Program Memorandum Carriers

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

Transmittal B-02-030 **Date: APRIL 30, 2002**

CHANGE REQUEST 2087

SUBJECT: Reporting Claims Accounting Information to the Healthcare Integrated General Ledger Accounting System (HIGLAS) for the Durable Medical Equipment Regional Carriers (DMERC)

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. The CMS and other Federal agencies are required to follow the Joint Financial Management Improvement Program (JFMIP) guidelines in implementing accounting systems. The 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 that 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 Medicare contractors and HIGLAS. 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. The 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. The HIGLAS will also perform the accounts receivable offsets and 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.

The HIGLAS will compute interest penalties and will calculate the interest based on the date of receipt and the elapsed number of days measured by the "HIGLAS Payment Floor." The 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 mailroom days. Procedures will be developed for Medicare contractors to follow when there are problems with a cycle, data center, or printer.

Action Requested

Establish Standard Interface Transaction to HIGLAS

The VIPS Medicare System (VMS) standard system maintainer, VIPS, will map the data in the file(s) that contain prepayment-floor adjudicated claims data used to support the payment of claims activities to a HIGLAS specific rendering of the ANSI X12 837 COB, version 4010, flat file format. The HIGLAS 837 COB will use the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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. The file will use ANSI X12 methodology and HIPAA field lengths.

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, but the fields used will be HIPAA compliant.

The Logistics Management Institute (LMI) is contracted to CMS to provide support for HIGLAS. The LMI will document the VMS crosswalk mapping effort from the extract files to the HIGLAS 837 COB. The VIPS 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 VMS standard system. The resulting detail system-level mapping will supplement this document. The LMI will make the system specific document available to the maintainer by early May.

Among the adjudicated claims to be mapped include all:

- Claims that have been both 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 Palmetto DMERC pilot carrier for the October 2002 release. The Palmetto DMERC pilot data will be transmitted as a 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. After pilot site testing of this interface with HIGLAS, a file will be produced on an as needed basis by carriers during their transition to HIGLAS. There will be a phased implementation of HIGLAS over an extended period. 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. Additional error handling procedures will be developed during pilot testing.

Extract File Control

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

Analysis for Future Releases

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

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

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

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2003.

If you have any questions, contact Maureen Hoppa at (410) 786-6958.