**FAQ regarding Proposed Changes to Chapter 243**

Q: Define the “Reason For Visit Diagnosis”; would this be the actual diagnosis field?

R: The Reason for Visit Diagnosis (or Patient Reason for Visit) is not the same as an admitting or a principal diagnosis. It is defined as the diagnosis code describing the patient’s reason for visit at the time of outpatient registration.

Q: “Permission on Admission Indicator” is one that I don’t believe is available, could you give an explanation of these fields?

R: There is no Permission on Admission Indicator. The Present on Admission Indicator is the code which provides an indication as to whether the diagnosis was present at the time of admission. Also note inclusion of these fields in the rule makes it mandatory that a payer provide this information to the extent that it is available in the payer’s system(s).

Q: Will there ever be a time when a file might contain both icd9 and icd10 codes?

R: The revised rule has retained all of the fields for ICD-9 codes and added new fields for ICD-10 codes. The code list qualifier code in your system will indicate which version of ICD coding is present, and consequently, which fields should be populated.

Q: Please confirm the code list qualifier is the ICD version indicator we discussed with MHDO.  This indicator is currently stored in our system and can be used to distinguish between ICD 9 and ICD10 codes.

R: Yes

Q: Do we continue to populate data elements MC039-MC053 and MC055-MC058  **only** with ICD 9 codes and add new data element fields MC200-MC326 for population of ICD 10 codes effective Oct 1, 2014?

R: Yes

Q: Clarification is required on setting the default value if a field is not zero. It is not clear if the field should be left blank or populated with zero or null.

R: The current convention is to leave blank or to populate with NULL.

Q: Confirmation is needed that no (ICD-10) indicator field will provided.

R: Our proposal on how to address the conversion to ICD -10 does not require a dedicated field for the ICD version indicator because the layout contains separate fields for ICD-9 and ICD-10.

Q: We could modify our file to include a "placeholder" and can fill it with whatever you wish (null, blanks?), but dentists do not currently submit claims with any ICD codes, version 9 or 10.

R: MHDO is not proposing changes regarding ICD codes to the dental file.

Q: For some records we do have SSNs, but not on all members. How do we handle if we don’t have SSNs for members?

R: If a health care claims processor does not collect the social security numbers for all members, the health care claims processor shall use the number of the subscriber and then assign a discrete two digit suffix for each member under the subscriber’s contract.

If the subscriber’s social security number is not collected by the health care claims processor, the subscriber’s certificate or contract number shall be used in its place. The discrete two digit suffix shall also be used with the certificate or contract number.

Q: It appears that some of the previously required information for service providers is no longer required. The fields MC033, MC034, and MC035 have been deleted. There is only information required for the Service Facility & Labs. Is this correct? If so, will we remove these fields or set to null?

R: Yes- the service provider location fields (formerly MC033-MC035) have been **retired** and properly named, described/defined and positioned with additional service facility location fields (MC085-MC091). Assuming the proposed rule changes are approved, fields MC033 - MC035 would remain as placeholders and would be left blank.

Q: MC071 - there is some concern that the pre-fix “A” may overlay DRGs that are only 4 bytes. This field is not consistently populated by all submitter entities. In some cases, where it is being populated, we are not able to identify what the DRG is and therefore would not know whether an "A" prefix is required.  It is assumed that the DRGs provided will follow the CMS methodology as they are captured off the claim, so we will populate the DRG as is.

R: The MHDO is not proposing any changes to this field.

Q: We may not be able to provide data on the POA fields as it is not collected.

R: The additional modifiers are consistent with current HIPAA 5010. Inclusion of these fields in the rule requires that a payer provide this information to the extent that it is available in the payer’s system(s).

Q: Procedure Modifiers - Some of our systems have only 2 modifiers.

R: Inclusion of these fields in the rule requires that a payer provide this information to the extent that it is available in the payer’s system(s).

Q: Eligibility Files - Should these files be submitted separately or one combined file for all eligibility?

R: This is not part of the proposed changes. Submission of one eligibility file is acceptable.

Q: Page 6 Item 2(A)(10) File Format: Is the encryption process changing or will we continue to use the 256-bit AEA encryption with our unique passwords?

R: Payers will continue to use 256-bit AES encryption with unique, assigned keys.

Q: Page 29 Data element MC039: In the description/codes/sources for the ‘ICD-9-CM’ the 9 has a strikethrough. Did you intend to do a strikethrough here as MC202 captures the ICD10 Admitting Diagnosis and the MC040 – MC053 refers to ICD-9-CM codes?

R: The strikeout was an error on our part and has been corrected in the proposed rule change.

**Q: Section 3.A. – Reference to Amount in Registration Survey -** We recommend modifying the first sentence in Section 3.A. with the text in blue font to read: Each health care claims processor not excluded from submitting claims data under Sec 2(A)(9)(a) shall complete or update by December 31st of each year a survey indicating ~~the total paid amount of health care claims for Maine-resident members,~~ the types of coverage and the current estimated enrollment.

R: The MHDO will remove references to amounts paid.

**Q: Section 3.D. – Timing for Testing of Files -** Section 3.D., previously identified as Section 3.E. does not specify a timeline for when the data set for comparison to the standards must be submitted. Given the addition of over 130 fields to this rule, we propose the addition of the following language, in blue, underlined text, to the first sentence in Section 3.D. Within one hundred and eighty days of the adoption of any changes to the data element content of the files as described in Section 2 and at least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 2 is subsequently altered, each health care claims processor shall submit to the MHDO or its designee a data set for comparison to the standards listed in Section 4.

R: Agree. The MHDO will add language to Chapter 243 to cover submission time frames following changes to the data element contents of data files described in Section 2.

Q: In addition, please confirm that the MHDO will specify the date that payers are to cease submitting data under the specifications of the old rule and start submitting data under the specifications of the new rule.

R: Unless otherwise specified, the effective date of a change is the effective date of the rule. The MHDO will continue communicating with payers and providing as much advance notice as possible.

**Q: New Data – Addition of Billing Provider and Service Facility Codes (MC079 – MC091)** We house limited billing provider and service facility information. If the State adds the billing provider and service facility codes as noted in the proposed rule, we will likely need to request variances for these fields.

R: Inclusion of these fields in the rule requires that a payer provide this information to the extent that it is available in the payer’s system(s). Payer-specific variances will be allowed.

**Q: New Data – Addition of Fields to Address ICD-10 Conversion -** We noted that the conversion to ICD-10 codes is being done with the addition of new fields for the longer 7 character codes.  We ask the Maine Health Data Organization to consider adopting the ICD-10 code conversion process implemented in other APCD states by lengthening the current fields, from 5 to 7 characters and inserting a new field for ICD Version Indicator: 9 for ICD-9 codes and 0 for ICD-10 codes.  For each individual claim record, all of the diagnostic and procedure fields will be with either ICD-9 or ICD10 codes.  There should not be a mixture of codes.  Additional procedure code fields will still be needed to accommodate the multiple procedure code fields.

R: The MHDO considered the approach to the ICD-10 conversion as described above; however, given the decision to postpone adoption of the PACDR based on Payer feedback, we believe that the proposed approach with dedicated fields for each ICD version is appropriate with the current file format.

**Q: New Data – Addition of External Cause of Injury Codes –** Some […] submitting entities do not house the suggested External Cause of Injury Codes. If the State requires the submission of these data fields, several of our submitting entities will need to request variances.

R: Inclusion of these fields in the rule requires that a payer provide this information to the extent that it is available in the payer’s system(s). Payer-specific variances will be allowed.

**Q: New Data – Present on Admission Indicators 1 – 24 -** We noted that the Present On Admission codes 1 through 24 are in fields MC207-MC253 and again in fields MC255-MC301.  We do not house POA information. Other data submitters only have one set of POA codes. Please explain the purpose of the second set of POA codes. If the State requires the submission of two separate sets of POA codes, we will need to request variances.

R: POA codes are paired with the Diagnosis, Other Diagnosis or External Cause of Injury Codes with which they are associated. Inclusion of these fields requires that a payer provide this information to the extent that it is available in the payer’s system(s). Payer-specific variances will be allowed.

**Q: New Data – Additional Diagnosis Codes –** We receive and maintain between one and eight diagnosis codes. If the State expands the number of diagnosis codes to be included in the data files, we will need to request variances.

R: Inclusion of these fields requires that a payer provide this information to the extent that it is available in the payer’s system(s). Payer-specific variances will be allowed.

**Q: New Data – Additional Procedure Codes –** We receive and maintain between one and ten procedure codes. If the State expands the number of procedure codes to be included in the data files, we will need to request variances.

R: Inclusion of these fields in the rule requires that a payer provide this information to the extent that it is available in the payer’s system(s). Payer-specific variances will be allowed.

Q: With the change to ICD10 effective 10/1/2014, will we be allowed to use ICD9 for claims with dates of service prior to 10/1/2014 and received after 10/1/2014?

R: The MHDO will NOT use repurposed or dual purpose fields to accommodate both ICD-9 and ICD-10 codes. Fields previously designated for ICD-9 will continue to be used exclusively for these. Fields MC200-MC326 are designated for ICD-10. For any claims/claims records, you will populate the appropriate fields.

Q: Fields MC200-MC326 are new fields and don’t apply to routine vision exams and materials.  Will we enter null in all those fields?

R: The ones that are not needed or for which data is not captured or available can be filled with ‘NULL’.

Q: We will be able to accept claims in both the ICD-9 and ICD-10 formats as of 10/1/2014.  Would your updated DSG allow for the submission of either type of code?

R: Yes.

Q: We will be reporting what we receive and do not envision cross-walking the codes to the ICD-10 for reporting.

R: Cross-walking would be unnecessary.

Q: We understand that this approach was decided upon to accommodate claims that receive updates and adjustments after 10/1/14 which would continue to use the ICD-9 codes.

R: Correct.

Q: Will your updated data submission guide accommodate both formats?

R: Yes.

Q: Also, our understanding from discussions with other payers is that they are using a similar approach for their ICD-10 implementations.

R: It appears that most will be using one of two approaches: 1) an ICD indicator with fields that will accommodate both ICD versions; or 2) separate fields for ICD-9 and ICD-10 coding. Either approach should not complicate reporting for Chapter 243.

Q: Please explain the status of columns MC033, MC034 and MC035 (Service Provider City-St-Zip).  These fields have been crossed out and fields have been added for Service Facility address (MC087-MC091).  Does this mean that they do not want to see a service address for individual providers and groups?

R: Fields MC033, MC034 and MC035 have been retired and will remain as placeholders. The strikeouts in the data element numbers will have to be removed in the draft. As placeholders, MC033-MC035 shall be left blank. Payers will be referred to the new fields, which are defined specifically for service facility, not service provider.

Q: Can new columns be added to the end of the file rather than inserted between existing columns?

R: In a flat-file layout like Chapter 243, both the number and the order of fields are important. So payer data cannot be submitted in a different file layout. Whenever logical groupings could be maintained conveniently, new fields were inserted between existing ones. Otherwise, new fields (especially for ICD-10) were added to the end of the file.

Q: Any changes regarding the X12 layout for files?

R: It appears that there is support for a standard file layout for APCD reporting, but not the PACDR or any X12 standard. This will be an important topic of discussion going forward.