

BACKGROUND

These rules are intended to be appropriate for all HMO encounter and claims transactions among providers, health plans, and purchasers. Readers should be aware that if there are disagreements between the CALINX Rules of Exchange and the rules and regulations established by the federal government for Medicare and Medicaid transactions, the federal regulations should supercede the CALINX Rules of Exchange. **The following rules apply to the HMO line of business only.**

CONTENT

- Complete encounter data from the provider will be given to health plans/provider organization
 - ANSI X12N 837 Professional and Institutional
 - HCFA 1500/UB 92 (ANSI 837 standards will supplant HCFA 1500 and UB 92 formats at the point a change-over occurs under HIPAA provisions)
 - HMOIS (ANSI 837 standards will supplant HCFA 1500 and UB 92 formats at the point a change-over occurs under HIPAA provisions)

FREQUENCY

- Provider Organizations will submit encounters to health plans on a 30 day cycle
- Information equivalent to that in HCFA 1500 and UB92 forms, except charge or other financial information that need not be included, will be completely and accurately reported within 60 days from date of service to health plans that prepay for services (i.e., an “encounter” report). This will include data from claims paid to network providers who contract directly with the provider organization.
- Complete HCFA 1500 and UB92 data, including financial charges, will be completely and accurately reported every 30 days to the direct payor of a claim.
- Plans will report complete and accurate encounter data compliance and edit reports to provider organizations within 30 days of receipt of the encounter/claim.
- Plans will report complete and accurate encounter data for out-of-network services that are not paid by the provider organization within 30 days of receipt of a clean claim. If the provider organization is at-risk for any portion of the out-of-network service, the amount paid to the out-of-network provider will also be included with the encounter report.

ENCOUNTER RULES OF EXCHANGE (cont.)

COMPLETENESS

- Provider Organizations are **not** required to submit cost data when they are reimbursed on a capitated basis.

APPROPRIATE USE

- Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party, as long as they meet confidentiality standards.
- The intent of this rule is to coordinate the accuracy of patient communication, and to ensure a coordinated approach to the care of the patient.
 - Plans directly contacting patients using information obtained from claims or encounter data will give 45-days advanced written notice to the provider organization or individual clinician, as appropriate.¹
 - Every provider organization will designate a recipient for the HMO communication process. This recipient is responsible for 1) verifying communication accuracy, 2) notifying or communicating with all involved individual physicians.
 - Any communication using encounter data must be specific regarding the exact information being sent to an individual member (i.e. suggesting a Pap Smear deficiency must include specific patient identifier).
 - The provider organization may object to the notice within the 45-day timeframe if it finds the specific data on specific patients inaccurate. The provider organization will notify the HMO of its findings and mutually create an accurate notice to specific patients.
 - No written objection by the provider organization within the 45-day timeframe (defined as from date of receipt by designated individual) is evidence of full approval.

¹ Appropriate should be considered as either the contracted entity – i.e., IPA or Medical Group – or the directly contracted clinician.