

Post-Adjudicated Claims Data (Encounter) Reporting on the 837 Payer-to-Payer COB

Presented by: Brent Ratterree

Arizona Health Care Cost Containment System

Goal(s)

- a) Show how the 837 may be used to report payer-to-payer COB post-adjudicated claims data; or
- b) Provide something useful for your claims/encounter environment; or
- c) Have a good time



Agenda

- Background
 - operational environment
 - encounter data use by the agency
 - encounter processing environment
- Professional services mapping example
 - current data elements
 - current to X12 837 data elements

Background



Operational environment

- AHCCCS established in 1982 to deliver health care under managed care concept
 - Acute, long-term care, and behavioral health services
 - Title XIX, XXI, and state-only population
- Small percent of population not enrolled in managed care

Operational environment continued

- AHCCCS maintains source data for:
 - Recipients (subscribers)
 - Providers (must be registered prior to rendering services and receiving MCO payment)
 - Reference (code sets)
- MCOs required to submit post-adjudicated claims (encounter) data to AHCCCS

Encounter data use

- Fee-for-service/MCO capitation rate setting
- Reinsurance calculation and payment
- Disproportionate share hospital rate calculations
- MCO evaluation (expected vs. actual)
- Utilization review and reporting
- Quality of care and outcome measurements

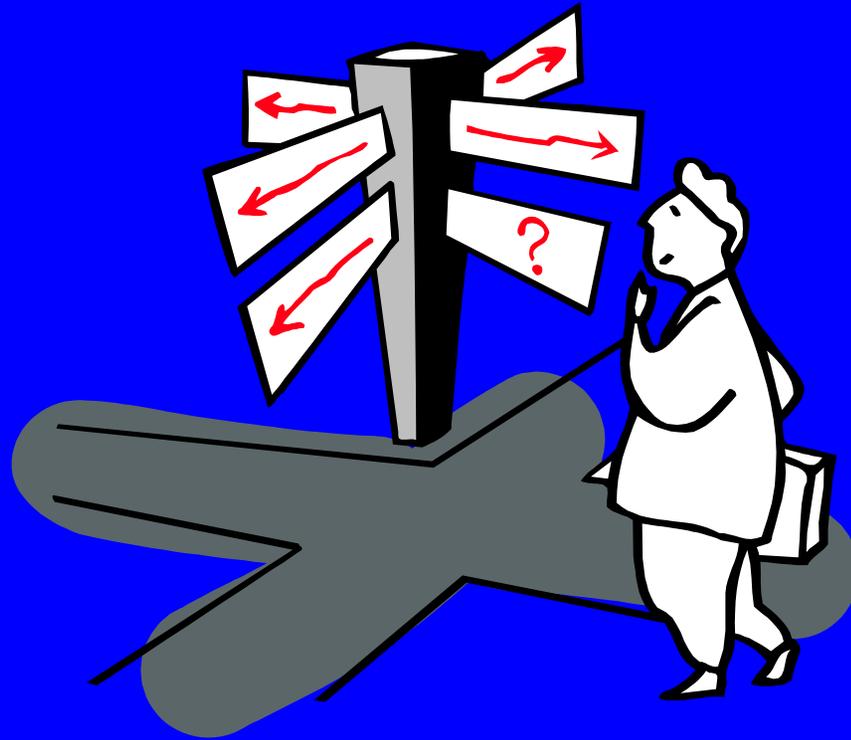
Encounter data use continued

- QISMC/HEDIS reporting and clinical performance measurements
- Medical record audits
- Federal (MSIS, HCFA-64, HCFA-416) reports
- Fraud and abuse analysis & reporting
- General information management
- Decision support and “what-if” analysis

Encounter processing environment

- Claims-type edits & processing results
 - Finalized
 - Pended
 - MCOs must correct errors in order to finalize
- Proprietary format
 - Professional, dental, institutional, and retail pharmacy services

Professional services mapping example



Current data elements

- Current required data elements
 - Header and trailer (not mapped)
 - Demographic
 - Clinical
 - Financial

Demographic data

- Contractor (MCO) ID
- Plan claim (transaction) number
- Service provider ID
- Service provider location code
- Medical record number
- Patient account number

Demographic continued

- Member AHCCCS (subscriber) ID
- Other insurance indicator
- Adjustment code (change to finalized encounter)
- Original AHCCCS control reference number (adjustments/voids/reversals)

Clinical data

- Line number
- From date of service
- Through date of service
- Place of service
- Procedure code
- First procedure modifier code
- Second procedure modifier code

Clinical data continued

- Units of service
- First diagnosis code
- Second diagnosis code
- Third diagnosis code
- Fourth diagnosis code

Financial data

- Claim line (billed) charge
- MCO allowed amount
- MCO paid amount
- Non-covered charges
- Non-covered units
- Subcapitated code (report MCO contractual arrangement with provider & processing exceptions)

Financial data continued

- Medicare allowed amount
- Medicare deductible amount
- Medicare coinsurance amount
- Medicare paid amount
- Other insurance payment amount
- AHCCCS allowed amount (derived)
- AHCCCS paid amount (derived)

Current to X12 837 mapping

- Contractor ID
 - Submitter identifier – loop 1000A NM109
 - Payer identifier – loop 2330B NM109
 - Other payer identifier reference ID – loop 2330B REF02
- Plan claim number
 - Rendering provider name identification code – loop 2310B NM109
- Provider ID/Location

Mapping continued

- Medical record number
- Patient account number
- Member ID
- Medical record number – loop 2300 REF02
- Claim submitter's identifier – loop 2300 CLM01
- Subscriber primary identifier - loop 2010BA NM109

Mapping continued

- Other insurance indicator
- Adjustment code
- Original control reference number
- Payer responsibility sequence code – loop 2320 SBR01
- Insurance type code – loop 2320 SBR05
- Claim frequency type code – loop 2300 CLM05-3
- ICN/DCN reference identification – loop 2300 REF02

Mapping continued

- Line number
- From & through date of service
- Place of service
- Service line – loop 2400 LX01
- Date – service date – date time period – loop 2400 DTP03
- Professional service facility code value – Loop 2400 SV105

Mapping continued

- Procedure code
- 1st modifier
- 2nd modifier
- Units of service
- Product/service ID – loop 2400 SV101-2
- Procedure modifier – loop 2400 SV101-3
- Procedure modifier – loop 2400 SV101-4
- Quantity – loop 2400 SV104

Mapping continued

- 1st Diagnosis
- 2nd Diagnosis
- 3rd Diagnosis
- 4th Diagnosis
- DX industry code – loop 2300 H101-2
- DX industry code – loop 2300 H102-2
- DX industry code – loop 2300 H103-2
- DX industry code – loop 2300 H104-2

Mapping continued

- Claim line charge
- MCO allowed
- MCO paid
- Monetary amount (submitted) – loop 2400 SV102
- Monetary amount (approved) – loop 2400 AMT02
- Line adjustment monetary amount – loop 2430 CAS03 (CAS01=CO)
- Monetary amount (paid) – loop 2430 SVD02

Mapping continued

- Non-covered charges
- Non-covered units
- Subcapitated code
- Medicare allowed
- Line adjustment monetary amount – loop 2430 CAS03
- Line adjustment monetary amount – loop 2430 CAS04
- Contract type code – loop 2400 CN101
- Line adjustment monetary amount – loop 2430 CAS03 (CAS01=CO)

Mapping continued

- Medicare deductible
- Medicare coinsurance
- Medicare paid
- Other insurance paid
- Line adjustment monetary amount— loop 2430 CAS03 (CAS01=PR)
- Line adjustment monetary amount – loop 2430 CAS06 (CAS01=PR)
- Line adjudication monetary amount – loop 2430 SVD02
- Line adjudication monetary amount – loop 2430 SVD02

Mapping continued

- Continue to derive
 - AHCCCS allowed
 - AHCCCS paid
- Situational required fields (example)
 - Patient information (newborn weight) – loop 2000B PAT07 and PAT08

Questions



Thank you for attending

Contact information:

Brent Ratterree

rbratterree@ahcccs.state.az.us

602.417.4571

602.417.4725 fax

Arizona Health Care Cost Containment System

www.ahcccs.state.az.us