

Connections

News from the Quadax Monthly Payer Monitoring Committees

Volume 11, Issue 3

June 2014

This newsletter is designed to help our clients understand the research and policies that feed our EDI processes, and to provide a foundation for discussion of the issues that affect your business office. The information contained herein is highly sensitive to our business. It is proprietary and protected by copyright. As such, you must maintain the confidentiality of this information. Reproducing, republishing, distributing, transmitting, displaying, or otherwise exploiting in any manner without the express written consent of Quadax, Inc., is strictly prohibited.

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June 2014



UB Committee Meetings
06/11/14



Insurance Meeting
05/27/14

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Quadax Ready for MyCare Ohio

MyCare Ohio is a pilot program sponsored by CMS and is part of the Integrated Care Delivery System (ICDS), which is a system of managed care plans selected to coordinate physical, behavioral, and long-term care services for individuals over the age of 18 who are eligible for both Medicaid and Medicare. This includes people with disabilities, older adults, and individuals who receive behavioral health services. Ohio's ICDS is called "MyCare Ohio" and is the state of Ohio's Dual Demonstration, a.k.a. Medicare-Medicaid Program (MMP).

The goal of the MyCare Ohio program is to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees, including long-term services and support. It more efficiently integrates the services provided by both Medicare and Medicaid programs and combines all benefits available through traditional Medicare and Medicaid programs. In addition, MyCare Ohio managed care plans may elect to include additional services in their benefit packages. By better coordinating the benefits offered through the Medicaid and Medicare programs, the MyCare Ohio program aims to improve the overall health and well-being of the individual while also improving health care quality and outcomes, as well as containing costs.

Ohio selected five managed care plans to manage the full spectrum of Medicaid and Medicare benefits: [Aetna](#), [Buckeye](#), [CareSource](#), [Molina](#), and [UnitedHealthcare](#). (Click on a link for more information about the individual plan.) Enrollment will be phased in by region through June and July until all eligible

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TOB 14X Update

As a follow up to previous *Connections* articles, [MLN Matters MM8776](#) delineates that OPPS hospitals should begin using modifier L1 on type of bill (TOB) 13X when seeking separate payment for outpatient lab tests under the Clinical Laboratory Fee Schedule (CLFS) in the following circumstances:

- 1) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
- 2) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day.

"Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Hospitals should no longer use TOB 14X in these circumstances. This CMS directive is **effective July 1, 2014. Quadax EDI**

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Tertiary Medicare Claims

The 07/06/14 CEM edit change implementation will allow for Medicare to act as a tertiary payer for Part A only. In other words, CMS will allow Tertiary Institutional (UB) claims to be billed. However, the required CR 8486 changes to the Fiscal Intermediary Standard System (FISS) that allow these new segments will not be in place until CR8486 is implemented sometime *after* July 2014. At this time, MACs are advising providers to continue submitting Tertiary claims hardcopy until CR8486 is issued to update FISS.

Quadax EDI will continue to monitor the CMS website for updates and will implement all necessary Xpeditor, edit, and back-end changes in as timely manner as possible to accommodate this new payer policy. ♦

QUADAX READY FOR MYCARE OHIO (from page 1)

individuals are enrolled. Individuals began enrolling in MyCare Ohio managed care plans for Medicaid services on May 1, 2014. Visit the [Ohio Medicaid MyCare Ohio website](#) for additional information. Individuals that receive Medicare Parts A, B & D and full Medicaid benefits and live in one of the seven multi-county demonstration regions are eligible to participate in MyCare Ohio. Eligible individuals will be able to choose from at least two managed care plans in each region to provide their Medicaid and Medicare benefits. They will have the option to have the managed care plan provide their Medicare benefits or to opt out of the Medicare portion of the program, and stay with their current Medicare Advantage plan or traditional Medicare. However, the individual's MyCare Ohio managed care plan will provide and pay for all their Medicaid services. In either case, **an individual must have both Medicare (either traditional or a MyCare Ohio plan) and Medicaid (a MyCare Ohio plan) coverage to be part of the MyCare Ohio program.**

In terms of Xpeditor, several UB edits have already been updated to facilitate this new program. More specifically, edit "U42111 - NF - Accommodation Rev Code is Missing" has been revised to treat revenue codes 0220 and 0658 as accommodation codes when a MyCare Ohio payer is being billed and the additional Ohio Medicaid edits are applied. Similarly, edits "UDAY01 - Line Item Days Not = Days Reported in Value Codes" and "UDAY06 - Admit-From-Thru Days Not = Line Item Days" have been updated for these five payers to include the number of days associated with the revenue codes 0220 and/or 0658 in the line item days calculation for SNF claims (Bill Type 2XX) that have the additional Ohio Medicaid edits applied.

The EDG is currently reviewing billing requirements associated with MyCare Ohio Physician claims to determine if updates to 1500 edit logic are warranted. Be sure to check future issues of *Connections* for updates regarding the ongoing implementation of MyCare Ohio and associated Xpeditor updates. ♦

TOB 14X UPDATE (from page 1)

strongly recommends that our Xpeditor clients review any custom coding related to the initial switch to the 14X Bill Type to proactively address potential issues.

The L1 modifier is valid for claims submitted on and after 07/01/14 for claims with dates of service on and after 01/01/14. However, per [CMS Transmittal \(CR8764\)](#), the L1 modifier was made valid retroactively 01/01/14.

CMS is providing related updates to the "Medicare Claims Processing Manual" (Publication 100-04; Chapter 2, Section 90; and Chapter 16, Sections 30.3, 40.3, and 40.3.1). ♦

Please note that the July Xpeditor Release has been pushed back one week from its regularly scheduled implementation. The July Xpeditor Release will now be implemented July 22nd.

**ICD-10 Updates**

- On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which stated that CMS may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services released an interim final rule that included a new compliance date that would require the use of ICD-10 beginning **October 1, 2015**. The rule also requires HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.
- As reported in previous issues of *Connections*, CMS planned to conduct ICD-10 testing during the week of July 21 through 25, 2014. However, CMS rescinded [CMS Transmittal 1352 \(CR8602\)](#), cancelling the July testing. According to CMS statement issued May 2: "CMS planned to conduct ICD-10 testing during the week of July 21 through 25, 2014, to give a sample group of providers the opportunity to participate in end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The July testing has been canceled due to the ICD-10 implementation delay." However, the statement went on to state that "Additional opportunities for end-to-end testing will be available in 2015."
- The 2015 ICD-10-CM and ICD-10-PCS files are now posted on the [2015 ICD-10-CM and GEMs web page](#) and [2015 ICD-10-PCS and GEMs web page](#). **There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.** The 2015 ICD-9-CM files are now available on the [ICD-9-CM Diagnosis and Procedure Codes: Abbreviated and Full Code Titles web page](#). Since there will be no ICD-9-CM updates, there is no FY 2015 addendum. **There are no new, revised, or deleted ICD-9-CM codes.** The 2015 General Equivalence Mappings (GEMs) will be posted later this summer.
- The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10, which would end one year after the implementation of ICD-10. The partial code freeze will continue through October 1, 2015, the new planned implementation date. Regular updates to ICD-10 will begin on October 1, 2016, one year after the implementation of ICD-10. Refer to the [Partial Code Freeze for ICD-9-CM and ICD-10](#) for more information.

Be sure to check the [Quadax ICD-10 Portal Page](#) for updates and information related to all things ICD-10. ♦



Odds & Ends

- Based on popular demand, Xpeditor Edit Rules functionality has been enhanced to allow users to apply MUE and OCE edits to claims on an as-needed basis. For more details about how to apply these edits via XpressBiller Rule, refer to the *July Xpeditor Release Notes*, which will be published next month.
- Quadax EDI was approved to transmit claims through a new gateway, effective 04/04/14: **TriZetto Provider Solutions**. The new UB Xpeditor Claim Types are **NACO 39 (Inpatient)** and **NACO 69 (Outpatient)**, while the new 1500 Claim Type is **NACO13**. We were also approved to transmit UB claims to **Premiera Blue Cross (WA Blue Cross)**, effective 04/23/14. The new Xpeditor Claim Types are **WABS31 (Inpatient)** and **WABS61 (Outpatient)**.
- Effective 06/27/14, a direct connection for UB claims submissions to **Tennessee Blue Cross** will be established, with Xpeditor Claim Types **TNBS31 (Inpatient)** and **TNBS61 (Outpatient)**. It is important to note that **TN Medicaid (BlueCare and TennCare Select)** claims will also be submitted via these two Claim Types or via Emdeon payers **UHC Community Plan (#95378)** or **Amerigroup Community Care (#27514)**.
- In order to increase the efficiency and timeliness of claims transmissions, the time of the morning run for the BI-HOURLY/DAILY transmissions batch, which accounts for the bulk of our Institutional (UB) claims transmissions, has been revised. Effective 06/04/14, rather than executing the first run of the day at 7:30AM, the first run will occur at **8:15AM**. This will permit more claims to be picked up and sent to payers sooner, reducing the number of claims that will be pending for inclusion in the 10:00AM run. Similarly, the CGS-only Medicare run has been revised to occur at **8:00AM** instead of 7:15AM.
- Per [CMS Transmittal 1390 \(CR8759\)](#), the Jurisdiction N A/B MAC re-competition procurement was awarded to the incumbent contractor, First Coast Service Options, Inc. The MAC designation will change from J9 to JN. The current MAC workload numbers of 09101, 09201, 09102, 09202, and 09302 will remain the same.
- BCBSM will retire its local claims processing system on 01/31/14. Since it will no longer process claims on that system, all claims filed on the local system must be submitted and received by 09/15/14 in order to be processed. All health care providers must follow claim-filing deadlines. If you submit a claim after the filing limits, BCBSM will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber. More information about this change can be found in the payer [March 2014 Record](#) newsletter.
- Anthem (IN, KY, MO, OH, and WI) will soon implement a new online ERA only registration process, replacing current paper forms. The payer expects this online process to begin in August 2014. Anthem will discontinue mailing paper remittance vouchers for providers receiving ERA. It anticipates cessation of mailed remittance vouchers to begin in September 2014. Complete details are available in the [05/15/14 Anthem Network eUPDATE](#).
- CMS [announced](#) that it will postpone the consolidation of Jurisdictions 8 and 15 to form Jurisdiction I, and Jurisdictions 5 and 6 to form Jurisdiction G. After appropriate consideration of Medicare program trends, CMS has determined to postpone these final two remaining A/B MAC contract area consolidations for up to five years. This decision will affect the scope of MAC contracts for the following states: KY, IL, IN, IA, KS, MI, MN, MO, NE, OH and WI. ♦



Texas Medicaid Drops ACS as Vendor

On May 9, *The Wall Street Journal* reported that the Texas Attorney General's Office filed a lawsuit against Xerox Corp. and its subsidiary ACS State Healthcare LLC over allegations that the companies approved unnecessary Medicaid payments for orthodontic and dental services.

The same day, *The Dallas Morning News* (Garrett, Jacobson) reported the lawsuit claims Xerox "permitted an unprecedented loss of Medicaid funds to predatory and unscrupulous dental providers." The company responded in a statement that it has "never engaged in fraudulent activity" and has "always operated with complete transparency." Additionally, the Texas Health and Human Services Commission informed Xerox Friday that it will terminate the company's "five-year, \$759 million claims administration contract 'for cause' about three years early." Accenture, a subcontractor under Xerox, will take over the Medicaid work beginning in August.

After reviewing the specifics of the case, Quadax EDI has determined that **there would be little to no impact to the transmissions of claims to this payer entity**, and clients would not experience any issues or other negative impact. The only potential issue realized for clients would involve prior authorization for dental claims, which would be reviewed manually. As noted above, ACS will continue to process claims until at least August, and the transition to a new Fiscal Intermediary (FI), if any, would be seamless, much like any other switch from one FI to another. ♦