CIVHC

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

All the information being requested for the 2013 Data Submission Guide is necessary to develop a comprehensive picture of spending and utilization in Colorado and ensuring that policymakers, purchasers and patients have complete data to inform health care decision-making.

UHC Request for Clarification	CIVHC Response
Medicare Supplement Code Addition; request for HCPF to reconsider requiring the submission of this type of claims information	**CIVHC recommendation: CIVHC will provide UHC with a waiver for 2013. We will work with UHC to obtain this information starting January 1st, 2014. These claims are not cross over claims; they are claims that have been denied by Medicare and then covered by the Medicare Supplement carrier.** Background: Currently 5 plans are submitting membership info on Medicare Supplemental and RMHP and Wellpoint are providing claims info. Medicare population spending is a priority for the Colorado APCD in order to complete the portrait of spending and utilization. CIVHC's intent was to include Medicare Supplement claims as this fills in the donut holes and shows what people are actually spending for health care. CIVHC is currently collecting it for multiple payers. (CIVHC is waiting to get specific submitters names from Treo) Medicare supplemental plans provide extended coverage for certain types of services, such as skilled nursing and extended home care. This information is not included in the Medicare data provided by CMS.
Dental Maintenance Plan & Dental Plan; request HCPF to reconsider requiring the submission of dental claims 1. Dental services are a small percentage of health dollars expended & has	**CIVHC recommendation: It is our intent to begin collecting Dental Claims January 1st, 2014. In the interim, we will provide UHC with a waiver for this information and work with UHC to collect the fields starting in 2014.** Background: There is growing evidence of the important link between oral health and physical

limited impact on overall health care analysis 2. Uniqueness of dental claims structure requires the creation of specific dental files in a format different than the medical file format 3. High cost medical dental procedures are included in the medical claim file 4. Dental data extracts do not match the medical claim file specifications and this makes it difficult…. UHC can only populate 60% of the data fields. 5. …….UHC recommends the use of a network adequacy report…..	health making the collection of dental info increasingly important to overall understanding of health, costs and utilization 1.Dental claims information will inform discussions about integrating oral health with physical health. 2. CIVHC has the full authority to apply waivers on data elements that do not pertain to dental claims 3.There are some high cost claims but not all are contained in the medical claims 4. We will develop a set of threshold and waiver criteria specifically for dental data. Our process will be to work with Treo to develop which elements are expected for a dental claim. CIVHC will then work with the carriers to communicate these elements; we have been very collaborative the the health plans where there is necessary further clarification 5. CIVHC is unable to respond to UHC's request to use a network adequacy report; CIVHC does not think this is an APCD issue CIVHC feels information on dental use and how it impacts overall health will help inform benefit design for both commercial plans as well as public plans such as Medicaid.
ME045 Exchange Offering – request to have this field required no earlier than January 2014	**CIVHC recommendation: We are noting in the DSG that data is not required until after January 1, 2014 when coverage under the Exchange goes into effect. The field is being added to the 2013 DSG.**
ME107- Risk Basis; clarify populating this data element will show fully insured because self-insured is not being submitted.	**CIVHC recommendation: UHC is currently only sending fully insured data so should mark their data as a 'F' for fully insured.** Background: Some self-funded employers are preparing to submit their claims data to the APCD and CIVHC would like to be able to capture this data appropriately for cost and utilization purposes across the state for comparison purposes.
MC005A Version Number; UHC would have to change business model & incur unduly burden & cost to their organization	**CIVHC recommendation: We will give UHC a waiver for this data element for 2013. For health plans that can provide this data element, it will be captured to support the electronic matching of re-adjudicated claims.** Requiring a version number is important to track re-adjudicated claims. Currently CIVHC is manually synching re-adjudicated claim to the original claim and a version number would eliminate this issue. CIVHC will continue to work collaboratively with health plans to understand a time frame and process for compliance. Our expectation is that health plans will incorporate this into claims processing systems when major systems changes are implemented over time.

MC056 Procedure Modifier 1; indicate the required value when a procedure modifier is not present and an OP or Prof claim	**CIVHC recommendation: Procedure code modifiers should be provided if the health plan has it, otherwise they can submit a blank value. This change had already been made to the DSG based on UHC's feedback in January, 2013.**
MC057 Procedure Modifier 2; same as MC056	**CIVHC recommendation: Procedure code modifiers should be provided if the health plan has it, otherwise they can submit a blank value. This change had already been made to the DSG based on UHC's feedback in January, 2013.**
MC201A – Present on Admission – PDX thru MC201M- Present on Admission DX12; requesting all fields be optional with a notation	**CIVHC recommendation: CIVHC agrees with UHC. The DSG is being updated to note that it should be provided for IP only and otherwise leave blank.**
MC205A thru MC205E- ICD-9-CM Procedure Dates; requesting these fields be consistently populated as optional fields with notation	**CIVHC recommendation: CIVHC agrees that it should be required for Inpatient, optional for O/P and when a date is not present, use "Unknown" The DSG is being updated to reflect this.**
Please include definitions for "inpatient claims" and "outpatient claims" so UHC can replicate the logic	**CIVHC recommendation: Payers determine whether a claim is inpatient or not. UHC currently provides to the APCD if a claim is an institutional claims in field MC036.** Background: The current DSG provides the Coding requirements that distinguish between inpatient and outpatient claims determines the bill classification: **Bill Classification - Second Digit if First Digit = 1-6** 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care - Level III Nursing Facility 8 Swing Beds OP is usually just type 3
Confirm the addition and aligning of MC058A-MC058E (ICD-9-CM) with respective MC205A-MC205E (ICD-9-CM Date) fields is for easier readability	**CIVHC recommendation: CIVHC confirms this alignment is for easier readability.**