

TO: All Providers

FROM: CareFirst of Maryland, Inc.

DATE: April 25, 2002

SUBJECT: Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry/Response Transaction (270/271) Standard

CareFirst of Maryland, Medicare Part A Intermediary will continue to provide the Direct Data Entry (DDE) functionality for eligibility benefit inquiry/response (as is being used currently). CareFirst of Maryland, Medicare Part A, will not implement the EDI transaction 270/271 for eligibility benefit inquiry/response.

Excerpts from CMS Program Memorandum A-02-013 (CR2009):

B. CWF HIQA and Standard Systems Direct Data Entry (DDE) Eligibility Inquiry-- HIPAA uses the term “direct data entry” generically to refer to a type of functionality operated by many different payers under a variety of titles. Within this instruction, the acronym DDE is being used to refer to any type of direct data entry system maintained by Medicare intermediaries, or standard system maintainers. DDE was specifically permitted to continue in the Transactions Final Rule (45 CFR162.923), with the stipulation that direct data entry is subject to “...the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard.”

Data content conformity means that the same information permitted or required by the 271-version 4010 implementation guide must be reported in the eligibility screens (DDE outbound). The DDE outbound may not report a data element for eligibility purposes that is not included in the 271, exceeds the maximum length of the data element in the 271, does not meet the minimum length for the data element in the 271, or that does not meet the 271 requirement that the data element be numeric, alpha-numeric, or meet another characteristic as specified in the 271. The standard system cannot issue a response with information above and beyond the information in the 271. X12 standard implementation guides include data element length and characteristics in their definition of data attributes.

Conformity does not mean that a DDE screen that includes eligibility information must display each of the data qualifiers or other means of data identification contained in the 271 version 4010 implementation guide. DDE screens typically identify, explicitly or by context, the type of information being reported in a field, e.g., would identify if a number

represents a health insurance claim number, date of birth, or etc. DDE screens would not be expected to use a qualifier contained in the 271 to identify data type if otherwise evident in the design or content of the DDE screen.

The standard system maintainers must map the DDE eligibility data elements to the 270/271 version 4010 implementation guide to determine if the DDE eligibility data elements meet the data content and conformity requirements above. If the standard system maintainer determines that DDE screen changes are required for data content and conformity requirements, the maintainer must modify the DDE screens to conform to the 271 version 4010 implementation guide.

If an FI currently supports the DDE functionality, then the FI must continue to do so.

CWF will be responsible for the data content and conformity requirements of HIHO, the HMO DDE eligibility process.

IV. Restricting and Controlling Access to Eligibility Information

FIs will allow Medicare certified providers, and their agents access to beneficiary eligibility data as long as an EDI Enrollment Form is on file (see MIM *Part 3 section 3601.4*) for that entity, and to network service vendors if there is an EDI Enrollment Form and EDI Network Service Agreement on file (see MIM *Part 3 section 3601.8*).

CWF will determine the appropriate information the provider is qualified to receive by the provider type; e.g., psych, HMO, home health, or other provider. The appropriate information will be displayed in a subsequent PM no later than March 31.

V. Audit Trail Requirements

The CWF module will capture the audit trail data (control information, sender/receiver information, etc.) for real time and DDE eligibility transactions. The standard systems will develop a program that will allow FIs to use the audit trail data to compare inquiry volume to paid claim volume. The FIs will generate a quarterly report using the standard systems software that will detect unusual volumes of eligibility submissions by providers. The audit trail file will contain such elements as the date/time, the HICN, the provider number, the vendor ID, etc. The appropriate information will be displayed in a subsequent PM no later than March 31.

Each quarter, the FIs will run the program developed by the standard system that compares inquiry volume to paid claim volume for use by the FIs. The standard system software will use the audit file created by CWF to tally the inquiries by provider, and then compare that total to the number of claims paid for that provider during the same quarter. Neither the standard systems nor the FIs are responsible for matching a particular inquiry with a particular claim. The sole purpose of the standard system software is to create counts and a ratio.

The claims to inquiry ratio should be at least 80 percent. This means that for every 100 inquiries submitted, we expect there to be 80 claims submitted for each provider. If the claim to inquiry ratio does not exceed 80 percent from a given provider, the FI must contact the provider to clarify inquiry volume expectations and restrictions. If there is a problem or the behavior continues, the FI must remove the provider from the FIs eligibility access system.

(Source: A-02-013; Change Request 2009)

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www.marylandmedicare.com.

Questions regarding this bulletin should be directed to the provider relations department at (866) 488-0545.