Program Memorandum
Intermediaries/Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-35 **Date: MAY 2000**

CHANGE REQUEST 1195

SUBJECT: FURTHER GUIDANCE ON APRIL RELEASE IMPLEMENTATION

The Common Working File (CWF) and Medicare Claims Processing Standard Systems release planned for April 3, 2000 is now targeted for implementation on May 15, 2000. The implementation instructions issued under Transmittal Number AB-00-20 (CR 1157) are to be implemented using May 15, 2000 as the reference date.

Change Requests (CRs) effective April 3, 2000 to be implemented May 15, 2000:

Even though the following changes will be made in this systems release, the effective dates of these changes will remain as reflected in the approved CR. Claims will continue to be processed as they are today until the release is implemented. Carriers and intermediaries should not initiate any actions for these CRs unless otherwise noted below in this section. With the exception of CR 1073, carriers and intermediaries should not initiate any reprocessing of claims. If they wish, providers may resubmit claims for appropriate adjustments after the release is implemented in order to benefit from the retroactive effective dates. Changes in this category are:

967 Chiropractic Services
969 Medicare Coverages of Abortion Services
994 Collection of Encounter Data for LTC
1006 Prostate Cancer Screening
1025 Changes for Clinical Lab Organs or Disease - Intermediaries should not take any action until further notice on the instructions issued within CR 1157 regarding reviewing claims on a post-pay basis to determine duplicate payments.
1044 Payment for Blood Clotting Factor
1049 Pancreas Transplant Diagnosis Codes
1073 SNF PPS changes - CR 1157 instructed the intermediaries to hold claims for services in April until the May release was available for processing claims. At this time the intermediaries are instructed to release and process in accordance with the current production software all claims that are being held. Within 45 days of the implementation date of the April release claims with dates of service April 1, 2000 and later need to be identified and adjusted.
1091 New and Waived PPMP Tests
1129 FY 2000 Hospital Inpatient Payments

Change Requests (CRs) effective with implementation on May 15, 2000:

937 Clarification of Modifier Usage in Reporting Hospital Outpatient Services
952 New COB Contractor NBRs for MSP Savings
978 Calculation of Average Allowed Charge for Residual Items
980 CMHC Requirements to Report Line Item Dates of Service and Changes in Reporting of Units
995 Update to the MSPPAY Module for Intermediary Claims processing
999 Cryosurgery of Prostate Gland
1004 CCI v6.1 quarterly update
1011 Reporting of Non-MSP Currently Not Collected

1016 NSF/ERA v.2.01U
1032 Hospital Requirements to Report Line Item Dates of Service, Changes in Reporting of Units, and Notification of Claims Line Item Expansion
1079 Addition of Modifiers 25 and 78 to the list Approved for Hospitals
1095 PS&R UNIBILL Record
1126 Correction to CR #952 COB Contractor Numbers
1130 Correction to CR #1016 NSF/ERA

Clarification of the implementation dates of certain Change Requests (CRs) mentioned in CR 1157:

In CR 1157, reference was made to certain CRs that were to be implemented as scheduled on April 3, 2000. We have determined that several CRs included in this category contained implementation dates other than April 3. These CRs will be implemented as noted below:

1083 HCPCS code L0430 (TLSO) SADMERC Report---implementation date of June 1, 2000
1089 Preapproval of Data Center Transitions---implementation date of February 11, 2000
1107 Paramedic Intercept Definition---implementation date of March 1, 2000
1123 Change Web Address for CPT Interest---implementation date of July 1, 2000
1137 Provider Access to Limited Eligibility Data---implementation date of March 31, 2000

Dark Days

There will be dark days for CWF hosts and fiscal intermediaries (FIs) on Friday, May 12 and Saturday May 13, 2000 to allow enough time for both the FI and the CWF hosts to complete the necessary file conversions for this release.

To ensure that all responses in the current format are processed prior to the dark days, the last claim file that the FIs are to send to their CWF host will be sent by the CWF host cut-off time on Wednesday, May 10, 2000. The response file that the FI processes Thursday, May 11, 2000 will be the last response file they will process in the current format. The resulting claim file created in FI processing on Thursday, May 11, 2000, will be converted by the FI and sent to their CWF host for processing in the CWF claim cycle on Monday, May 15, 2000. Any contractor requiring an alternative dark day schedule must request prior approval from HCFA.

Because all of the CWF hosts will need to have the beneficiary master database and all the auxiliary and claim history files closed to CICS in order to load the converted history files beginning on Friday, May 12, 2000, and this process will last through most, if not all of Saturday, May 13, 2000, the HIQA/HUQA, HIQM, HIHO, and HIMR online inquiry systems will not be available on Friday, May 12, 2000 or Saturday, May 13, 2000.

The CWF host dark day will also impact carrier claim processing. Since the carriers do not have to convert any files in preparation for installing the new release, the carriers can send their last claim file to their CWF host by the host cut-off time on Thursday, and process these responses on Friday. The carriers will send the claim file they create on Friday to their CWF host for processing in the CWF claim cycle on Monday, May 15, 2000.

Carriers and FIs should supplement the provider notice below with information explaining the impact of the dark days.

Provider Notification

Carriers and intermediaries should review the information in this instruction to determine the impact on providers and take appropriate steps to convey relevant information about this Program Memorandum (PM), and the CRS mentioned herein, to their provider communities. This includes posting these instructions on carrier or intermediary web site, providing this information to customer service representatives who deal with providers, contacting relevant provider associations, etc. If any provider education events, training classes, or speaking engagements are planned during the remainder of April and May, carrier and intermediary trainers and speakers should include relevant information regarding this PM in their remarks.

The following information is a collection of pertinent information issued through PMS over the past year, and is being provided as a model for intermediaries to inform their providers about the impact of the changes for claim expansion and line item processing. Intermediaries may reproduce this information in whole or in part for their provider notification efforts.

Provider Billing Requirements and Remittance Advice Information

New Provider Requirements

May 2000 — Providers must report line-item dates of service for every line where a HCPCS code (including modifiers) is required for hospital outpatient, community mental health center (CMHC), and outpatient partial hospitalization services. This includes services for which the from and through dates are equal.

Providers must report units as the number of times the service or procedure being reported was performed.

Hospitals whose intermediaries use the Arkansas Part A Standard System (APASS) can bill up to 450 revenue lines via direct data entry (DDE) per claim and up to 297 lines via EMC per claim. These intermediaries are: Mutual of Omaha, Rhode Island, New Hampshire/Vermont, Washington/Alaska, North Carolina, Maine/Massachusetts and New Jersey (until 8/1/2000).

The remaining hospitals, whose intermediaries use the Fiscal Intermediary Standard System (FISS), can bill up to 297 revenue lines per claim via EMC or DDE.

July 2000 — EMC version 6.0 of the UB-92 will be available for all users. This version expands the number of revenue input lines to 450 as well as the number of COB crossover revenue lines.

Hospitals whose intermediaries use FISS can now bill up to 450 lines via DDE as needed.

NOTE: The claims input version that the provider uses has no correlation with the electronic remittance advice (ERA) version that the provider elects to receive. These are distinctly different transactions. Should the provider choose to receive a different version of the ERA than they are currently on, the intermediary must be notified of that election.

System Outputs

May 2000 — The paper remittance advice (RA) will continue to display claim level information only.

An upgraded release of PC-Print (remittance advice software) is available which has an increased file size in order to display up to 450 revenue lines. There are two versions being supported. The latest version will print ERA versions 3051.4A and 3051.3A. The prior version works with the 3030M version. Providers using PC-Print will be able to see the same information as before, based on the version of the ERA in use. If line item-level information was provided on the ERA, then the line item-level information will also be printed by PC-Print. There are file limitations, however. PC-Print is designed primarily for use by smaller providers, and cannot accommodate more than 30,000 X12 segments.

FISS providers submitting claims using EMC version 5.0 with line item details will receive full line item payment data in their ERA if they have elected to receive ERA version 3051.4A.

APASS users will see no change to their ERA at this time.

FISS users will see no change to ERA versions 3030M (2.A) or the 3051.3A.

FISS users will see the following changes to the 3051.4A ERA:

1. All information will be reported at the line level, including deductible, coinsurance, professional component, psychiatric and MSP determinations.

2. Each line will carry at least 3 adjustments representing coinsurance, deductible and a contractual group adjustment code attached to a specific reason code rather than the A2 contractual obligation reason code returned in the past.

3. Multiple lines with identical services for the same date will be rolled up to a single line and the units increased in that line to reflect the number of services performed.

4. There will no longer be claim level adjustments for the 3051.4A version.

Providers whose intermediaries use FISS and are currently receiving the 3051.4A ERA must evaluate the impact of these changes on their accounting systems and make applicable systems changes. Providers or vendors should request intermediary version 3051.4A retesting if they are not confident that their accounting system will be able to accept this change in the version 3051.4A output.

DDE providers using FISS will be able to see the reimbursement, coinsurance, deductible, MSP, and non covered monies by line, but will not have the specific non covered reason displayed for that line item. (Some intermediaries may provide options for their providers to query reason codes and make claims corrections during entry on those items that would be returned to the provider because of errors.)

July 2000 — Providers whose intermediary uses APASS will receive deductible, coinsurance, professional component, psychiatric and MSP determinations at the line item-level on the 3051.4A version of the ERA with the implementation of Outpatient PPS. Claim-level data will no longer be reported on this ERA version. APASS users currently receiving the 3051.4A ERA must evaluate the impact of these changes on their accounting systems and make their applicable systems changes. Providers or vendors should request intermediary version 3051.4A retesting if they are not confident that their accounting system will be able to accept this change in the version 3051.4A output.

There will be no change to the prior versions (3030M and 3051.3A) of the remittance advice for any user.

Transitional Payments (TOPs) and outlier payments associated with Outpatient PPS, where applicable, will be reported at the provider level in all ERA versions for all users. TOPs will also be reported at the provider level in the paper RA.

The *effective date* for this PM is May 15, 2000.

The *implementation dates* for this PM are noted above.

These instructions should be implemented within your current operating budget.

This PM may be discarded after May 15, 2001.

If you have any questions, contact Joseph Broseker at (410) 786-1950 or Chester Robinson at (410) 786-6963 and for dark days contact Joe Alascio at (410) 786-5372.