# Program Memorandum Carriers

**Department of Health & Human Services (DHHS)**
**Centers for Medicare & Medicaid Services (CMS)**

**Transmittal B-01-70** **Date: OCTOBER 31, 2001**

**CHANGE REQUEST 1924**

**SUBJECT: Reporting Claims Accounting Information to the Healthcare Integrated General Ledger Accounting System (HIGLAS)**

## Background

The Federal Financial Management Improvement Act (FFMIA) of 1996 requires that Federal agencies implement and maintain financial management systems that comply with Federal management systems requirements. CMS and other Federal agencies are required to follow the Joint Financial Management Improvement Program (JFMIP) guidelines in implementing accounting systems. JFMIP has identified seven financial accounting functions of an integrated government financial management system. These functions are General Ledger Management, Payment Management, Receipt Management, Core Financial System Management, Funds Management, Cost Management, and Reporting Functions.

In order to comply, CMS will install Commercial Off-The-Shelf (COTS) software that contains modules for general ledger, accounts payable, accounts receivable, budget, procurement, grants, etc. This COTS will be the financial software application which supports HIGLAS, for which there are two parts. One part will replace CMS's current administrative accounting system Financial Accounting Control System. The second part and the subject of this Program Memorandum (PM), programmatic benefit accounting will replace the benefit accounting processes used by Medicare contractors.

Medicare contractors' existing American National Standards Institute (ANSI) capabilities with the 4010 version of the ANSI X12N 837 Health Care Claim and Coordination of Benefits (COB) transactions provides an excellent way to simplify the transmission of data between the Medicare contractors and the HIGLAS System. The COB format contains the gross dollar data needed for net payment calculations and will afford CMS an opportunity for data integrity, as each field in the transactions will have consistent data definitions and standards.

Medicare contractors will be in control of the HIGLAS payment management functions for certifying and scheduling payments. HIGLAS will perform all of the payment warehouse functions currently performed by the standard systems including determining payment due date based on type of claim and the claim receipt date. HIGLAS will also perform the accounts receivable offsets. HIGLAS will perform the balance forward or carryover functionality for checks less than a dollar.

Medicare contractors will use HIGLAS functions to control the check number range to be used in the check processing run in the nightly cycle.

HIGLAS will compute interest penalties. HIGLAS will calculate the interest based on the date of receipt and the elapsed number of days measured by the "HIGLAS Payment Floor." HIGLAS Team will work with each Medicare contractor during their transition over the number of mail days required between the release of claims from the floor and their actual mailing, including controls over contractor-specific holidays and planned outages regarding their mail room days. Procedures will be developed for the Medicare contractors to follow when there are problems with a cycle, data center, or printer.

## Action Requested

### Establish Standard Interface Transaction to HIGLAS

The Multi-Carrier System (MCS) standard system maintainer, EDS, will develop an extract of the file(s) that contain their prepayment-floor adjudicated claims. This file or files are used to support the payment of claims activities. Accounts receivable files that may support this process do not need to be included in this extract. The extract will be mapped to a HIGLAS specific rendering of the ANSI X12 837 COB, version 4010, flat file format. The HIGLAS 837 COB will use the HIPAA (Health Insurance Portability and Accountability Act of 1996) 837 COB, version 4010, flat file format as the base starting point for common data dictionary terms. This base flat file structure format can be found at http://www.hcfa.gov/medicare/edi/hipaadoc.htm.

While HIPAA requirements are mentioned in relationship to file transfer between HIGLAS and the standard systems, HIPAA merely provides a foundation for Electronic Data Interchange (EDI) language for HIGLAS. HIPAA requirements do not determine HIGLAS needs.

Logistics Management Institute (LMI) is contracted to CMS to provide support for HIGLAS. LMI will document the MCS cross walk mapping effort from the extract files to the HIGLAS 837 COB. The EDS staff, as directed under a separate work order, will provide information and answer questions to support LMI in documenting the data elements and data uses for every type of claim processed by the MCS standard system. The resulting detail system level mapping will supplement this document. LMI will make the system specific document available to the maintainer by mid-November.

The adjudicated claims to be mapped include all:

- Adjudicated and priced claims,
- Adjusted claims,
- Non-payment demo claims such as: Veterans Administration,
- Medicare Choices,
- Encounter Data,
- Indian Health Services,
- Demonstration claims, and
- Unassigned claims.

The HIGLAS 837 COB file will be produced only for the Empire-NJ pilot carrier for the April 2002 release. The Empire-NJ pilot data will be transmitted as a single file batched in Medicare contractor, provider, and claims order hierarchy. This data will be created on a daily basis as a part of the Medicare contractor batch processing cycle. The pilot site testing of this interface with HIGLAS will be completed by June 3, 2002. Subsequently the file will be produced on an as needed basis for each carrier during their transition to HIGLAS. There will be a phased implementation of HIGLAS over an extended period of time. Therefore, the standard system must be capable of operating in a dual mode. The standard system must operate as it currently does for Medicare contractors that are not interfacing with HIGLAS but will be transitioning to HIGLAS in the future and interfacing with HIGLAS for the transitioned carriers.

Error processing will be done at the file (i.e., batch level) and at the field level. Error correction processing will be required at the file level. If the transmitted file is deemed corrupt by HIGLAS it will be rejected and retransmission will be required. Individual transactions that fail edit checks will need to be corrected by the Medicare contractors in HIGLAS based on HIGLAS error diagnostic reports.

**Extract File Control**

Creation of the extract file will be controlled by the Medicare contractor and data center interfacing with HIGLAS. The MCS maintainer should only provide the capability to create the files for contractors interfacing to HIGLAS. In providing this capability, the MCS maintainer does not need to maintain identification of which contractors are using this interface. In this release no MCS functions should be disabled or changed.

**Analysis for Future Releases**

LMI will develop process flows for all claims transactions and payment functions contained in MCS. The maintainer shall provide information and answer questions to support this analysis. This documentation will be used to determine the July release data interchange requirements from HIGLAS to MCS. In addition, the documentation will be used to identify how the Oracle best practice functionality will compliment the MCS processes to create complete claims processing, payment management, receivable management, and CFO reporting operation.

**The *effective date* for this PM is April 1, 2002.**

**The *implementation date* for this PM is April 1, 2002.**

**These instructions should be implemented within your current operating budget.**

**This PM may be discarded after April 1, 2003.**

**If you have any questions, contact Maureen Hoppa at (410) 786-6958 or Rich Stevens at (410) 786-7547.**