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AUC Update

February 19, 2014

The AUC Update is published monthly and provides news and updates regarding the Minnesota Administrative Uniformity Committee (AUC) and Minnesota's health care administrative simplification initiative pursuant to Minnesota Statutes, section 62J.536 and related federal and state regulations. The Minnesota Department of Health (MDH) administers MS §62J.536 and publishes this newsletter in association with the AUC.

More information about the AUC is available at: AUC home page.

Inside this issue:

AUC Planning for 2014 Discussions and Projects -- Interested Participants and Leaders Sought

Note: Following are two trailers for coming AUC attractions planned for 2014. For more information, and/or to indicate interest in participating/leading in the making of the actual movies, please contact MDH staff at the AUC mailbox (health.auc@state.mn.us).

Standard Notification of Grace Period for Premium Non-payment

A federal rule for implementationof Health Insurance Exchanges, 45 CFR §156.270, "Termination of coverage for qualified individuals," requires that a qualified health plan issuer "*must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must: … (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.*"

However, the rule does not specify how the provider notification above is to be accomplished most effectively and efficiently. As a result, the AUC, as well as others in the industry, are exploring options for standard, electronic provider notifications to meet the above requirements. ASC X12 for example has recently developed a series of best practices for using the eligibility, claim payment advice, and acknowledgment transactions to notify providers of the grace period.

The AUC Executive Committee and MDH staff are planning next steps to help address the issue, starting with learning more about and building upon the ASC X12 best practices. The Executive

Committee will be coordinating with the relevant AUC Technical Advisory Groups (TAGs) on the project but also seeks anyone else interested in participating or helping lead the project. For more information, or to indicate interest in participating or helping lead the project, please contact MDH staff via the AUC mailbox by February 21.

Alternative Forms of Care Delivery and Payment

Nationally, and across states and other organizations, the health care industry is being challenged to develop and test new alternative health care delivery and payment arrangements to bring about more comprehensive, integrated, accountable forms of health care and financing, including "accountable care organizations (ACOs)" and new forms of "bundled payment."

In order to transition to these new, alternative models of health care delivery and financing, it will be important to help develop and maintain the corresponding administrative billing and coding infrastructure that will be needed. The AUC will be working in 2014 to learn more about administrative issues associated with new forms of care delivery and payment, and to help address them.

As with the Standard Notification project above, the Executive Committee will be coordinating with the relevant AUC Technical Advisory Groups (TAGs) on the project but also seeks anyone else interested in participating or helping lead the project. For more information, or to indicate interest in participating or helping lead the project, please contact MDH staff via the AUC mailbox by February 21.

AUC Operations Meeting on March 3 to Focus on ICD-10

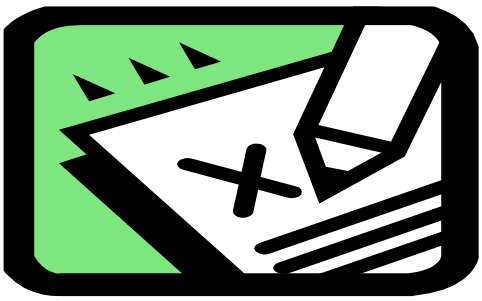
The AUC Operations Committee (committee of the whole) will meet March 11, 2:00 p.m. – 4:00 p.m. The meeting location is pending at this time, and additional meeting information will be posted on the AUC website calendar page in the near future.

The focus of the meeting will be to provide information and updates regarding the health care industry's required transition to ICD-10 coding for dates of health care services on or after October 1, 2014.

The transition to ICD-10 has been likened by some as similar to computer system upgrades and testing that were undertaken as part of Y2K preparations prior to year 2000. As noted in the article below, recent surveys have shown that the industry nationally is lagging behind in ICD-10 preparations and readiness.

AUC Operations members can expect to receive additional information in advance of the meeting, and the information will also be posted on the AUC Operations meetings web page.

Recent National Surveys Show Lack of ICD-10 Readiness



A number of recent independent national surveys of ICD-10 readiness paint a similar picture of an industry that is generally unprepared and not yet taking sufficient action to successfully transition to ICD-10 coding by the required date of October 1, 2014. Excerpts of several recent survey results are provided below.

National Medical Group Managers Association (MGMA) - Jan. 2014 survey

According to MGMA, 38.4% of clinics responding in a recent national survey reported they had not started ICD-10 implementation; another 40.9% said they were "somewhat ready."

Navicure – Fourth quarter 2013 survey

"Results from the second survey revealed a high degree of optimism towards being prepared for ICD-10. This is ironic given providers' general lack of preparation thus far. For instance, 74% of respondents have not begun implementing their transition plan, yet most are confident they will be prepared by the October 1, 2014, deadline."

"Another seeming contradiction is related to respondents' faith in their technology vendors. Most respondents do not anticipate any disruptions due to their electronic health record (EHR), practice management (PM) system or clearinghouse vendors' performance, yet many say they have not received substantive communication from vendors regarding upgrades and timing."

KPMG International - Fourth quarter 2013 survey

"The KPMG poll …found that …the majority of payer and provider respondents … were significantly deficient in preparing for key aspects of implementation."

"Nearly three-quarters (74 percent) of respondents said that they have yet to or are not planning on conducting testing that involves external entities, such as health plans, providers and trading entities…"

Workgroup on Electronic Data Interchange (WEDI) – October 2013 survey

"Based on the survey results, it is clear the industry continues to make slow progress, but not the amount of progress that is needed for a smooth transition. The industry is far behind the milestones suggested in the WEDI/NCHICA timeline, and has slipped further behind when compared to the February 2013 survey results."

"Unless all segments move quickly forward with their implementation efforts, there will be significant disruption on Oct 1, 2014."

Updated CARC-RARC Combinations Available, Must be Followed by Those Subject to Minnesota's Requirements

The Committee on Operating Rules for Information Exchange (CORE), which is responsible for developing and maintaining federally mandated operating rules, recently announced that an updated version of the federally mandated "CAQH CORE 360: Uniform Use of CARCs and RARCs Rule" for the health care claim payment/advice (electronic remittance advice – ERA) transaction is now available. The latest version is version 3.0.4 (February 1, 2014), available at CORE 360 Update.

The CORE 360 operating rule defines a minimum set of common or problematic business scenarios along with a maximum specified set of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) combinations for each of the scenarios. These code combinations must be updated periodically to align with the current published CARC and RARC lists, which are maintained by separate national code committees and updated at least three times per year.

Minnesota's rule for the standard exchange of ERAs requires that if the applicable business scenario is described by the CORE 360 rule, then the CORE 360 CARC-RARC code combinations must be used. Minnesota's rule, known as the "Minnesota Uniform Companion Guide" for the ERA, also incorporates by reference any changes to the CARC-RARC code combinations. Consequently, those subject to Minnesota's rule must use the correct CORE CARC-RARC code combinations as applicable, including any adjustments or updates as they become available from CORE.

AUC change request to X12 approved

As reported previously, the Minnesota Department of Health (MDH) submitted a change request on behalf of the AUC to ASC X12, requesting that

particular capabilities in the claims transaction for reporting taxes be continued in future versions of the transaction. The change is needed to continue to adequately report Minnesota's provider gross revenue tax known as the "MinnesotaCare" tax, which differs from a sales tax, and for reporting other provider taxes in other states.

X12 recently approved the request to continue capabilities for reporting the tax in future versions of the ASC X12 claims implementation guides. X12's statement of business requirements for the change include:

- B.1. 837I, 837P, 837D 837R, Loop 2400 - Need the ability to have a new AMT segment for state care taxes.
- B.2. New Code value(s) in DE 522 - Amount Qualifier Code is needed for the AMT01.
- B.2.1 Recommend code value definition as "State Care Tax."
- B.3 – Situational Rule would only be required when the State Care Tax applies to the service line and the submitter is required to report that information to the receiver. If not required by this implementation guide, do not send.
- B.4 TR3 Note added to state that the State Care Tax Amount would be included in the Line Charge Amount (SV102) for this service line.
- B.5 TR3 Note added to state that Sales Tax would not be reported in the new State Care Tax Amount AMT segment.

AUC Technical Advisory Group (TAG) Updates

For additional information about AUC TAGs and their activities, please see the TAG page at AUC TAG page. TAG meetings are open, public meetings, and are generally conducted via teleconference rather than in-person. Meeting agendas and other materials are posted on the AUC website in advance. Information about upcoming TAG meetings is available by going to the AUC calendar page at: AUC Calendar.

AUC Executive Committee

The AUC Executive Committee met on February 3, 2014. Highlights of the meeting included:

- Initial planning for AUC efforts to address needs for standard notification of providers of grace periods for non-payment of premiums, and initial planning for AUC discussions of administrative needs and issues in implementing new forms of more integrated health care delivery and financing;
- Initial discussion and planning of the next AUC Operations Committee meeting on March 11, with a focus on the transition to ICD-10 coding; and
- A number of updates and additional reviews and planning, including final steps for submission of an AUC Comment regarding a recent federal notice of proposed rulemaking (NPRM) for health plan certification, as well as planning for AUC orientation and education, and membership and policy and procedure updates.

Upcoming TAG meetings

- **February 18**, 1:00 p.m. - 2:30 p.m. -- **EOB Remit TAG** (Teleconference & WebEx only) --***Canceled***
- **February 26**, 2:00 p.m. - 4:00 p.m. -- **Eligibility TAG** (Teleconference & WebEx only)
- **March 3**, 8:30 a.m. – 10:30 a.m. – **Executive Committee** (Teleconference & WebEx only)
- **March 11**, 2:00 p.m. – 4:00 p.m. – **Quarterly Operations Meeting** (Location TBD)
- **March 13**, 9:00 a.m. – 12:00 p.m. – **Medical Code TAG** (HealthPartners, Bloomington, MN)
- **March 13**, 2:00 p.m. – 4:00 p.m. – **HPID/OEID TAG** (Teleconference & WebEx only)
- **March 17**, 1:00pm - 2:30pm -- **EOB Remit TAG** (Teleconference & WebEx only)
- **March 26**, 2:00 p.m. - 4:00 p.m. -- **Eligibility TAG** (Teleconference & WebEx only)

National Industry News

NCVHS meets February 19-21, will discuss numerous issues of interest to the AUC

The National Committee on Vital and Health Statistics (NCVHS), a formal, chartered advisory body to the US Department of Health and Human Services (HHS), is scheduled to meet February 19-21, 2014. The NVCHS makes recommendations to HHS regarding health care administrative simplification and other issues.

The NCVHS Subcommittee on Standards will meet February 19 to review and discuss a number of topics of interest to the AUC, including Operating Rules, ICD-10, pharmacy prior authorization, and Health Plan ID (HPID). The NCVHS Full Committee meets February 20 and 21 and will discuss reports from the Standards Subcommittee, HHS, and others.

More information, including how to attend via teleconference, is available at the NCVHS website.

WEDI announces free "ICD-10 Success Initiative" webinar series starting February 21

[The following article is summarized from the WEDI "ICD-10 Success Initiative" press release.]

The Workgroup for Electronic Data Interchange (WEDI), in partnership with the Centers for Medicare and Medicaid Services (CMS) and others, recently announced the launch of an "ICD-10 Success Initiative" webinar series. The goal of this initiative is to ensure a successful ICD-10 implementation for all healthcare industry stakeholders including healthcare providers, payers, clearinghouses and vendors. The first webinar of this series, the *Guide to Jumpstart Your ICD-10 Compliance Efforts*, is free to attend and will take place on Feb. 21 at 10:00 a.m. – 11:00 a.m. CST. The agenda for the first session includes essential tips to:

- Guarantee documentation is upgraded;
- Code in ICD-10;
- Confirm practice management systems can take in ICD-10;
- Ensure transactions can be produced with ICD-10;
- Test with trading partners;
- Clarify the role of the clearinghouse and what it can and cannot accomplish.

Additional information and registration for the webinar is available at WEDI Jumpstart webinar.

Additionally, members of the health IT community may also send their implementation challenges to a searchable database of ICD-10 issues, which is open to the public for submission. As part of the ICD-10 Success Initiative, WEDI, CMS and their partners will help to triage issues submitted through the database and provide valuable information and resources to help healthcare organizations understand how the new codes and coding standards will impact diagnosis and inpatient procedures.

For more information, please see the press release and related links at the websites above.

WEDI announces the availability of several recent new white papers

WEDI has recently announced several new white papers and issue briefs on a variety of administrative simplification-related topics. The documents are available on the WEDI

complementary resources website page and include:

- *"Reassociating Healthcare Payments White Paper*: Addresses the reassociation process of all formats, with an emphasis on electronic formats and non-zero payments. Gain an understanding of the process …, along with recommended best practices and tools for overcoming obstacles, to allow providers to manage the reassociation process more easily."
- *"Overpayment Recovery 5010 Education Issue Brief*: Offered as a resource to provide education on overpayment recovery challenges …, this issue brief explores the complexities on both the payer and provider sides."
- *"Sales Tax Best Practices Guideline White Paper:* This document serves as a guideline for reporting taxes on dental services in jurisdictions where applicable. Individuals from payers, practice management, clearing houses and provider organizations compiled this best practices guideline to instruct the dental community on how and to apply the code consistently."