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11300 GENERAL REQUIREMENTS

The system requirements in §§11300 through 11375 form a basis for the improvement of title XIX programs through the mechanization of claims processing and information retrieval systems. They will be used with other requirements by HCFA as a basis for determining whether the system qualifies for 90-percent or 75-percent Federal funding. Federal MMIS requirements are to be considered minimal, not exclusive requirements.

The intent of §1903(a)(3) is the improvement of title XIX programs through Federal assistance in the mechanization of approved Medicaid claims processing and information retrieval systems. To accomplish this and still allow for necessary variations among the States, HCFA has developed functional system requirements of §1903(a)(3) and (r). These system requirements can be used as a model for new systems and a measure of existing systems. Accordingly, HCFA will use system requirements contained in this chapter as its standard for evaluation and approval of systems for which funding is requested under §1903(a)(3). Recognizing that variations in the expression and/or implementation of identical concepts are not necessarily detrimental, HCFA is guided by a policy of "demonstrable conceptual equivalence" when evaluating systems. This concept is defined in §11110.

HCFA is further guided by the principle of avoiding duplicate systems design and development costs whenever possible by requiring the transfer of existing approved systems in situations where the feasibility of a successful transfer is assured.

To receive HCFA approval for funding under 42 CFR 433, an existing or proposed system must:

o Be mechanized;

o Include or encompass all subsystems/functionalities;

o Conform in concept with each subsystem describe herein;

o Provide security from anticipated threats or hazards to its data.

NOTE: Due to the Privacy Act and the requirements of §1902(a)(7), any system changes that propose to transmit data via the Internet, must contain adequate security measures, as determined by preapproval from HCFA;

o Maintain a record of every query directed against an individual's record, including the identity of the person or organization originating that query;

o Be able to eliminate from the system data which are no longer timely;

o Contain and utilize the data elements described in §11375;

o Provide and apply the following minimum edits to all input data regardless of how such data enters the system;

- Proper field content,

- Accuracy of data, and

- Reasonableness of data

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o Produce and disseminate in a timely and accurate manner all systems reports using identification coding systems for providers, other payees, and beneficiaries that are used under title XVIII.

o Accept and use the HCFA Common Procedures Coding System (HCPCS);

o Accept and use a common hospital billing form (i.e., the Uniform Bill (UB-82), (Standard Form HCFA-1450));

o Accept the same provider electronic billing data set required by the Medicare program; and

o Accept and use the common claim form, Health Insurance Claim Form, HCFA-1500, for noninstitutional providers (physicians, durable medical equipment suppliers, laboratories, chiropractors, and podiatrists).

o Effective January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the MSIS (Medicaid Statistical Information System), including enrollee encounter data and other necessary data. (Refer to §2700.)

NOTE: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

11301 FUTURE ADDITIONAL SYSTEM REQUIREMENTS

When HCFA determines that additions or changes will improve the Medicaid claims processing and information retrieval system, it will publish these changes by notice in the Federal Register making the proposed change available for public comment. After allowing an appropriate period, HCFA will respond to the comments received in a subsequent notice. When the final notice is published, HCFA will issue the new or modified standards or conditions in the SMM. Based upon the requirement's complexity, HCFA will allow the States an appropriate time period to meet the new requirement.

For Example: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health

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information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

11310 MMIS FUNCTIONAL REQUIREMENTS

The federally required MMIS presently consists of the following six core subsystems (Eligibility determination systems are not part of MMIS or enhancements to MMIS):

o Recipient

o Provider

o Claims Processing

o Reference File

o Surveillance and Utilization Review

o Management and Administrative Reporting

11315 RECIPIENT SUBSYSTEM

A. Basic Functions and Objectives.--Your recipient subsystem must:

o Maintain identification of all applicants eligible for Medicaid benefits.

o Allow for timely updating of the subsystem's data base to include new recipients and all changes to existing recipient records.

o Maintain positive (active as opposed to passive) control over all data pertaining to Medicaid recipient eligibility.

o Build and maintain a computer file of recipient data to be used for claims processing, administrative reporting, and surveillance and utilization review.

o Distribute eligibility data to other processing agencies, if such a requirement exists.

o Maintain control over the Medicare Part B Buy-In processing for eligible recipients.

o Receive appropriate Medicaid recipient eligibility data from all sources of eligibility determination.

o Provide file space for, and record whenever available, the Social Security Number of each eligible recipient.

o Contain and use the data necessary to support third party liability recovery activities. (See §3900.)

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B. Ancillary Functions and Objectives.--

o A shared on-line recipient subsystem must provide Medicaid data and reports as required by the Medicaid Agency.

o If the EPSDT system is integrated into the MMIS, then case identification, tracking, and referral functions will be performed as part of the recipient subsystem.

11320 PROVIDER SUBSYSTEM

Your provider subsystem must accomplish the following functions and objectives:

o Facilitate the participation of qualified providers in the Medicaid program.

o Enroll providers in the Medicaid program after they agree to abide by the rules and regulations of the State Medicaid program.

o Ensure that providers are qualified to render specific services under the Medicaid program by screening applicants for State license and certification, by Specialty Board certification if appropriate, and by visit to the provider by a review team if necessary.

o Process provider applications and changes in a timely manner and maintain control over all data pertaining to provider enrollment.

o Build and maintain a computerized file of provider data for claims processing, administrative reporting, and surveillance and utilization review.

o Review enrolled providers on a continuing basis to ensure that they continue to meet provider eligibility requirements.

11325 CLAIMS PROCESSING SUBSYSTEM

A. Basic Functions and Objectives.--Your claims processing system must:

o Ensure that all input into the subsystem is captured at the earliest possible time and in an accurate manner.

o Establish control over all transactions during their entire processing cycle, including claims in pending status.

o Verify that all providers submitting input are properly enrolled.

o Ensure that all recipients for whom input is submitted were eligible for the type of service at the time the service was rendered.

o Ensure that all input submitted to the subsystem is processed completely.

o Verify that charges submitted by providers are reasonable and within acceptable limits.

o Ensure that reimbursements to providers are rendered promptly and correctly.

o Maintain accurate and complete registers and audit trails of all processing.

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o Maintain all processed data necessary to satisfy legal requirements and the needs of other subsystems.

o Respond to queries concerning recipient eligibility and benefit status.

o Process approved prior authorization requests.

o Process provider credits and adjustments.

o Identify uniquely and be able to locate any provider claim.

o Automatically suspend all transactions in error until corrections are made.

o Check each claim prior to payment against all current and previously paid claims for which a duplicate payment could exist.

o Provide a prompt response to all inquiries regarding the status of any claim.

o Issue remittance statements to providers detailing claims and services covered by a given payment at the same time as the payment.

o Provide EOB individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan as described in §11210. To assist MMIS States in implementing the option to send EOBs on a sample basis, the following sampling methods are recommended:

-- Sampling instructions are the Medicaid fraud guidelines on Verification of Services to Recipients. They provide for a sample of claims from high-volume providers and a sample of claims from low-volume providers. Sample sizes may be increased or decreased each month at your discretion. Note that each sample only represents each set of providers, not all claims paid.

-- One random sample from all claims you pay each month is large enough to obtain some overall representation of the population, at a minimum, a monthly sample ranging from 500 claims up to 100 percent of the State population. The distribution of claims in such a sample will tend to mirror that of the population, including many drug and doctor claims and relatively few hospital and nursing home claims.

-- A random sample of providers, then a sample of claims from each of the sampled providers. The sample of providers can be structured several ways, e.g., a specified number of each type of provider, or a random sample from all providers. A minimum sample of 100 providers each month, with at least five claims sampled from each provider, is suggested.

-- A random sample of recipients (or cases) with all claims paid in a month for each. This method would provide the most comprehensive list of services for each sampled recipient (or case). A sample of at least 400 recipients each month is suggested. Structure the recipient sample according to your needs -- either a random sample of recipients, or a specified number of each type of recipient (AFDC, SSI, medically needy, etc.)

-- Other sampling methods if approved by the HCFA RA.

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B. Ancillary Functions and Objectives.--Your claims processing subsystem must also:

o Assure adjudication for payment within 30 days after:

-- Receipt of any properly submitted correct claim which passes all required edits and checks; or

-- Correction of any error condition(s) preventing payment which are attributable to the provider; or

-- Correction of any error condition(s) preventing payment which are attributable to the agency or its system or its data; or

-- Correction of any condition(s) preventing payment which are beyond the agency's control.

o Identify claims paid for all services covered by the State plan, including:

-- Early and Periodic Screening, Diagnosis, and Treatment

-- Family Planning Services

o Record Medicare deductibles and coinsurance paid by Medicaid on crossover claims.

o Ensure that the payment for services is consistent with 42 CFR Part 447 -Payments for Services.

o Have the capability to identify, by recipient, the screening and related diagnosis and treatment services.

o Have the ability to identify TPL and assure that the title XIX program is the payor of last resort in accordance with the State plan. (See §3900.)

o Have the ability to identify enrollee encounter data. Encounter data and other data for electronic transmissions must be reported in a format consistent with the MSIS (Medicaid Statistical Information System), effective January 1, 1999. (See §2700.) Encounter data will also be subject to encounter data transaction standards when such standards are established under HIPAA.

11330 REFERENCE FILE SUBSYSTEM

Your reference file subsystem must:

o Provide an updating facility for the MMIS Procedure, Diagnosis, and Formulary File.

o Provide a means of obtaining various listings of the Procedure, Diagnosis, and Formulary File.

o Provide a reasonable and customary charge file for Medicaid charges, Medicare charges, or both.

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o Enable the reasonable and customary charge file to be updated.

o Provide a means of transferring history records used for duplicate claims detection from an active file to a file used only periodically.

o Generate various listings of the claims processing suspense file.

o Maintain the data necessary to support the claims processing subsystem in ensuring that claims are paid in accordance with 42 CFR 447 - Payment for Services.

11335 SURVEILLANCE AND UTILIZATION REVIEW (SUR) SUBSYSTEM

A. Basic Functions and Objectives.--Your SUR subsystem must:

o Develop a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants in various categories of services authorized under the Medicaid program.

o Investigate and reveal misutilization of the State's Medicaid program by individual participants and promote correction.

o Provide information which reveals and facilitates investigation of potential defects in the level of care and quality of service provided under the Medicaid program.

o Accomplish the above objectives utilizing a minimum level of manual clerical effort and a maximum level of flexibility with respect to management objectives of the State's Medicaid program.

o By means of computerized exception processing techniques, provide the ability to perform analyses and produce reports responsive to the changing needs of title XIX managers, PROs, and State Medicaid fraud control units.

o Be capable of developing provider, physician, and patient profiles sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

B. Ancillary Functions and Objectives.--Your SUR subsystem must also have:

o The capability to perform exception processing.

o At least 9 months of adjudicated claims data in the SUR History file, of which a full 6 months or more must be used for exception processing.

o The capability to separate federally-assisted program participants from any others in the claims data.

o A technical and user training program.

o The capability to generate SUR reports and special reports as needed; including, a required annual run of all reports for all participants.

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o The flexibility to produce claim detail and special reports by provider and recipient.

o The capability to perform focused review.

o The capability to profile group practices and to profile each individual within the group practice.

o The capability to suppress (i.e., not generate or print) processing on individuals within a category of service or class group on a run-to-run basis.

o Capability to access all data elements required by this chapter.

11340. MANAGEMENT AND ADMINISTRATIVE REPORTING (MAR) SUBSYSTEM

A. Basic Functions and Objectives.--Your MAR subsystem must:

o Report information to assist management in fiscal planning and control.

o Provide information required in the review and development of medical assistance policy and regulations.

o Monitor the progress of claims processing activity and provide summary reports which reflect the current status of payments.

o Review provider performance to determine the adequacy and extent of participation and service delivery.

o Report recipient participation in order to analyze usage and develop more effective programs.

o Be kept responsive to State users requests for information according to State defined time frames and priorities.

o Produce program data necessary to satisfy Federal Medicaid reporting requirements, e.g., those contained in §2700.

B. Ancillary Functions and Objectives.--Your MAR subsystem must also:

o Prepare budget allocations for various categories of service for the fiscal year.

o Project the cost of program services for future periods from past experience.

o Compare current cost with previous period cost to analyze current cashflow.

o Compare expenditures with budget to control financial position.

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o Analyze areas of program expenditure to determine relative cost benefit.

o Review services used by recipient categories for participation and relative cost.

o Analyze progress in accreting eligible Medicare Buy-In recipient data and the break-even point between Medicare and Medicaid payments.

o Review provider participation and analyze provider service capacity in terms of recipient access to health care.

o Present claims processing and payment information for an analysis of timely reimbursement.

o Analyze the frequency, extent, and type of provider and other claims processing errors.

o Monitor third party avoidances and collections in accordance with State plan requirements.

o Provide information needed for institutional and capitation rate setting.

o Analyze provider claim filing for timeliness, fiscal controls, and ranking.

o Analyze drug use by individual and by eligibility category for cost and potential abuse.

o Present geographic analysis of expenditures and recipient participation.

o Provide information to support State and Federal program initiatives and reporting requirements.

11350 MARS AND SURS REPORTS

You may accomplish the functions and objectives of both MARS and SURS through the timely and accurate production of reports focused on the specific functions of both subsystems. Whether these reports are produced in a regular, recurring pattern or are ad hoc reports is left to your discretion. In the final analysis, it is your responsibility to demonstrate that these two subsystems meet their objectives and perform their functions in an unambiguous fashion.

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