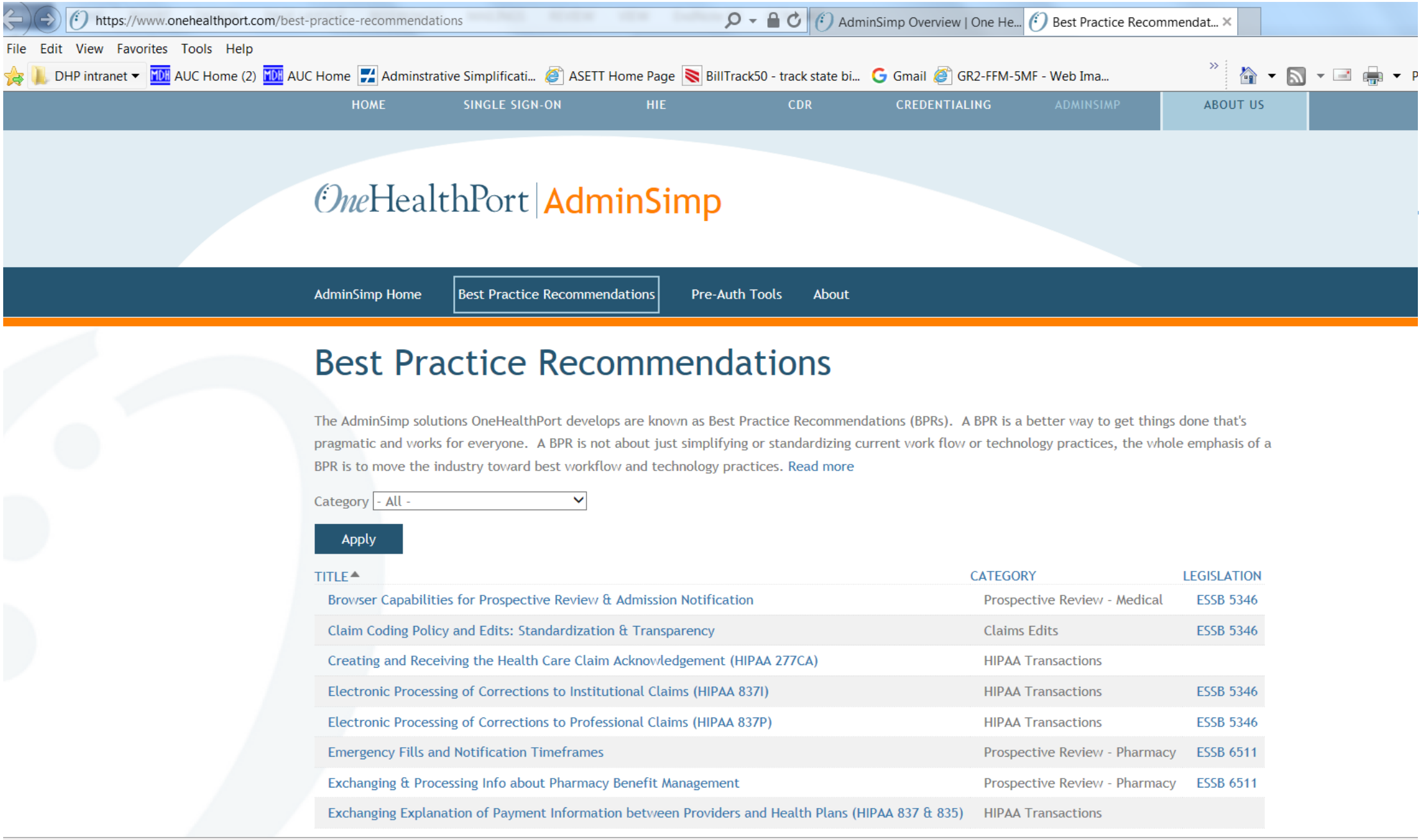
Contact Us


https://www.onehealthport.com/best-practice-recommendations
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AUC Home (2)
AUC Home
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ASETT Home Page
BillTrack50 - track state bi...
Gmail
GR2-FFM-5MF - Web Ima...
HOME
SINGLE SIGN-ON
HIE
CDR
CREDENTIALING
ADMINSIMP
ABOUT US
OneHealthPort | AdminSimp
AdminSimp Home
Best Practice Recommendations
Pre-Auth Tools
About
Best Practice Recommendations
The AdminSimp solutions OneHealthPort develops are known as Best Practice Recommendations (BPRs). A BPR is a better way to get things done that's pragmatic and works for everyone. A BPR is not about just simplifying or standardizing current work flow or technology practices, the whole emphasis of a BPR is to move the industry toward best workflow and technology practices. Read more
Category - All -
Apply
TITLE
CATEGORY
LEGISLATION
Browser Capabilities for Prospective Review & Admission Notification
Prospective Review - Medical
ESSB 5346
Claim Coding Policy and Edits: Standardization & Transparency
Claims Edits
ESSB 5346
Creating and Receiving the Health Care Claim Acknowledgement (HIPAA 277CA)
HIPAA Transactions
Electronic Processing of Corrections to Institutional Claims (HIPAA 837I)
HIPAA Transactions
ESSB 5346
Electronic Processing of Corrections to Professional Claims (HIPAA 837P)
HIPAA Transactions
ESSB 5346
Emergency Fills and Notification Timeframes
Prospective Review - Pharmacy
ESSB 6511
Exchanging & Processing Info about Pharmacy Benefit Management
Prospective Review - Pharmacy
ESSB 6511
Exchanging Explanation of Payment Information between Providers and Health Plans (HIPAA 837 & 835)
HIPAA Transactions

Next steps

- Goal – AUC website changes within next 2-3 months
- List of webpages to be taken down
- Mock-ups

Companion guide and TAG updates

- Status of rulemaking for 837D guide
- Renewed exception from the 270-271 for entities not subject to HIPAA
- Modifying how DHS specific information is presented in the companion guides (links to DHS website)
- TAG co-chairs reports and updates

Status of rulemaking for 837D guide

- Annual maintenance undertaken in summer/fall of 2016
- Proposed for public comment – addition of new section with coding for teledentistry services
  - U9 modifier proposed to identify services delivered via teledentistry
  - One comment, later withdrawn
  - AUC votes to recommend proposed rule be adopted as final rule
- Nov. 2016 -- CMS announces adoption of new Place of Service (POS) code 02 for telehealth
  - Issues and concerns also raised with proposed U9 modifier
- Completion of rulemaking process put on hold to assess option of using POS 02 to report services provided via teledentistry

Home > Medicare > Place of Service Codes > Place of Service Code Set

Place of Service Codes

- Place of Service Code Set
- Process for Requesting New Codes or Modification of Existing Codes

Place of Service Code Set

Place of Service Codes for Profess

Database (updated Novembe

Listed below are place of service codes and descriptions. These codes specify the entity where service(s) were rendered. Check with individual p insurance) for reimbursement policies regarding these codes. If you woul (s), please send your request to posinfo@cms.hhs.gov.

NOTE: Please direct questions related to billing place of service codes to (MAC) for assistance, and not to posinfo@cm

Place of Service Code(s)	Place of Service Name	Place of Service
01	Pharmacy **	A facility or location where drugs and and services are sold, dispensed, or patients. (Effective October 1, 2003)
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
03	School	A facility whose primary purpose is education.

REQUIRED CLM05-01 1331 **Facility Code Value** M AN 1/2

Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.

IMPLEMENTATION NAME: **Place of Service Code**

REQUIRED CLM05-02 1332 **Facility Code Qualifier** O ID 1/2

Code identifying the type of facility referenced

SEMANTIC:
C023-02 qualifies C023-01 and C023-03.

CODE	DEFINITION
B	**Place of Service Codes for Professional or Dental Services** CODE SOURCE 237: Place of Service Codes for Professional Claims

SITUATIONAL SV303 1331 **Facility Code Value** O 1 AN 1/2

Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.

SEMANTIC: SV303 is the place of service code representing the location where the dental treatment was rendered.

SITUATIONAL RULE: ***Required when value is different than value carried in CLM05-1 in Loop ID-2300. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Place of Service Code**

See CODE SOURCE 237: Place of Service Codes for Professional Claims

Renewed exception for entities not subject to HIPAA

TIME TO SHIFT GEARS

1.2.1. Exceptions to applicability

Minnesota Statutes, section 62J.536, subd. 4 authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

ii. another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

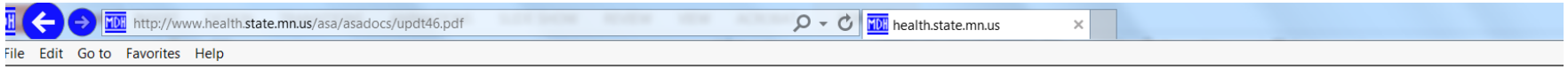
Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X222A1 Health Care Claim: Professional (837). Version 12.0. Adopted into rule on September 19, 2016.

MDH

Minnesota Department of Health Rule

Title:	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271). Version 10.0.**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	This document was adopted into rule on March 9, 2015. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) hereinafter referred to as 005010X279A1, by entities covered under Minnesota Statutes, section 62J.536, • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 10.0 of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271). It was announced as an adopted rule in the Minnesota State Register, Volume 39, Number 36, March 9, 2015 pursuant to Minnesota Statutes, sections 62J.536 and 62J.61. This document is available at no charge at: www.health.state.mn.us/asa

Renewed exception for entities not subject to HIPAA



MDH Minnesota Department *of* Health

Limited Exception for Non-HIPAA Payers from Minnesota's Requirements for Only the Standard, Electronic Exchange of Eligibility Transactions (270-271) is Continued For ~~2016~~ 2017

Per MN State Register announcement 12-12-2016

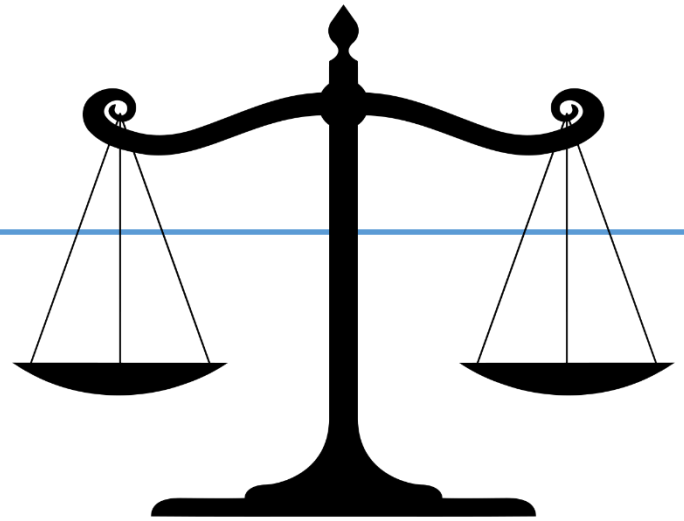
Intended Purpose and Audience

Modifying how DHS specific information is presented in the companion guides (links to DHS website)

- As discussed at September AUC Ops meeting
- Changes for next round of companion guide maintenance

Slide from September 13 AUC Op meeting

Companion guide goals



- Accurate
  - Up to date
- Clear, useful
- Commitment to “annual maintenance”
  - In consultation with the AUC
  - Via rulemaking process pursuant to MS §62J.536 and MS §62J.61
    - Proposed changes published in the State Register with opportunity for 30 day public comment period
    - Comments reviewed, final version adopted into rule via announcement in State Register

Slide from September 13 AUC Op meeting

Appendix "A"

- Includes significant amount of coding instructions and requirements specific to public programs administered by the Minnesota Department of Human Services (DHS)
  - Primarily in *"TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs"*
  - Also in *"Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare"*

Slide from September 13 AUC Op meeting

Challenges of synching DHS information with companion guide maintenance

- Companion guide goals
- Environmental factors
  - Legislative process and timing
  - CMS oversight and review
  - Development/interpretation of policy, details
  - Business needs
- Pace, scope, complexity of change
  - Changes in health care delivery and financing
    - Services, providers, settings, documentation, timing

Working toward a solution

- No single best answer – pros and cons of any change
- Experiment – reference DHS website (similar to referencing external code sets)

3.2. Information About the Health Care Claim: *Professional* (837) Transaction

3.2.1. Business Terminology

The terms below were published with definitions and other information in the previous version of this companion guide to provide additional clarification and/or because of changes that occurred as a result of the adoption of version 5010. Definitions of these terms are no longer being included in this companion guide. However, the terms are discussed and defined in the reference document to this companion guide (the *005010X222A1*), which is available for purchase from ASCX12 at http://store.x12.org/store/.

The following terms that were previously defined in the Minnesota Uniform Companion Guide can be referenced as noted above:

- Billing provider
- Billing provider name
- Billing provider address
- Pay-to address
- Other payer
- Patient
- Pay-to plan

Minnesota Department of Health (MDH) Rule

Title:	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X222A1 Health Care Claim: Professional (837) Version 12.0**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	This document was adopted into rule on September 19, 2016. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*, hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 12.0 (v12.0) of *the Minnesota Uniform Companion Guide (MUCG) for the* Implementation of the *ASC X12/005010X222A1 Health Care Claim: Professional (837).* It was announced as an adopted rule in the Minnesota State Register, September 19, 2016 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version 10.0 was the last version of this document to be adopted into rule prior to this v12.0. This document is available at no charge at MDH's "Health Care Administrative Simplification" webpage (http://www.health.state.mn.us/asa/rules.html).

From the current 837P guide -- A possible precedent for how to proceed

Changes in this companion guide regarding billing and coding of services specific to publicly administered programs in Minnesota (e.g., Medical Assistance (Medicaid))

In previous versions of this companion guide we included instructions for coding and billing of certain services specific to publicly administered programs in Minnesota (called "Minnesota government programs" in previous versions of the companion guides). The most notable example of such programs is the state's Medical Assistance (Medicaid) program, administered by the Minnesota Department of Human Services (DHS).

Beginning with this companion guide, information regarding coding and billing of services specific to publicly administered programs in Minnesota can be found on the DHS website at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_157386

For questions or assistance in accessing information from the DHS website, please also contact the DHS helpdesk at http://mn.gov/dhs/general-public/about-dhs/contact-us/

Below is a list of services specific to publicly administered programs in Minnesota that were previously included in this companion guide. Please now refer to the DHS website above for information regarding billing and coding for these services.

Service description	Applicable Minnesota statute for publicly administered program
Behavioral health services (from "Table A.5.2" in the previous version of the companion guide):	
• Assertive Community Treatment (ACT)	MS 256B.0623
• Adult Crisis Response Services	MS 256B.0624
	42 U.S.C. 1396w-4 Minnesota Statutes 256B.0757 Minnesota Statutes 245.461 to 245.468, Minnesota Comprehensive Adult Mental Health Act

Try some-thing similar

Continued goals

- As above
- DHS involved in coding discussions
- Awareness of changes/updates
  - DHS outreach and communications
  - AUC outreach and communications

http://legendglobalcommunications.com/

TAG co-chairs reports and updates

Acknowledgment TAG	Last met on 10/27/16; completed comments to x12 re. v7030 277CA; comments submitted to meet Nov. 30 deadline.
Claim DD TAG	Last met Dec. 7. Discussed SBAR seeking clarification of POS for telehealth. Also examining coding for accident date for workers comp-related claims.
EOB/Remit TAG	Met Nov. 21 to review the v7030 835 for possible comments. The TAG next meets on Dec. 19 to continue its review.
Medical Code TAG	Met Dec. 1. Discussed changes to 837 claims guides to reference DHS-specific coding instructions rather than including the instructions in the guide. Reviewed educational materials regarding telehealth and telemedicine.
Eligibility TAG	Met Nov. 23, scheduled to next meet on Dec. 28. Discussed challenges related to use of the 270-271 for entities not subject to HIPAA. Developing best practice for reporting “Restricted Recipient Program Information”

Example TAG work

Minnesota Restricted Recipient Program was the subject of December 3, 2016 Star Tribune article

The AUC Eligibility TAG is developing a best practice for communicating on the 271 eligibility inquiry response that Medical Assistance enrollees are listed on the MN Restricted Recipient Program

150 ER visits in a year? Minnesota officials get alerts about 'high-use' patients

The program is saving taxpayers at least $7 million a year in unnecessary medical costs.

By Chris Serres Star Tribune DECEMBER 3, 2016 — 11:45PM

Each year, Minnesota's hospital emergency rooms see thousands of patients with minor illnesses — from coughs to fevers — who could be better treated at a neighborhood clinic at drastically lower cost.

To stem that tide, state authorities are using a sophisticated computer screening tool that detects when people on public health insurance programs make dozens of unnecessary trips to hospital ERs and medical clinics. While largely unknown outside government circles, the program has quietly become a powerful tool to control waste in the multibillion-dollar Medical Assistance program while improving patient care.

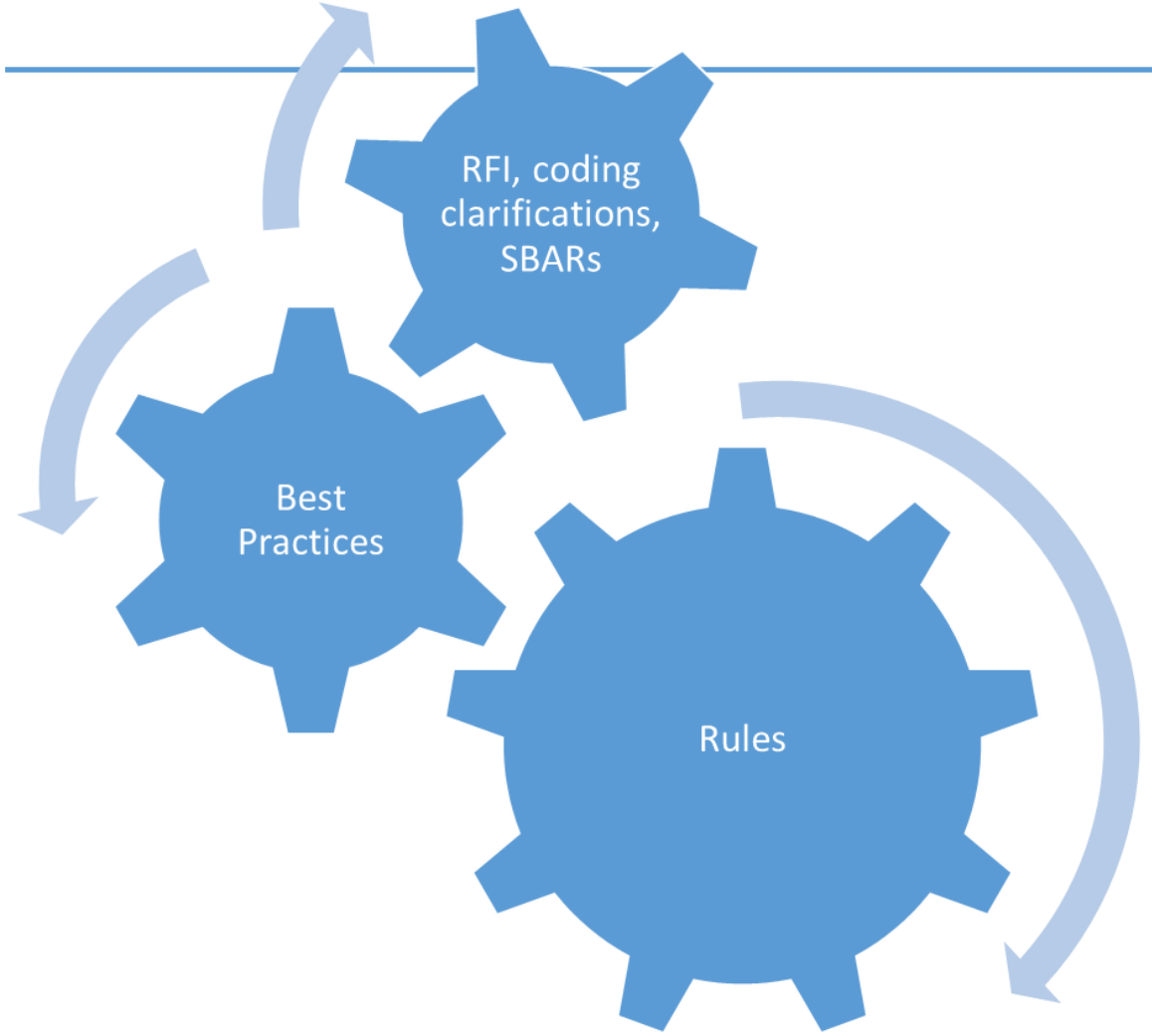
The system, known as the Minnesota Restricted Recipient Program, has flagged patients who visited hospital ERs as much as 150 times in a single year. It also found people who routinely hop from one physician to the next searching for prescription painkillers.

By limiting these "high use" patients to a single primary care provider, along with a hospital and one pharmacy, the program is saving taxpayers at least $7 million a year in unnecessary medical costs, state data show.

….

Accessed on 12/12/2016 at http://www.startribune.com/state-deploys-powerful-tool-to-rein-in-medicaid-waste-costly-er-use/404506396/

2016 in review – real world impacts



Examples:

- Reporting APR-DRGs on 835
- ACO enrollee data files
- Common billing and coding
- Billing and coding for new services
- Restricted recipient program reporting (pending)
- Overpayment recoupment (pending)
- Telehealth/teledentistry (pending)
- Public comments/responses (eg., v7030)

2016 in review

- Updated companion guide rules:
  - 837P; 837I; 277CA; 999; TA1
- Pending updated rules
  - 837D (as discussed previously)
- Best practices, SBARs, coding clarifications, public comments
  - ACO enrollment data – complete
  - X12 RFI response re. APR-DRGs
  - SBARs
  - Pending best practices
  - Comments – v7030 Acknowledgments; v7030 HIX notification via 270-271
- Continuing presence and involvement
  - 41 meetings

Looking ahead to 2017

- MDH focus on reducing health disparities, applying that “lens” to administrative simplification
- 2016 WEDI conference
- Ongoing – rule maintenance, best practices, education
  - Implementation and improvement
- Electronic claims attachments for workers comp claims
- Telehealth/telemedicine
- V7030 comments and timelines
- CMS regulatory activity

Reducing health disparities, applying that “lens” toadministrative simplification

TIME TO SHIFT GEARS

This report reveals that:

- Even where health outcomes have improved overall, **… American Indian and African American babies are still dying at twice the rate of white babies.**
- **Inequities in social and economic factors are the key contributors to health disparities and ultimately are what need to change** if health equity is to be advanced.
- **Structural racism** — the normalization of historical, cultural, institutional and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians — **is rarely talked about. Revealing where structural racism is operating and where its effects are being felt is essential for figuring out where policies and programs can make the greatest improvements.**
- **Improving the health of those experiencing the greatest inequities will result in improved health for all.**

Strategy: Change systems, structures, and policies that perpetuate inequities and structural racism.

MDH partners with policymakers to make changes in public policy.	Identify two public policies (that are not traditionally public health or health care policies) and make the link to health each year between January 2016 and December 2019.
MDH applies health equity questions to all new and existing internal policies, programs, and practices.	100 percent of MDH policies have undergone a health equity review by December 31, 2019. 100 percent of MDH programs have completed a health equity review by December 31, 2019.
MDH examines and redesigns hiring processes to eliminate institutional barriers to diversity and inclusion.	Barriers to diversity and inclusion in the MDH hiring process will be identified and a plan will be developed to address them by December 31, 2016. Additional objectives will be added once barriers are identified.
MDH examines and redesigns its grant-making process with a health equity lens.	100 percent of new, MDH initiated RFPs undergo a health equity review by December 31, 2019. 50 percent of new, MDH initiated RFPs are developed with input from the communities they are intended to impact by December 31, 2019.

2016 WEDI conference

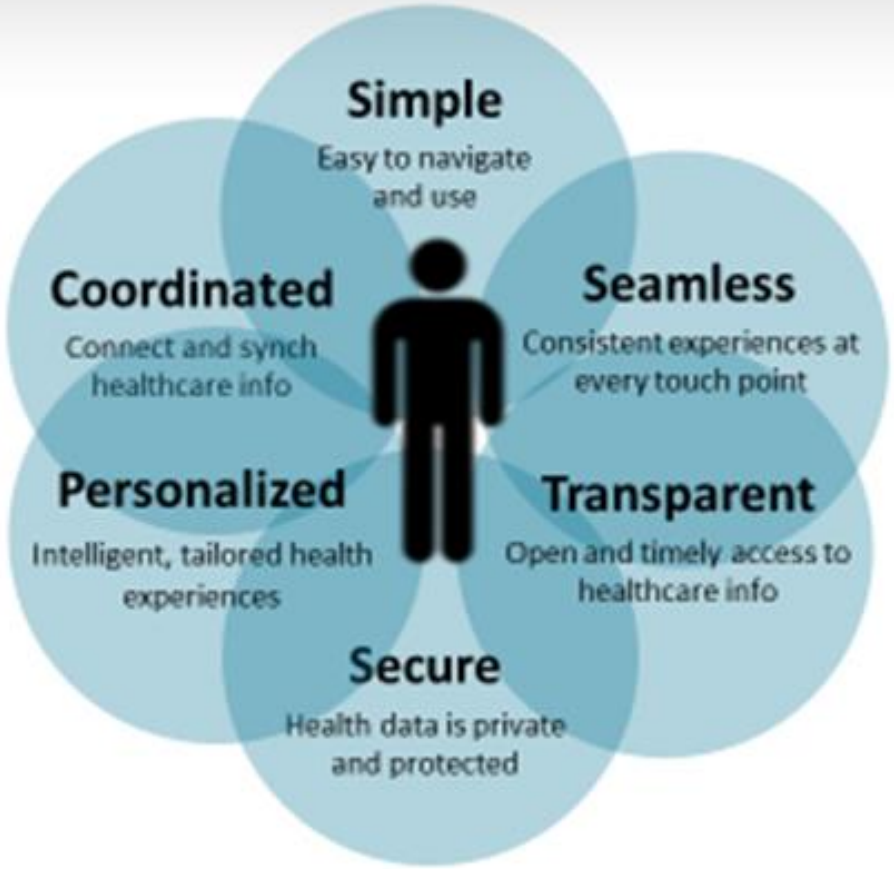
- November 7 – 9, 2016
- Board meeting as well
  - Laurie Darst, Mayo, incoming chair for 2017
  - Dave Haugen, MDH, government representative for 2017
- Juxtaposition of old and new

New -- Consumer valuation of health care changing

- Technical competence assumed, so consumers looking for other value added
- Analogue: air travel. Consumers expect to take off on time, land safely. Value added for consumers is other features – comfort, convenience, amenities
- Health care consumers increasingly assume technical competence. Value added is personalization, comfort, convenience, etc.
- Technology will play an important role (because is less expensive and more deployable than people)

Care and compassion

What qualities empower people today will inform the services of tomorrow



Source: FJORD Era of Living Services 2015

Healthcare will become more virtual

Virtual health benefits the already served, not just the underserved

- Matching supply to demand
- One to many
- Asynchronous
- Augmented experience
- Digital Therapy

Source: Silverdoud

Internet of Things

- Sense-interpret-respond
- Platforms over products
- Systems over devices
- Productivity and effectiveness

Petabyte storage cost 2010=$80,000 2020=$4. I suspect that the electricity to run it will cost more. #CMLS2015

4G … 1400-fold faster
5G … 100X faster than 4G (Download movies in second vs minutes) by 2020

Internet of Things

- 6.4b connected things in use in 2016 – up 30% from 2015 (Gartner)
- IoT will grow from 2 billion "things" to 200 billion by 2020 (Intel)
- 10-15 devices per hospital bed

New -- Setting the world on FHIR?

A possible alternative –

- Demonstration of FHIR® – Fast Healthcare Interoperability Resources for claims attachments
  - FHIR is a “next generation standards framework created by HL7,” and “is designed to enable information exchange to support the provision of healthcare in a wide variety of settings.”

Technology may be great but …

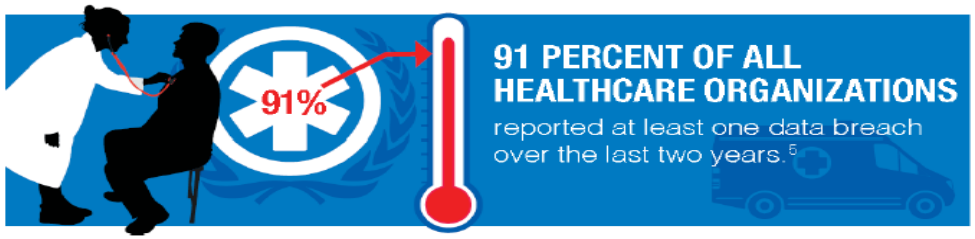
Emerging Risks- Technological

Cybersecurity (Cyber Attacks)

Some of the risks that entities face in this realm include:

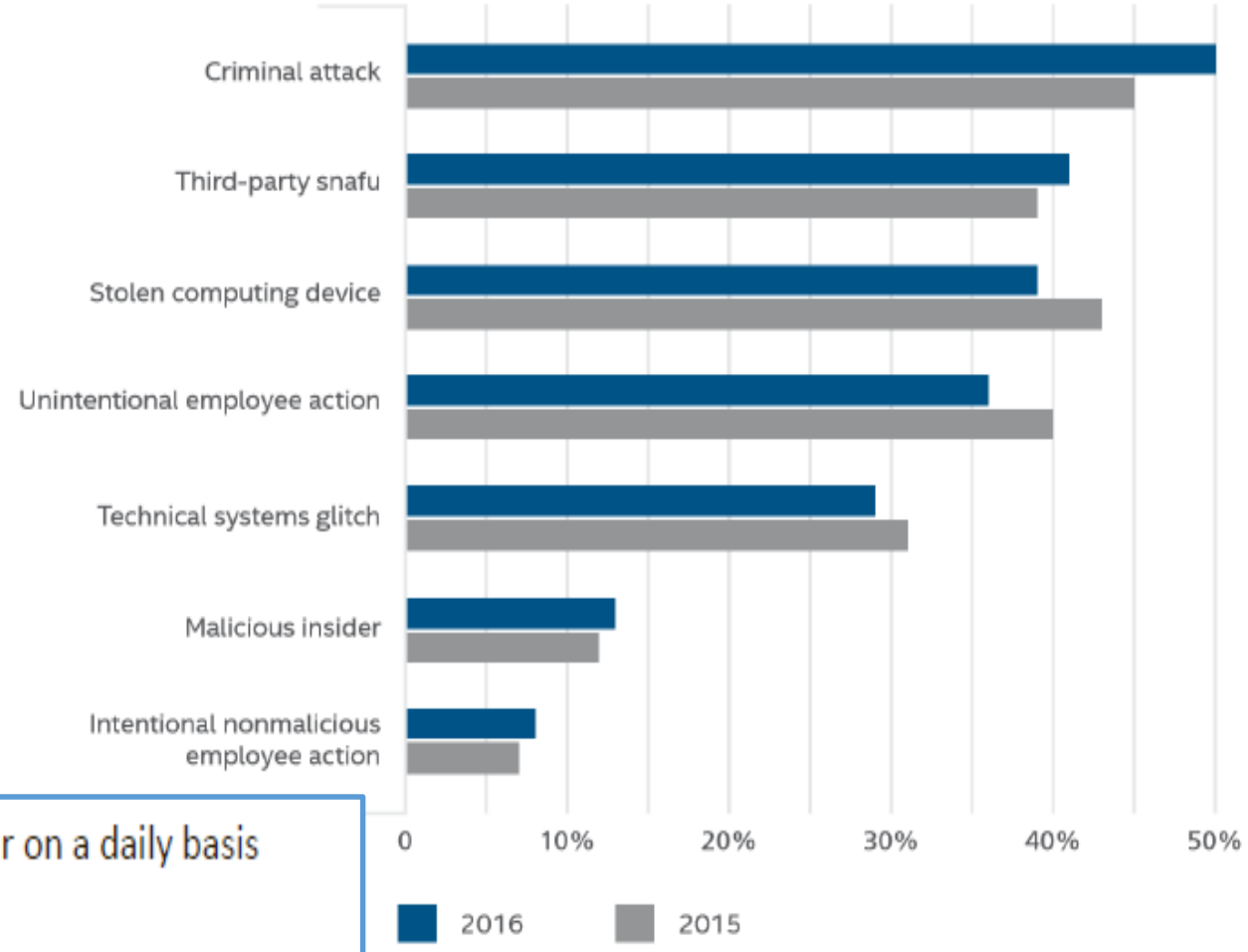
- Legal liability
- Computer security breaches
- Privacy breaches
- Cyber theft
- Cyber espionage and cyber spying
- Cyber extortion
- Cyber terrorism
- Loss of revenue
- Recovery of costs
- Reputational damage
- Business continuity/supply chain disruptions
- Cyber threats to infrastructure

Emerging Risks- Healthcare Sector



Source: Experian 2016 Data Breach Industry Forecast

Top Causes of Breaches in Healthcare



Benchmark Study on Privacy & Security of Healthcare Data, May 2016, Ponemon Institute.

- In 2016, as of June, there are 4,000 ransomware attacks that occur on a daily basis *(Symantec Security Response)*
  - A 300% increase from 2015; 2015 had 1,000 attacks per day
  - Targets home users, businesses, and government networks

- IoT will bring added challenges to protecting patient information on top of an already challenge environment:
  - New avenues for hackers to attack
  - Connecting to devices for which security updates are no longer being made
  - More medical devices which is attacked could increase chances of patient harm

But we are still having trouble implementing the 20th century

WEDI-Con Session title:

- “Why hasn’t the increase in Eligibility & Benefits transactions resulted in a reduction in phone calls?

NCVHS Testimony

Value

The eligibility transaction is a key to the success of the claim payment cycle. The survey results showed that the expected benefits have not been realized by stakeholders.

- The current transaction does not support the information needed for automating the eligibility process.
- Results in providers using web portal or phone applications to obtain more detail eligibility information.

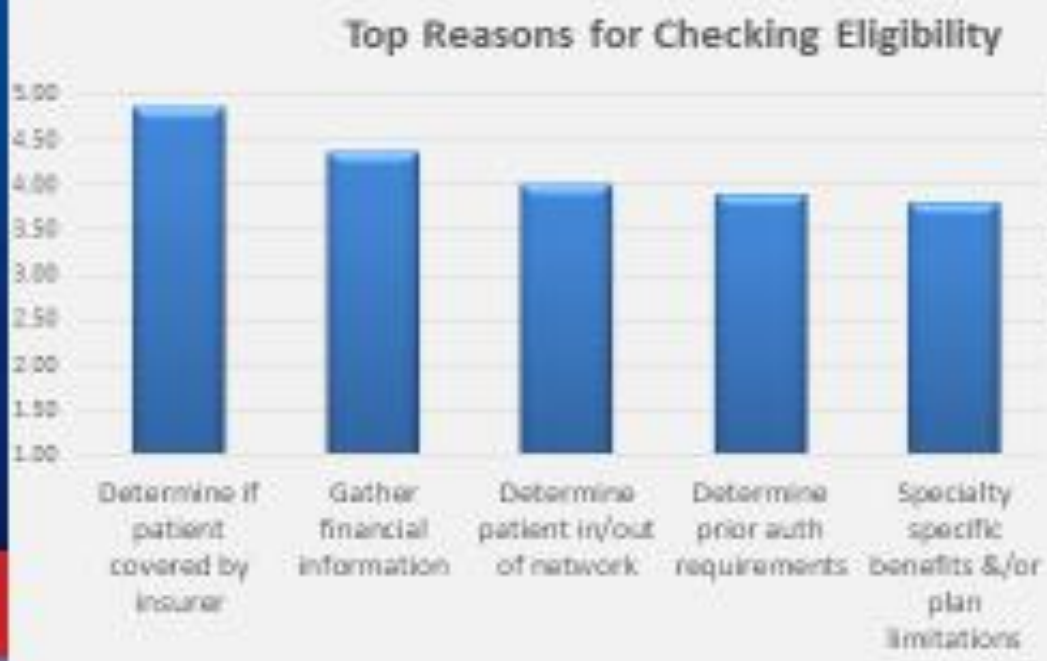
6

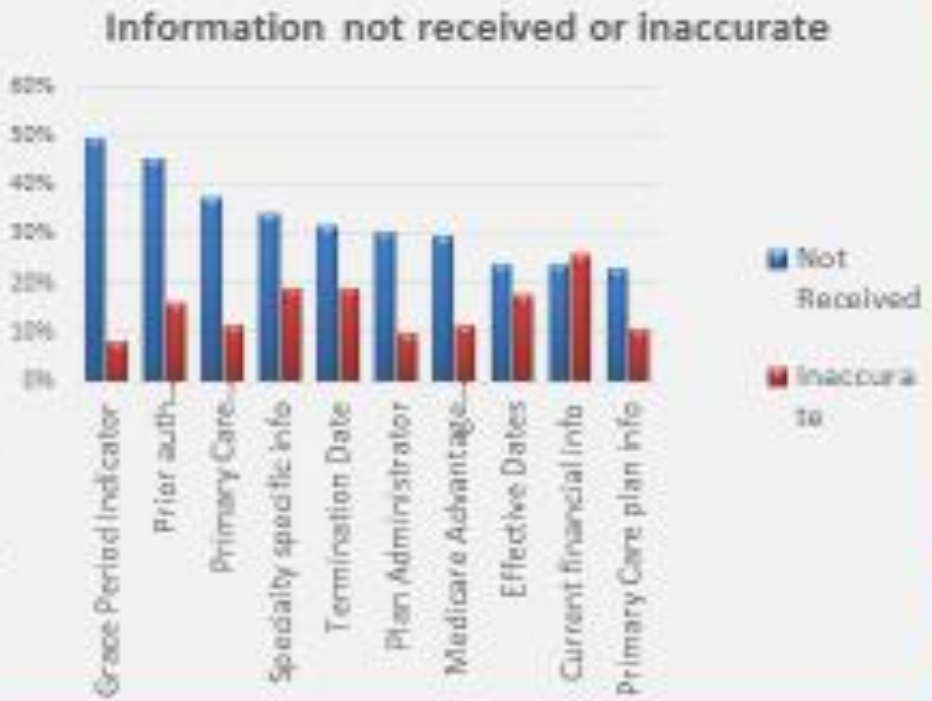
Findings:

27% of respondents continue to struggle getting accurate information through electronic eligibility checks through their Practice Management system

87% still find the need to occasionally, frequently or always utilize secondary methods to gather more detailed, accurate or current information.

To identify the areas we want to focus on for improvement, we'll take a look back at the reasons practices check eligibility compared to what's missing or inaccurate:





Barriers

- Lack of real time response and/or detailed responses due to payer disparate systems
- Does not meet business need, requiring providers to leave their workflow to make costly phone calls and access web portals.
- Payers do not provide CPT/HCPCS code level benefit detail.
- CPT/HCPCS code level benefit detail requests allow payers to provide upfront authorization or referral information.
- Complex benefits such as tiered benefits/narrow networks are not always supported.
- PMS may not provide capability or integrated user interface to automate workflow.

With more exposure, increased concerns whether data is current, accurate

Due to high cost of procedures/services and higher POS cost sharing at point of service, providers double and triple check – Is this patient covered? What is his/her out of pocket cost?

NCVHS -Opportunities/Recommendations

- Many barriers today are addressed in the next iteration of the ASC X12 270/271 transaction
- Provide transparency leading to automation, including what role each organization plays in the patients healthcare
  - The entity with primary financial responsibility for paying the claim
  - The entity responsible for administrating the claim
  - The entity that has the direct contact with the healthcare provider
  - The specific fee schedule that applies to the claim
  - The specific plan/product type
  - The location where the claim is to be sent and any secondary/tertiary payers

Opportunities/Recommendations

- Encourage payers to respond to HCPCS/CPT eligibility requests and provide benefit information, authorization requirements and referral requirements.
- Encourage PMS systems to become HIPAA covered entities and subject to the HIPAA TCS rule. Require capability to send/receive eligibility transactions and automate the use of this information within the workflow.
- WEDI facilitate an industry forum for stakeholders to address identified barriers and strategies for remediation
- Further research to be completed to confirm the next HIPAA version will remove the industry identified barriers and ensure ROI before adopting.

Other examples of implementing 20th century

- Electronic attachments via v6020 275
  - NGS pilot for Medicare part B
  - Currently supports unsolicited attachments for surgical procedures with modifier 22 (“work required to provide a service is substantially greater than typically required”) or modifier 62 (“Two surgeons are required to perform a specific procedure”)
- 278 for prior authorization (Humana-athenahealth pilot)

Old being updated – SSN replaced by Medicare Beneficiary Identifier (MBI)

SSN removal:

- all Medicare cards with the new Medicare Beneficiary Identifier (MBI) by April 2019
- Assign 150 million MBI's in the initial enumeration (60 million active and 90 million decease/archived) and generate a unique MBI for each new Medicare beneficiary

Medicare Beneficiary Identifier (MBI)

- New Non-Intelligent Unique Identifier
- 11 bytes
- Key positions 2, 5, 8, and 9 will always be alphabetic

Key	Example
SSA HICN	123-45-6789-A1
MBI	1EG4-TE5-MK73

2017 Ongoing – rule maintenance, best practices, education

Looking ahead – more juxtaposition of the old and the new

- Companion guide maintenance
  - 277CA Acknowledgment companion guide
  - ??
- Complete best practices
  - Recoupment of overpayment via the 835
  - Reporting APR-DRG on v5010 835
  - Minnesota Restricted Recipient Program
- Implementation
  - ACO data file
  - Grace period notification
  - Electronic claims attachments

Electronic claims attachments for workers comp claims

MS 176.135 Subd. 7a

No later than January 1, 2017:

(1) health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the ASC X12N 5010 version of the ASC X12N 275 transaction …

(2) workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the ASC X12N 5010 version of the ASC X12 electronic acknowledgment for the attachment transaction …

Telehealth/telemedicine

- Widespread interest, rapidly changing environment
  - New codes, modifiers
  - State telemedicine parity law
- Medicare, Medicaid, Commercial
  - Often similar and overlapping, but some differences
  - Check definitions, billing, coding, and reimbursement requirements
  - Potential for questions with new POS code 02 and new CPT modifier 95
- Detailed white paper/issue brief coming

Telehealth -- General similarities across jurisdictions

General similarities across laws/regulations for Medicare Part B, MN Medicaid, and MN health plans –

- In order to qualify as telehealth/telemedicine, a health care service/consultation must:
  - Occur while the patient is at an originating site and the licensed health care provider is at a distant site
  - Be provided via an “interactive telecommunications system” comprised of equipment that can provide two-way, real-time audiovisual communications

Example differences

- Two types of telehealth technologies
  - Synchronous (patient present) vs. asynchronous ("store and forward" – patient does not have to be present)
    - Medicare generally only reimburses for synchronous
    - MN Medicaid and MN health plan law allow for both synchronous and asynchronous
- Requirements for "originating site"

Medicare Part B	Restricts types of sites to be reimbursed, restricts sites by geography (emphasizes rural ares); facility fee must be paid to originating site
MN Medicaid	DHS website lists types of originating sites to be reimbursed
MN health plan law	Does not restrict or list originating sites, but health plans can impose criteria to be met to assure safety, efficacy

Additional telehealth wrinkles and questions

- CMS has created a new POS code (02) for or use by the physician or practitioner furnishing telehealth services from a distant site, effective January 1, 2107
- Medicare requires the use of one or the other of modifiers GT or GQ
  - GT -- telehealth via interactive audio and video telecommunications systems
  - GQ -- telehealth via asynchronous telecommunications system
- AMA has recently published a new CPT modifier “95”
  - “Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system”
    - Appendix “P” in CPT lists services that can be modified by modifier “95”

v7030 comments and timelines

- X12 standards adopted in HIPAA
- Standards updated and modified over time, new versions adopted under HIPAA supersede previous versions
  - X12 development and adoption process
  - HHS rule making process
- Current HIPAA adopted versions (5010) adopted in 2006-2008, required per HIPAA in 2012
- Next X12 version to be adopted into HIPAA: v7030
- Public comment period announced for v7030
  - **Vital to carefully review and comment – decisions now could be in effect for years to come**

V7030 recently revised public comment timeline as it applies to MN companion guides

Review and comment period	Transaction	Notes
Cycle 2: October 1 through November 30, 2016	007030X330 Health Care Claim Acknowledgment (277CA)	AUC submitted comments developed by Acknowledgment TAG
Cycle 3: November 1, 2016 through January 30, 2017	007030X322 Health Care Claim Payment/Advice (835)	EOB/Remit TAG reviewing v7030 to develop draft comments
Cycle 4: February 1 through May 2, 2017	007030X323 Health Care Claim: Professional (837P)* 007030X324 Health Care Claim: Institutional (837I)* 007030X325 Health Care Claim: Dental (837D)*	Claims DD TAG will be leading review and comment development
Cycle 5: March 1 through May 30, 2017	007030X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)*	Eligibility TAG will be leading review and comment development

Challenges

- Scope and time available
  - E.g., v7030 835
    - Industry specific remark codes (ISRC); payment via credit cards; relationship to CORE operating rules
- Limited tools and resources available
  - No downloadable versions of 7030
  - limited change log, no underline strikeout versions

CMS regulatory activity

- Per America's Health Insurance Plans (AHIP)

Topic	Plans/timeline
Health Plan Identifier	Expected on the CMS unified regulatory agenda in 2017
Health Plan Certification	A new Notice of Proposed Rulemaking (NPRM) will appear on the unified regulatory agenda after HPID in 2017
CORE Phase IV Operating Rules	CMS will not adopt Phase IV Operating Rules at this time
New 275 Electronic Attachments Transaction	CMS aims to take regulatory action in 2017

Other business

- AUC Membership Requests –
  - Minnesota Birth Center
  - Planned Parenthood