

EPRA Enhancements August 2008

Effective in August 2008, Medica will implement several enhancements to its electronic provider remittance advice (EPRA), for the 835 transaction of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes — which will apply *only* for claims processed on Medica’s new administrative platform — should improve both convenience and security of EPRAs for providers.

This notice outlines details regarding these changes to allow physician practices and facilities to make any adjustments to their systems, if needed.

The tentative effective date for the following five changes is August 19, 2008.

1. Reporting member ID numbers

The 835 will report the original member ID submitted on the claim in the Patient Name (NM1 with QC Qualifier) and Insured Name, if applicable, (NM1 with IL Qualifier) segment/segments. If the submitted member ID is different than the adjudicated, the corrected ID will be returned in the Corrected Patient/Insured Name (NM1 with 74 Qualifier) segment. The group number will be reported in the Other Claim Related Identification (REF with 1L Qualifier) segment.

Up to this time, when the member identification number submitted on a claim was different than the ID the claim adjudicated under, the 835 would report only the member’s identification number the claim processed under. The group number, ID type code, and member’s identification were combined and reported in one element of the 835 transaction. It’s important to note that only the nine digit member ID will be reported for the adjudicated member ID.

Examples:

Provider submits correct member ID number - as determined by the source of truth that also populates the member ID card.

Insured is patient:

Claim Payment Information (2100)

60028 CLP*ABC123*1*120*95*25*13*1234567890 112233449*13*3~
 60029 NM1*QC*1*SMITH*JOHN****MI*123123123~
 60030 NM1*82*2*MEDICAL CENTER*****XX*7897897890~
 REF*1L*123456~
 60031 DTM*050*20070413~

Patient is different than Insured:

Claim Payment Information (2100)

60036 CLP*ABC123*1*120*95*25*13*1234567890 112233449*13*3~
 60037 NM1*QC*1*SMITH*JOHN****MI*123123123~
 60038 NM1*IL*1*SMITH*KATHLEEN**** MI*123123123~
 60039 NM1*82*2*MEDICAL CENTER*****XX*7897897890~
 REF*1L*123456~
 60040 DTM*050*20070402~

(cont.)

Provider submits incorrect member ID number - as determined by the source of truth that also populates the member ID card. Assumption – 123123123 is the correct member ID.

Insured is patient:

Claim Payment Information (2100)

- 60028 CLP*ABC123*1*120*95*25*13*1234567890 112233449*13*3~
- 60029 NM1*QC*1*SMITH*JOHN****MI*654321987~
NM1*74*1*****C*123123123~
- 60030 NM1*82*2*MEDICAL CENTER****XX*7897897890~
REF*1L*123456~
- 60031 DTM*050*20070413~

Patient is different than Insured:

Claim Payment Information (2100)

- 60036 CLP*ABC123*1*120*95*25*13*1234567890 112233449*13*3~
- 60037 NM1*QC*1*SMITH*JOHN****MI*654321987~
- 60038 NM1*IL*1*SMITH*KATHLEEN****MI*654321987~
NM1*74*1*****C*123123123~
- 60039 NM1*82*2*MEDICAL CENTER****XX*7897897890~
REF*1L*123456~
- 60040 DTM*050*20070402~

2. Enhanced population of Remittance Advice Remark Codes

In addition to adding functionality to report remark codes at the claim level in the MIA and MOA segments, the 835 transaction tables will report the HIPAA required remark codes for the specified claim adjustment reason codes (A1,16,17, 96, and 125). Up to this time, logic only allowed the population of the remark code at the service line level in the LQ segment and claim level segments MIA and MOA were not used in the 835 transaction.

- A1 = Claim/Service Denied
- 16 = Claim/service lacks information which is needed for adjudication
- 17 = Payment adjusted because requested information was no provided or was insufficient/incomplete
- 96 = Non covered charge(s)
- 125 = Payment adjusted due to a submission/billing error(s)

3. Institutional Claims Servicing Provider NPIs

Institutional claims reported in the 835 transaction will report the Billing/Pay to Provider NPI originally submitted on the claim as the Servicing Provider NPI in the Service Provider Name segment (NM1) of the 835 Transaction. Up to this time, the NPI number, if received, was not returned in the 835 transaction for the servicing provider for institutional claims.

4. Enhanced NPI reporting for adjusted claims

When claims are adjusted, the NPI numbers that were submitted on the original claim will now be reported in the 835 transaction. Up to this time, adjusted claims in the 835 transaction were not reporting the NPI.

5. Truncated patient account numbers on bulk recovery claims

Bulk recovery claims reported in the 835 transaction will contain the entire patient account number that was submitted on the original claim. Up to this time, if claims were involved in an overpayment bulk recovery, the 835 would only return the first 12 digits of the patient account number.

For more information:

Providers with questions can call the Medica Provider Service Center toll-free at 1-800-458-5512 or send an e-mail to medica.electroniccommerce@medica.com.