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OREGON MEDICAID
MANAGEMENT
INFORMATION SYSTEM

Oregon MMIS
EDI Overview for
Managed Care
Organizations

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1 Transaction Changes

Implementation of the replacement Oregon MMIS allows the Department of Human Services (DHS) to develop new policies and procedures to improve efficiency; therefore, the MCOs will see a variety of changes. This section provides a description of some of the changes.

1.1 Electronic Data Interchange Testing

MCOs must conduct pre-implementation testing. Testing is critical for all MCO and EDI submitters: It ensures that in the replacement MMIS, transaction standards are met, incoming transactions remain Health Insurance Portability and Accountability Act (HIPAA)-compliant, and that all revised or new submission practices are followed.

Prior to Oregon's replacement MMIS implementation, DHS will notify all MCOs of the connectivity and testing process to make sure DHS can process their EDI transactions in the replacement system. MCOs and their submitters will not need to re-apply.

Only those MCOs and EDI submitters who test and who are authorized by DHS to continue exchanging EDI transactions will be able to submit EDI transactions once the replacement MMIS goes live.

1.2 DHS Companion Guides

There are new versions of the DHS Companion Guides (CG) available. These guides will provide you with information about the technical changes to each transaction that you will need to successfully continue EDI transactions with DHS in the replacement system. To help prevent confusion between current CGs and replacement MMIS CGs, DHS posted the replacement guides to the MMIS web site at:

www.oregon.gov/DHS/mmis/edi.shtml

1.3 MCO EDI transactions changes

Below is an outline of the changes in EDI transactions MCOs can expect.

1.3.1 Eligibility Benefits Inquiry (270/271)

The current system processes the 270 batch files overnight. The replacement MMIS will process them as they come in, giving more timely eligibility information.

DHS will no longer support individual real time Internet direct connect 270/271 transactions.

DHS will instead support an individual fast batch 270/271-client eligibility inquiry and response. Response times will be at the same rate as currently supported.

The 271-free form proprietary segment (EB05 and MSG01) will not be available at Go Live. The information contained in these segments currently is:

- Client FIPS code
- Client Zip code
- Case number
- Division
- Branch Office number
- Worker ID
- Program Eligibility Resource Code
- Benefit package
- Managed Care Rate group code
- Capitation rate group code
- Managed Care Enrollment

The information identified above is contained within the MCOs 834 Enrollment file and would be duplicative for the most part.

1.3.2 Claims Status Inquiry (276/277)

The current system processes the 276 batch files overnight. The replacement MMIS will process them as they come in, giving more timely information.

The replacement system will also process real-time claims status inquiries submitted through both VANs and SFTP.

DHS will no longer support individual real time Internet direct connect 276/277 claims status transactions.

DHS will instead support an individual fast batch 276/277-claim status inquiry and response. Response times will be at the same rate as currently supported.

1.3.3 MCO Premium Capitation Payments (820)

The 820 will contain premium payments for enrollees only and not payments for encounter claim generated payments such as maternity case rate or bariatric case rate as it does today. The case rate payment will appear in the 835 Remittance Advice. In those cases where a case rate is paid the FCHP/PCO must use both the 820 and 835 to balance to the electronic funds transfer (EFT) amount.

1.3.4 MCO Enrollment File (834)

Current Process: Prospective MCO enrollment is provided in an 834 transaction on a weekly basis. The business rule is that Wednesday is always the cutoff for a change to be effective the following Monday. There is a monthly dead-zone where no activity is allowed: it is 4 days prior to the first day of the next month.

If a daily change is made, or a retroactive enrollment occurs, the plan is contacted by DHS. This process will continue in the future.

New Process: The same business rules apply except that the 834 transaction is provided on a daily basis, giving the plan more current information regarding Adds, Changes / continuing enrollment, or termination of enrollment.

If a daily change is made, or a retroactive enrollment occurs, the plan will be contacted by DHS (as is the practice today). MCO enrollment activity is always entered Thursday through Wednesday for the FOLLOWING Monday - i.e., it is always PROSPECTIVE.

The weekly and monthly enrollment creation is being changed to a daily and

monthly. The daily will contain added, changed or terminated enrollees. The monthly will contain a snap shot in time of all the enrollees DHS has assigned to the MCO. This transaction is called the Audit and Compare.

MCOs can 'save up' their daily 834 transaction files and load them on the same day if they choose. However, MCOs incur a risk if files are loaded out of sequence, and are strongly encouraged to load the files daily. In any case, **the daily 834 files must be loaded in sequential order.**

One disadvantage of not loading the files on a daily basis is a missed opportunity to have the most current information loaded.

Another difference is that the enrollment file can support both the mailing and residential address of the recipient. If the address are different both address will be sent. If the addresses are the same only the mailing will be sent.

Some examples of client specific information contained in the 834-enrollment transaction following actions taken by DHS are:

- New enrollee
- Enrollee termination
- Enrollee Benefit package change

1.3.5 Electronic Claims Remittance Advice (835)

The Claims RA currently is a reflection of encounter claims processing only.

The new claims RA will contain line item payments for case rate payments (MCR and bariatric). It will also contain the amount paid for payments identified in the 820-premium capitation transaction as a total amount only. For client specific details you still refer to the 820 Capitation. The total amount in the RA is what should be used to balance to the EFT amount. This information is currently supplied in the 820-premium capitation transaction.

1.3.6 MCO Claims (837 P//D)

MCOs will no longer be required to 'roll-up' claims that exceed DHS' 28 line or dollar amount limits. MCOs or their submitters will be able to submit up to 999 detail lines on institutional claims and 50 detail lines on professional and dental

claims. Dollar amounts can be up to \$9,999,999.99 per detail line and \$99,999,999.99 per total claim payment amount, both are HIPAA transaction standards.

1.3.7 MCO Pharmacy Claims (NCPDP)

Some changes will occur, including how to use processor control numbers on NCPDP transactions.

For more information on transaction changes, see the Companion Guide at: www.oregon.gov/DHS/mmis/edi.shtml

1.4 EDI Connectivity/Electronic Mailbox

EDI connectivity and Electronic Mailbox information for Oregon EDI trading partners is changing.

If you have questions regarding EDI connectivity or need assistance, please contact your Encounter Data Liaison or DHS EDI Support Services at:

Email: DHS.HIPAATesting@state.or.us

Phone: 888-690-9888 (8:00 a.m. to 5:00 p.m. PST, Monday through Friday) except state observed holidays.

1.5 Submission of X12 Transactions

Procedures for submission of X12 transactions are changing.

If you have questions regarding submission of X12 transactions or need assistance, please contact your Encounter Data Liaison or DHS EDI Support Services at:

Email: dhs.edisupport@state.or.us

Phone: 888-690-9888 (8:00 a.m. to 5:00 p.m. PST, Monday through Friday)

1.6 Pended Encounter Claims - New Edit: 3509 - Encounter Claim

Requires Correction

Managed care contract requirements for correcting failed encounters will not change.

When the replacement MMIS edits identify encounter claim errors that require correction, the claim status code will be 'deny' instead of 'pend' for Edit 3509-Encounter Claim Requires Correction and the encounter claim must be corrected by the MCO.

All processed encounters are reported back to the MCO on an electronic remittance advice (ERA) 835 the week following submission. The 835 RA will list the associated Claim Adjustment Reason Codes (ARC) and applicable Remark Codes associated to the MMIS error code 3509 in addition to other specific errors that indicate the reason for a correction.

Managed care organizations will continue to receive the proprietary file of just those encounters that require correction: a Status File. The format has virtually no changes from the format today.

Encounter claims that need to be corrected are submitted as an adjustment transaction. Adjustments can be submitted through EDI as today or the secure Web portal. For submitting adjustments via the secure Web portal, see the MCO professional, institutional, and dental billing instructions at:

www.oregon.gov/DHS/mmis/training-info.shtml

If you have questions regarding electronic encounter claims processes or need assistance, please contact your Encounter Data Liaison or DHS EDI Support Services at:

Email: DHS.HIPAATesting@state.or.us

Phone: 888-690-9888 (8:00 a.m. to 5:00 p.m. PST, Monday through Friday) except state observed holidays.

2 MCO Provider Enrollment

All providers providing services for managed care organizations must be enrolled with the minimum amount of demographic information. During this transition period MCOs may continue to use the current 3108 Provider Enrollment form available at:

<http://dhsforms.hr.state.or.us/Forms/Served/OE3108.pdf>

The replacement MMIS will also provide an option to enroll managed care providers through the public web portal application process.

DHS has established interfaces with three Oregon licensing boards: Oregon Board of Pharmacy, Oregon State Board of Nursing and the Oregon Medical Board (formerly Board of Medical Examiners). Through these interfaces license expiration dates will automatically come over to the replacement MMIS and update the provider's information with termination end dates. What this means is an encounter claim to pass processing must have a date of service prior to the end date.

DMAP Encounter Data Liaisons can distribute report information to the MCOs but it would be for all providers whose termination date has been end dated not just those the MCO has utilized. The distribution would be on an 'as requested' basis. The providers with this end date applied are automatically sent a letter notifying them of their terminated status. This may be a surprise to those providers not fully enrolled as a FFS provider. As a courtesy to the MCO providers, DHS asks that they be informed of this potential event by their respective MCO.

Providers that are enrolled as an MCO provider and not otherwise as a FFS provider and not part of the licensure verification check through the boards identified above will have an "infinity" end date (12/31/2299). For this reason these Providers will not receive any termination letters. MCOs need to remain vigilant on ensuring credentials and licensures are appropriate and active.

PLB -- Provider Adjustment - page 164

Usage: Situational

Segment Repeat: >1

Loop ID: None

Example: PLB*123456*19960930*WO:9876514*1.27~

ELEMENT	NAME	USE	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
PLB03-1	Adjustment Reason Code	R	2/2	ID		OR-DHS most commonly uses: 72 = Authorized Return CS = Adjustment CT = Capitation Payment FB = Forwarding Balance WO = Overpayment Recovery
PLB04	Provider Adjustment Amount	R	1/18	R		Adjusted amount of provider's remittance.

BPR -- Financial Information - page 35

Usage: Required

Segment Max Use within Loop: 1

Loop Repeat: 1

Loop ID: None

Example: BPR*I*100000*C*ACH*****20040401~

ELEMENT	NAME	USE	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
BPR01	Transaction Handling Code	R	1/2	ID	I	
BPR02	Total Premium Payment Amount	R	1/18	R		Total of detail Premium Payment Amounts

TRN -- Re-association Key - page 43

Usage: Required

Segment Max Use within Loop: 1

Loop ID: None

Example: TRN*3*12345*1936001787*~

ELEMENT	NAME	USE	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
TRN01	Trace Type Code	R	1/2	ID	3	
TRN02	Check or EFT Trace Number	R	1/30	AN		If BPR04 = ACH, EFT trace number. If BPR04 = CHK, check number.
TRN03	Originating Company Identifier	S	10/10	AN	1930592162	OR-DHS Federal Tax ID number preceded by a one (1) with no hyphen.

REF -- Premium Receivers Identification Key - page 48

Usage: Situational

Segment Max Use within Loop: >1

Loop ID: None

Example: REF*14*123456~

ELEMENT	NAME	USE	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	14	
REF02	Premium Receiver Reference Identifier	R	1/30	AN		OR-DHS assigned Prepaid Health Plan Number.

N1 -- Premium Receiver's Name - page 56

820 CAPITATION PAYMENT Companion Guide - Encounter

Version .01

Division of Medical Assistance Programs (DMAP)

MMIS/MCO Issues Log

Open Issues

Date Added	Issue #	Originator	Issue	Response
11/13/07	07-03	P. Krewson	How will the MCOs reconcile the weekly/monthly capitation to the daily/monthly enrollment?	