

IAIABC ISSUE RESOLUTION REQUEST FORM

IRR: MED547R1.0

BUSINESS REQUIREMENT/ISSUE: The State of California requires claims payers to report medical bills via the 837 reporting standard. When multiple medical bills in dispute are settled in a lump sum payment (one payment for Multiple medical bills) the state is requiring this medical dispute settlement via the 837 reporting standard.

CURRENT PROCESS: Currently the 837 does not have a mechanism to report lump sum settlements because this has not surfaced previously. What would currently have to occur is that the claims payer would have to re work every bill involved and apportion the settlement against all line items for all the bills included in the settlement. Settlements of this nature sometimes cover hundreds of bills over a period of any where from a couple of months to 5 years or more. The current process is intrusive to the work flow of most claims payers and would skew the state's database regarding payments for individual services provided.

BILL/ADMINISTRATIVE RULE (Optional):

REQUESTER'S PROPOSED SOLUTION (Optional): The sub committee composed of stakeholders from the industry and the state came up with a consensus resolution to this issue. The committee has determined that the 837 can be used to report a lump sum payment on multiple medical bills. The resolution would require the jurisdiction to adopt special CPT codes which describe the type of lump sum settlement payment made by the claims payer. Currently, the resolution is only for claims for which the claims payer has been found liable. The subcommittee recommends that the IAIABC adopt the following CPT codes as the standards that states adopt when wanting lump sum payments for multiple medical bills reported using the 837 standard.

State	Code	Description
Jurisdiction	MDS10	Lump sum settlement for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.
Jurisdiction	MDO10	Jurisdiction orders a lump sum payment for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider
Jurisdiction	MDS11	Lump sum settlement for multiple bills where liability for a claim was denied but finally accepted by the claims payer
Jurisdiction	MDO11	Jurisdiction orders a lump sum payment for multiple bills where claims payer is found to be liable for a claim which it had denied liability.

Once a dispute involving multiple medical bills is completed, the claims payer would create a bill using one of the above recommended jurisdictional CPT codes to report the transaction. The billed amount would be the amount in dispute. Paid amount would be the amount the claims payer paid out in the settlement.

REVIEWED BY: Faith Howe

DATE: January 8, 2007

DISCUSSION/HISTORY: This issue surfaced in the summer of 2006 during a regular meeting of the California/IAIABC implementation work group. A sub committee was formed to address the issue and determine if resolution could be worked out and if in fact the 837 could accommodate the reporting of lump sum settlements. From October till December 18th the sub committee met numerous times either in full committee or one off discussion groups. See attached for a complete history of the discussions and work papers of this process.

WORKGROUP COMMITTEE FINAL PROPOSED RESOLUTION:

Final Report California Lien Bill Sub Committee

The charge of the IAIABC Medical Work Group Sub Committee on California Lien Bills was to determine if the IAIABC ANSI 837 Standard could be used to report additional lump-sum lien bill settlements paid to the medical provider. The sub committee was to determine if there was an acceptable alternative to having the claims payer cancel the original bill previously reported to the DWC, apportion the lump-sum settlement payment across bills spanning months or years then re-submit the bill(s) as an original. The sub committee was also charged with establishing a standard for the IAIABC ANSI 837 if an acceptable alternative could be developed.

During the course of sub committee meetings, a number of issues surfaced which, while the issues certainly have an impact on state reporting in California, the resolution of those issues are not the purview of this sub committee. One of those issues will be addressed in part because it was raised in the context that what the state was requiring regarding reporting was not appropriate under the IAIABC ANSI 837. The sub committee met over the course of 3 months and considered a number of scenarios regarding lien bills in California to derive the proposed standard. In addition to the actual committee meetings, a number of committee members met separately with the sub committee chair to assist the chair in developing the various scenarios that the sub committee considered in formal sessions. The time and energy that individual members of the committee sacrificed in educating the chair of the sub committee greatly aided the sub committee in completing its work in a timely fashion.

While the focus of the sub committee work was the California Lien Bills, the solution is designed to be applicable in multiple jurisdictions where similar scenarios exist. While the states may not call their process lien bill scenarios, the results would be the same. Therefore, this standard should be applicable in any jurisdiction which allows for the lump sum payment of medical bills that are in dispute for various reasons.

Findings of the Sub Committee:

- During the course of the sub committees meetings, the issue was raised that the IAIABC ANSI 837 standard did not support the reporting of zero-dollar payments. The committee determined, in consultation with Medical Work Group and our ANSI liaison, that the standard does support the reporting of zero-dollar payments. While this was not a part of the charge of the sub committee, the sub committee decided to address it since it was a question regarding the IAIABC ANSI 837 standard. This determination should not be construed as to whether or not it is appropriate to require the reporting of zero-dollar payments. Nor should this determination be construed as to whether or not a jurisdiction has the authority to require the reporting of zero-dollar payments. It simply determines that the IAIABC 837 standard does support the reporting of zero-dollar payments.
- The sub committee has determined that there is an acceptable alternative for reporting multiple medical bills included in a lump sum payment in lieu of canceling and re submitting each bill as an original submission.
- The alternative would require the jurisdiction to adopt up to 4 jurisdictional CPT codes that are recommended to become a part of the IAIABC ANSI 837 standard.
- Once the dispute is resolved, the claims payer would create a bill in their system using the appropriate jurisdictional CPT code and would report the bill with the appropriate information.
- The information to be reported should include the following information regarding the specific transaction on the created bill:
 - DN6 Insurer FEIN
 - DN7 Insurer Name
 - DN187 Claim Administrator FEIN if applicable
 - DN188 Claim Administrator Name if applicable
 - DN15 Claim Number
 - DN31 DOI
 - DN43 Employee Last Name
 - DN44 Employee First Name
 - DN42 Employee SSN
 - DN638 Rendering Bill Provider Name
 - FN 643 Rendering Bill Provider State License Number
 - DN 521 Diagnosis Code
 - DN 715 A state specific jurisdictional CPT code and/or ANSI reason for _lien bill settlements_
 - DN 508 Bill Submission Reason Code: (_00_) Original (additional payment only without canceling the previous bills sent)
 - DN 509 Start Date (Date of Service)
 - DN 509 End Date (Date of Service)
 - DN 501 Total Amount billed (amount in dispute; it is recommended that the jurisdiction not add this amount into the total charges for the claim)

- Units (default to 1)
- DN 516 Settled Amount (amount paid)
- This standard is to be used to report the resolution of a dispute where money is paid involving multiple medical bills. It should not be used to report the resolution of a single medical bill.
- This standard is also intended to be used to report the resolution of a dispute where money is paid because it is determined that the claims payer is liable for the claim or the claims payer accepts liability of the claim. It is not intended to report monies paid without the claims payer accepting liability of the claim.

The following are the jurisdictional CPT codes recommended for adoption by a jurisdiction to enable to report using the above recommended standard

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Jurisdiction	MDS10	Lump sum settlement for multiple bills where the amount of reimbursement is in dispute between the claims payer and the healthcare provider.
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