EDI Xpeditor User Conference

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Ohio Hospital Association, in addition to the first of four Breakout Sessions offered throughout the event, followed.

Clients chose from a variety of meetings with topics ranging from the enhanced tools available for managing Xpeditor, tips and tricks to effectively use the system, and a CMS-1500 discussion. The first set of Breakout Sessions led to the vendor networking reception and entertainment portion of the conference. Attendees were given the chance to "Move into the Winner's Circle" at the night's event. "A Night at the Races" featured many pre-recorded horse races displayed on a large screen that the participants could choose to bet on. Winners' names were inserted into a drawing for prizes, including a $100 Visa Card, digital camera, and Home Entertainment Center.

The second day of the conference began with a demonstration of the soon-to-be released Xpeditor 5.0 and the differences between this new software and our classic Xpeditor. The Client Case Studies were presented next, during which a Quadax EDI Account Representative and Xpeditor client displayed the client's testimonies of how Quadax worked with them to overcome certain problems.

The remaining three Breakout Sessions followed, which focused on Medicare Part A claim management tools, basic fundamentals of Xpeditor, understanding its COB functions, and a round table discussion of the UB-04. The day also consisted of Panel Discussions led by recognized leaders in healthcare organizations throughout the region, in addition to Quadax EDI Management, who addressed questions and suggestions submitted by clients covering assorted Xpeditor subject matter. The conference then came to a close with gift giveaway drawings for those who attended.

The success of this year's Xpeditor Enterprise User Conference was made possible by the dedicated individuals of the Quadax EDI department. Their hard work and commitment to client satisfaction contributed to the best User Conference yet, and paves the way for next year's event. ◊

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Q-TIPS

Volume 12, Issue 2 The Quadax quarterly newsletter of technical information and corporate news Spring 2007

Plan For the UB-04 Health Plan ID Field

By Chuck Parker, EDI Project Leader

With the implementation of this new billing form, there are several new fields that have been introduced, many of which have unfortunately caused some confusion with regard to their usage. This field, Block 51 on the UB-04, is described in the NUBC manual as:

"The number used by the health plan to identify itself."

Eventually, this field will be used to report the **National Plan Identifier**, once CMS and other groups decide on a coding scheme that can meet every insurance company's needs to identify themselves. Until the NPI for insurance carriers can be decided on, whichever code is currently being used to identify an INSURANCE COMPANY should be used in this block. This is **NOT**, in most cases, the Provider's legacy Provider Number. This information should be put in Block 57 A/B/C on the UB-04, directly below the Provider's NPI (Block 56).

For many commercial payers, the information placed in Block 51 should be the 5 character ID assigned by either the payer or entities like Emdeon or THIN. Some examples would be: AETNA - **60054** or Medical Mutual - **29076** (Emdeon's assigned #'s) or Anthem Blue Cross - **00332**. The code is generally used by the receiving payer(s) to determine their respective payer lines (Primary, Secondary or Tertiary) on the incoming claim(s). Quadax has already noticed instructions from a couple of major insurance companies that do not use this field properly.

As the UB-04 form takes its place as the new vehicle for sending Institutional data to payers, it is critical that **every field** is understood by Providers, so that information can be used and translated properly into the ANSI 837 format. Other **new** fields on the UB-04 that special attention should be paid to, include:

Blocks 2a-e – Pay-To Provider Name and Address
Block 9e – Patient Address Country Code
Block 29 – Accident State
Block 56 – Provider NPI
Block 66 – Diagnosis and Procedure Code Qualifier
Blocks 66a-q – Diagnosis POA Code
Blocks 70a-c – Patient Reason for Visit Codes
Block 71 – PPS/DRG Code
Block 72a-c – External Cause of Injury Codes (E-Codes)
Block 76a – Attending Physician NPI
Block 76b – Attending Physician Legacy Number Qualifier
Block 77a – Operating Physician NPI
Block 77b – Operating Physician Legacy Number Qualifier
Block 78a – Other Physician 1 NPI Qualifier
Block 78b – Other Physician 1 NPI
Block 78c - Other Physician 1 Legacy Number Qualifier
Block 79a - Other Physician 2 NPI Qualifier
Block 79b - Other Physician 2 NPI
Block 79c – Other Physician 2 Legacy Number Qualifier
Block 79d – Other Physician 2 Legacy Number
Block 79e – Other Physician 2 Last Name
Block 79f – Other Physician 2 First Name
Blocks 81a-d – Code-Code Qualifier, Code-Code Code, Code-Code Value ◊

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HARP is Ready...

For the NPI-Revised CMS-1500, UB-04

By Kathy Novak, Vice President, Quality Assurance

As May 23, 2007 is fast approaching, "Contingency Plans" are in the air. May 23, 2007 is when the National Provider Identifier (NPI) will be required on electronic transactions for HIPAA covered entities. However, The Centers for Medicare & Medicaid Services (CMS) have announced a one year non-enforcement contingency plan.

The contingency plan permits health plans to accept legacy identifiers until May 23, 2008. During the transition, they may accept legacy numbers with NPI or NPI alone. Each health plan, however, may set their own timetable.

Medicare published guidance on how they will edit NPIs after May 23, 2007. They will begin to require NPI for primary providers as early as July 2007 if a sufficient number of claims they receive have NPIs. Legacy numbers will continue to be acceptable for secondary providers such as referring providers until May 23, 2008. See http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf for complete details.

HARP and Quadax EDI are successfully sending NPIs on electronic transactions for those payers who are ready to accept them. HARP users and Quadax Service Consultants continue to work together gathering NPIs and legacy qualifiers and populating them into HARP.

Another step in this transition is to include NPIs on hardcopy claims. With HARP software release 2.29F, the new CMS-1500 form (08/05) was successfully implemented. These claims now include an NPI if entered into HARP. A HARP software release which includes the new UB-04 form was planned for the week of May 7, 2007.

What should HARP clients be doing to prepare?

♦ Providers should obtain their own NPI and the NPIs for any provider that refers patients to you

♦ Billing Services should gather NPIs from providers you bill for and the NPIs for referring/ordering providers as well

♦ Share your NPIs with the payers you are currently registered with

♦ Work with your Quadax Service Consultant to populate NPIs in HARP and the Quick EDI System

♦ Work with your Quadax Service Consultant to populate legacy qualifiers (see HARP 2.28c release notes for details)

♦ Work with your Quadax Service Consultant to populate taxonomy codes (institutional providers only)

♦ Obtain new CMS-1500 forms and/or UB-04 forms ◊

Xpeditor Enterprise User Conference

By Mary Beth Bennett, Marketing Specialist/Newsletter Editor

On May 8-9, Quadax EDI held its 5th annual Xpeditor Enterprise User Conference at the Sheraton Suites Akron/Cuyahoga Falls in Cuyahoga Falls, Ohio. Set on a lush landscape overlooking the Cuyahoga River, the conference was attended by numerous Enterprise clients from hospitals and medical facilities throughout Ohio and the neighboring regions. The two-day event provided clients the opportunity to sit in on Xpeditor-related presentations by Quadax EDI personnel and vendors.

Over 115 Enterprise clients were present for the conference, an increase of more than 30 from the previous year, making 2007 the highest attended conference yet. On the first day, EDI Services CEO Tom Kish, VP Tony Petras, General Manager Len Stusek, Operations Manager Brent Pagel, and Manager of EDG Tom Klemens gave overviews of the EDI accomplishments of 2006 and goals for 2007. The presentation segment of the conference began with a comedic boost by Tim Walker, Partner and Senior Consultant at Fox Health Management, Inc., whose humorous interpretation of NPI and HIPAA's impact on the healthcare industry was well-received by those in attendance. A presentation by Charles Cataline of

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Exclusion, Exception, Ejection:

Does Your Compliance Plan Address Sanctioned Individuals and Entities?

By Catherine Sicker, Corporate Compliance Officer

The model compliance programs http://oig.hhs.gov/fraud/complianceguidance.html issued by the Office of Inspector General (OIG) have identified that employment of sanctioned individuals is a risk area that all healthcare providers and entities must address. The OIG has authority to exclude from participation in Medicare, Medicaid, and other federal healthcare programs individuals and entities that have engaged in fraud or abuse and to impose civil monetary penalties (CMP) for certain misconduct related to federal healthcare programs. The General Services Administration (GSA) also maintains a list of parties "debarred, suspended, proposed for debarment, or declared ineligible by agencies or by the General Accounting Office."

Exclusion from federal healthcare programs, as well as employing an excluded individual or contracting with an excluded individual or entity, may have very serious consequences for healthcare entities. Items or services provided by excluded individuals or entities are not covered by the federal healthcare programs and payments made for such items and services are generally considered to be overpayments.

In addition, no payment will be made for any items or services furnished at the direction of an excluded individual. The payment ban also extends to administrative and management services not directly related to patient care, but that are necessary for providing items and services to federal program beneficiaries.

Excluded healthcare providers that submit or cause to be submitted, claims to federal healthcare programs for reimbursement may be subject to civil monetary penalties of $10,000 per item or service and may be subject to treble damages. The entity could also face additional penalties for filing false claims. A violation of the False Claims Act can result in penalties of up to $11,000 per claim, plus three times the amount of the damages that the government sustains.

Healthcare entities must establish mechanisms and procedures for regularly monitoring the lists of excluded entities and individuals. Excluded and debarred individuals and entities can be identified by referencing the OIG's List of Excluded Individuals/Entities at http://exclusions.oig.hhs.gov/ and the U.S. General Services Administration's Excluded Parties List System at http://www.epls.gov/. ◊

Exclusion Timeline

Section 1128 of the Social Security Act ("the Act") (42 U.S.C. § 1320a-7) contains the exclusion authority for the Medicare and Medicaid programs. As initially written, section 1128(a) required the OIG to exclude from the programs any individual or entities convicted of a program-related crime or of patient abuse or neglect.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-91, amended the exclusion provisions of the Act to strengthen the OIG's sanction authority. The mandatory exclusion provisions were expanded to include any felony conviction under federal, state, or local law relating to healthcare fraud, regardless of whether government programs were involved.

The Act was amended further by the 1997 Balanced Budget Act which allowed the OIG to impose new civil monetary penalties on individuals or entities that arrange or contract with an individual or entity that is excluded from participation in a federal healthcare program.

In 1998 the OIG issued a significant final rule expanding the scope of its administrative sanction powers by broadening its authority to extend to indirect providers and suppliers of items reimbursed by federal healthcare programs. Until that time the OIG had not applied its exclusion authority to "indirect" providers that did not also directly participate in federal government healthcare programs. The OIG defines "indirect" providers as those individuals or entities who provide items and services to healthcare providers, practitioners or suppliers without billing the federal programs. ◊

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