

Summary: Business Rules Development for Roll Up of 837 Institutional Claims – In Patient

Background

Key constraints identified with DHS trading partners as problematic include Oregon's MMIS having a maximum capacity of 28 line segments per claim and a limitation in the dollar field of 7 characters that prevents the MMIS from processing claims over \$99,999.99. DHS has increased its dialogue with its trading partners and has pursued a collaborative approach to resolution of this issue.

DHS, in conjunction with its business partners, has narrowed the scope of the MMIS enhancement needed to only 837 institutional claims. The solution means that trading partners will be able to send in all HIPAA complaint transactions up to 999 lines (institutional claims) and the dollar amount per line can exceed \$99,999.99 up to 18 characters. DHS is creating a process to "roll up" transactions exceeding line limits. The work session May 21 was needed to develop the business rules that will be the foundation of this "roll up" process.

Business Rules: Scope

In developing the business rules, the following scope was agreed to:

- The solution covers 99% of potential dollar claims. Claims under 28 lines will not be rolled up. The solution is limited to:
 - 837 Institutional Claims,
 - In-patient Claims,
 - Claims over 28 lines,
 - Dollar lines over \$99,999.99.
- The roll-up will occur between the translator and MMIS processing.

General Business Rules

The following general rules were agreed to in developing the business rules:

- Claim adjustments would be handled -- at the claim roll-up level.
- The roll-up will occur to the general category – not to exceed the line limits.
- The roll-up process should not change the claim edit process.
- Claims that would have been denied will still be denied
- Claims that should be paid will still be paid.
- Remittance advice (835) will occur at the claim roll-up level.
- Identical revenue codes will be compressed, if need be, with the lines to the dollar limit only. Similar revenue codes will be rolled up within a family of codes; for example lab codes (300 series) would be rolled up to 300 general category if needed.
- The maximum number of detail lines will be maintained. The claim roll up process will stop when the claim lines are less than 28. There is a priority order of revenue code roll-up processing. (See chart below.)

- This process only applies to “exception claims” – those over the limitations. If the dollar amount on any line is too high – that line will be split first.
- The translator solution will maintain the data history on claims submitted. Data will be stored at different steps along the process.
- The split criteria will use the same revenue codes and will mark as “non-dup.”
- In a roll-up where units exceed 999, the units will contain a value of 999.

Roll up Order

The following table illustrates the order of roll up as part of the business rules:

REVENUE ROLL UP TABLE		
General Categories and Order of Roll Up		
Proposed Order	Revenue Code	Revenue Code Description
1	30X	Laboratory
2	31X	Laboratory - Pathological
3	32X	Radiology - Diagnostic
4	33X	Radiology - Therapeutic
5	35X	CT Scan
6	40X	Other Imaging Services
7	42X	Physical Therapy
8	43X	Occupational Therapy
9	44X	Speech-Language Pathology
10	48X	Cardiology
11	41X	Respiratory Services
12	37X	Anesthesia
13	45X	Emergency Room
14	56X	Medical Social Services
15	73X	EKG
16	98X	Professional Fees
17	26X	IV Therapy
18	62X	Medical/Surgical Supplies - Extension of 27X
19	27X	Medical/Surgical Supplies & Devices