New Hampshire Comprehensive Healthcare Information System Annual Healthcare Claim Processors Meeting

In-person (NH DHHS Brown Room 468) and WebEx

Wednesday, October 11, 2017
1:00pm – 2:30pm EDT

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Agenda

- Introduction
  - DHHS
  - NHID
  - Milliman
  - UNH
- Updated NH CHIS Registration Website
  - What's New and Improved
  - 2017/2018 Registration
- Exception Requests, TPA File Submissions, New Thresholds and Quality Checks
  - Exception Requests
  - TPA's File submissions
  - New Thresholds and Quality Checks
- Population of Billed Amount, Paid Amount and Deductible Amount
- How are Payers coding Final Claims?
- Implementation Dates
- Questions

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NH CHIS Updated Registration Website

Presenters: Mary Fields (DHHS); Rose Hess (Milliman)

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Updated NH CHIS Registration Website

- What's New and Improved?
  - Registration pages clearer and easier to understand.
  - Questions regarding NH rule changes from 2016 are incorporated in the Registration process.
  - Ability for carriers to "jump" to different pages when registering.
  - Ability for carriers to add text notes to each of the registration pages.
  - New Platform page to add carrier information regarding source platform and/or location.
  - New Submission Status and Platform Changes page for documenting platform changes or if a carrier is sun-setting.
  - Parent company and Child Payer code section on "Company Information" page.
- 2017/2018 Registration:
  - Once updates have been moved to production, the NH CHIS Registration Website will be available for all carriers to register for 2017/2018.
  - Anticipated Go-Live for deploying updated NH CHIS Registration Website is December 1, 2017

Exception Requests, TPA File Submissions, New Thresholds and Quality Checks

Presenters: Maureen Mustard (NHID); Mary Fields (DHHS)

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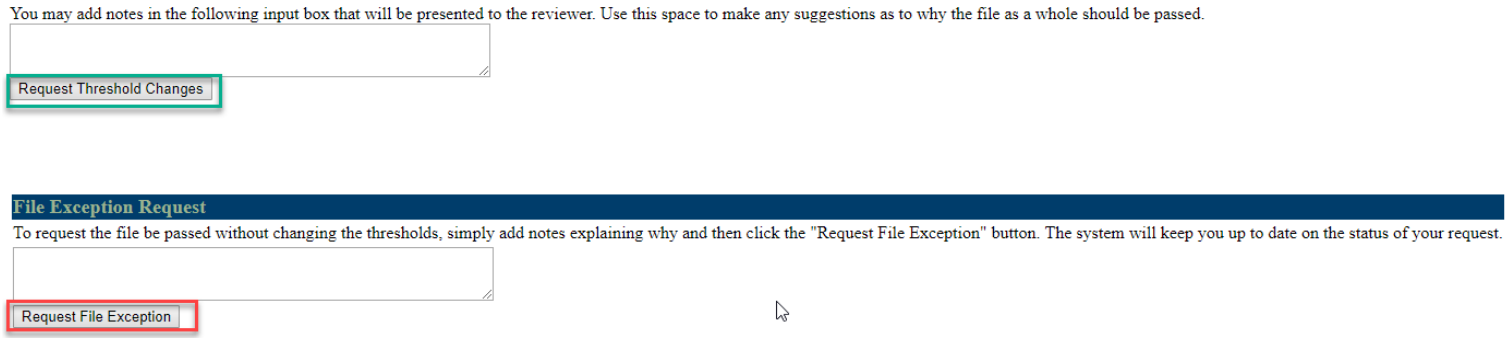
Exception Requests

- Provide proper reasons for Exception Requests in order for NHID to grant threshold changes.
  - NHID will deny exception requests when notes are left blank or if there isn't appropriate reasoning provided in the Exception Notes section.
    - Examples of exception notes that result in the Exception Request denied:
      - "It's kind of close to the threshold"
      - "It's close to what you have approved before"
    - Examples of acceptable notes in reason for request:
      - We do not require that field to be populated on claims.
      - "This month had a large number or X (reversals, professional claims, institutional claims) that resulted in unusual results."

- Submit Exception Requests with Threshold Changes instead of requesting the file be passed "as is".



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TPA File Submissions

- TPA's file submissions:
  - It is the Parent Payer's responsibility to ensure that the data is correct.
  - Any carrier who collects the premium for the policy is responsible for data submissions. If you have a TPA and will wish to have that TPA submit on your behalf you need to work directly with NHID for approval.

New Thresholds and Quality Checks

- New Data Elements documentation can be found on NHCHIS website:
  https://nhchis.com/Documents/DataSubmission/INS%204000%20Summary%20Of%20Changes.xlsx

- New Data Elements were implemented in 2016 without Thresholds and Quality Checks:
  - Beginning **1/1/2018**, new thresholds and new Quality Checks will be implemented.
    - New Thresholds:
      - Medical Claims File
        - MC202-MC206: Valid Value Checks (100%) for all ICD-CM Procedure codes
        - MC212: Allowed Amount – Minimum population (100%) – No Decimals
        - MC215: Service Line Type - Minimum population (100%) and Valid Value Check (100%)
        - MC216: Payment Arrangement Type - Minimum population (100%) and Valid Value Check (100%)
        - MC217: Pay for Performance Flag - Minimum population (100%) and Valid Value Check (100%) *
        - MC219: Denied Claim Indicator - Minimum population (100%) and Valid Value Check (100%) * – Null (empty) is not a valid value
        - MC220: Denial Reason- Valid Value Check (100%) *
        - MC221-MC222: Valid Value Checks (100%) for all Procedure Modifiers

* Already implemented

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New Thresholds and Quality Checks (continued)

- New Thresholds:
  - Pharmacy Claims File
    - PC212: Allowed Amount – Minimum population (100%) – No Decimals
    - PC215: Service Line Type - Minimum population (100%) and Valid Value Check (100%)
    - PC216: Denied Claim Indicator - Minimum population (100%) and Valid Value Check (100%) * – Null (empty) is not a valid value
    - PC217: Denial Reason- Valid Value Check (100%) *
  - Dental Claims File
    - DC203: Practitioner Group Practice – Minimum population (5%)
    - DC204: Tooth Number/Letter – Valid Value Check (100%) – Null (empty) is a valid value
    - DC205: Dental Quadrant – Valid Value Check (100%) – Null (empty) is a valid value
    - DC206: Tooth Surface – Valid Value Check (100%) – Null (empty) is a valid value
    - DC207: Claim Version – Valid Value Check (100%) *
    - DC208: Diagnosis Code – Valid Value Check (100%) * – Null (empty) is a valid value
    - DC215: Service Line Type - Minimum population (100%) and Valid Value Check (100%)
    - DC219: Denied Claim Indicator - Minimum population (100%) and Valid Value Check (100%) * – Null (empty) is not a valid value
    - DC220: Denial Reason- Valid Value Check (100%)

* Already implemented

New Thresholds and Quality Checks (continued)

- New Thresholds:
  - Eligibility File
    - ME203: Member's Assigned PCP – NH to review and determine minimum population threshold.
    - ME204: HIOS Plan ID – All QHP payers are required to have this populated 100%
    - ME205: Plan Effective Date – All QHP payers are required to have this populated 100%
    - ME206: Minimum Value – All QHP payers are required to have this populated 100%
    - ME207: Exchange Indicator – All QHP payers are required to have this populated 100%
    - ME208: High Deductible Health Plan – All QHP payers are required to have this populated 100%
    - ME209: Active Enrollment – All QHP payers are required to have this populated 100%
    - ME210: New Coverage – All QHP payers are required to have this populated 100%
    - ME211: Monthly Premium or Premium Equivalent – Per the NH Rule, this field is required to be populated.

  - Provider File
    - MP004: Provider Tax ID – Minimum population (100%) *
    - MP005: Provider Entity - Minimum population (100%) and Valid Value Check (100%) *
    - MP006: Provider First Name – Minimum population (40%)
    - MP008: Provider Last Name or Organization – Minimum population (100%) *
    - MP010: Provider Specialty – Minimum population (90%) *
    - MP011: Provider Office Street Address – Minimum population (95%) *
    - MP012: Provider Office City – Minimum population (95%) *
    - MP013: Provider Office State – Minimum population (100%) *
    - MP014: Provider Office Zip – Minimum population (95%) *

* Already implemented

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New Thresholds and Quality Checks (continued)

- New Quality Checks:
  - Medical Claims File:
    - MC207 (Carrier Associated with Claim) – Should always be populated when the carrier submitting the file is a TPA and is contracting with a carrier under a carve out relationship.
    - MC208 (Carrier Plan Specific Contract Number) – Should always be populated when the carrier submitting the file is a TPA.
    - MC210 (Coordination of Benefits – Third Party Liability) – Percentage of records where this field is populated when the Claim Status is not primary.
    - MC211 (Cross Reference claim ID) – The original Payer Claim Control Number (MC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (MC005A) is not used.
    - MC212 (Allowed Amount) – If MC038 (Service Line Status) = 4 or 22, then Allowed Amount should contain a Zero.
    - MC220 (Denial Reason) – The percentage of records where MC219 (Denied Claim Indicator) = 1 or 3 or where MC219 (Denied Claim Indicator) = 2 or 4 and contains a valid Denial Reason that is not null. *
    - MC223 (HIOS Plan ID) – Percentage of records having the HIOS ID populated for carriers considered to be a QHP Plan.
  - Pharmacy Claims File
    - PC203 (Carrier Associated with Claim) – Should always be populated when the carrier submitting the file is a TPA and is contracting with a carrier under a carve out relationship..
    - PC204 (Carrier Plan Specific Contract Number) – Should always be populated when the carrier submitting the file is a TPA.
    - PC211 (Cross Reference claim ID) – The original Payer Claim Control Number (PC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim.
    - PC212 (Allowed Amount) - If PC025 (Service Line Status) = 4 or 22, then Allowed Amount should contain a Zero.
    - PC213 (HIOS Plan ID) – Percentage of records having the HIOS ID populated for carriers considered to be a QHP Plan.
    - PC217 (Denial Reason) – The percentage of records where PC216 (Denied Claim Indicator) = 1 or 3 or where PC216 (Denied Claim Indicator) = 2 or 4 and contains a valid Denial Reason that is not null. *

* Already implemented

New Thresholds and Quality Checks (continued)

- New Quality Checks (Continued):
  - Dental Claims File:
    - DC201 (Carrier Associated with Claim) – Should always be populated when the carrier submitting the file is a TPA and is contracting with a carrier under a carve out relationship..
    - DC202 (Carrier Plan Specific Contract Number) – Should always be populated when the carrier submitting the file is a TPA.
    - DC204 (Tooth Number/Letter) – Percentage of records where DC204 is populated and when DC032 is in the range of D2000 – D2999
    - DC205 (Dental Quadrant) – – Percentage of records where DC205 is populated and when DC032 is in the range of D2000 – D2999
    - DC206 (Tooth Surface) – – Percentage of records where DC206 is populated and when DC032 is in the range of D2000 – D2999
    - DC209 (ICD Indicator) – Percentage of records where DC208 is populated and DC209 is populated with valid values.
    - DC211 (Cross Reference claim ID) – The original Payer Claim Control Number (DC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Claim Version (DC207) is not used.
    - DC213 (HIOS Plan ID) – Percentage of records having the HIOS ID populated for carriers considered to be a QHP Plan.
    - DC220 (Denial Reason) – The percentage of records where DC219 (Denied Claim Indicator) = 1 or 3 or where DC219 (Denied Claim Indicator) = 2 or 4 and contains a valid Denial Reason that is not null. *
  - Eligibility File:
    - ME204 (HIOS Plan ID) – Percentage of records having the HIOS ID populated for carriers considered to be a QHP Plan.
    - ME205 (Plan Effective Date) – Percentage of populated ME205 records must be the same percentage of records populated as ME204.
    - ME206 (Minimum Value) – Percentage of populated ME206 records must be the same percentage of records populated as ME204.
    - ME207 (Exchange Indicator) – Percentage of populated ME207 records must be the same percentage of records populated as ME204.
    - ME209 (Active Enrollment) – Percentage of populated ME209 records must be the same percentage of records populated as ME204.
    - ME210 (Plan Effective Date) – Percentage of populated ME210 records must be the same percentage of records populated as ME204
  - Provider File:
    - MP006 (Provider First Name) – Percentage of records populated when MP005 (Provider Entity) = 1
    - MP018 (Entity Code) – Percentage of records where MP018 is populated with a valid value when MP005 (Provider Entity) <> 1 (Individual Provider)

* Already implemented

Population of Billed Amount, Paid Amount and Deductible Amount

- Definition of how these fields should be populated:
  - Billed Amount: This should always reflect the amount on the claim as billed from the provider.
  - Paid Amount: This should always reflect the amount paid to the provider.
  - Deductible Amount: This is the deductible amount, not the co-insurance and/or copay applied toward deductible.

How are Payers coding for Final Claims?

- Medical Claims
  - MC004 – Payer Claim Control Number
  - MC005A - Version Number
  - MC211 – Cross Reference Claims ID

- Pharmacy Claims
  - PC004 – Payer Claim Control Number
  - PC211 – Cross Reference Claims ID

- Dental Claims
  - DC004 – Payer Claim Control Number
  - DC207 – Claim Version
  - DC211 – Cross Reference Claims ID

Implementation Schedule & Important Dates

- December 2017 – New NH CHIS Registration Website available for 2017/2018 carrier registration.
- January 1st 2018 – New Thresholds and Quality checks implemented.
- TBD – NH will be evaluating and updating existing Field and SQL Quality checks and thresholds. We will be communicating before changes are implemented.

Questions or Comments Regarding Policy?

Please direct any questions or comments to:

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Questions or Comments?

Please direct any questions or comments to:

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Thank you

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