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Provider Perspective on Medicare's COB Edits

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Background & Purpose

- CMS Transmittal 107 (MM#3031) introduces new edits to the HIPAA 837 Institutional Claim
- Intended to resolve issues preventing successful Coordination of Benefits
- Effective date for the edits is July 1st
- Coincidentally CMS intends to modify their Contingency Plans related to the time lines for handling legacy electronic formats – to be the same as paper claims

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WEDI Hearings

- Late January 2004 – testimony indicates the importance of contingency plans until sufficient volume of success is achieved
  - Recognition that the testing process is complex
- WEDI issues recommendation letter to NCVHS to ensure progress in the transition to the HIPAA standards
  - Market forces will forge greater use of the HIPAA standards
  - Importance of sequencing readiness – health plans, clearinghouse, and then providers
  - Consistency in testing, interpretation, and application of the standards is essential

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Provider Concerns

- Importance of maintaining payment cycle is essential for providers
- Growing proliferation of health plan “companion guides” along with inconsistency in the handling of the standard
  - Acknowledgement of receipt
  - Handling of errors or deficiencies in the transaction
    - Rejection of entire transaction or Claim specific
- Provider reliance on vendors to help them comply with the HIPAA standards
  - Inability of providers to control vendor readiness
  - Inability of vendors to handle multiple payer nuances in the application of transaction standard

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What is the Basis for the July changes?

- Appears that CMS intends to force the use of the standards – because it is costly to maintain multiple formats
  - Creates punitive measures on providers for not using the HIPAA format (delay in processing claims)
    - Ignores provider problems in utilizing standards
      - Testing
      - Vendor
      - Funding
- Impose additional edits in order to conduct COB
  - Creates additional reasons for rejecting the provider's claim even though there are health plan inconsistencies in the application of the standard while very little COB is underway
  - Intended to provide additional ROI
    - Providers, however, need better remittance, eligibility and claims status from health plans – greater ROI

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Provider View

- Lack of fairness and understanding of the problem
  - Providers want a STANDARD
  - Complexity of the testing and transition process (as noted in the WEDI hearings)
    - Progress toward adopting the standard is key
    - “Safety Net” is essential for providers for providers to continue to make progress – ensuring continuity of the payment cycle
  - CMS is not compliant in several areas of the transaction
    - Revenue Code
    - Patient Status Code
    - Condition Code
  - Importance of problem solving and dialogue among trading partners
    - Understanding issues and obstacles – working collaboratively to resolve them

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Recommendations

- Do not impose additional payment delays for use of legacy formats if the provider is making a good-faith effort in moving to the HIPAA standard
- Do not reject claims for failing to contain additional COB edits
  - Allow primary payment to continue
  - Do not delay payment
  - Notify provider that COB could have been completed if additional data elements were provided

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Questions

- Thank you
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