Health Plan Identifier (HPID) and 2014 CMS Updates

Christol Green, WellPoint, Inc.
Business Consultant Sr.
E-Solutions Strategy and Standards Governance

HPID Overview

- Part of the Affordable Care Act calls for the Department of Health and Human Services (HHS) to create a series of rules over five years designed to help streamline HIPAA transactions known as “Administration Simplification.”
- In September 2012, HHS approved a national unique health plan identifier (HPID) rule wherein controlling health plans must obtain a HPID. WellPoint is committed to enumerating its controlling health plans.
- The HPID rule creates requirements for different types of health plans to apply for and get HPIDs.
- Self-funded (ASO) health plans and fully-insured health plans with more than 50 employees are “health plans” per HIPAA.
HPID Overview

What is an HPID number?
The HPID is a 10-digit identifier assigned to Controlling Health Plan and Subhealth Plan upon application to CMS’ Health Plan and Other Entity Enumeration System (HPOES).

How does a Controlling Health Plan or Subhealth Plan obtain an HPID?
The HPID application is available through the Health Plan and Other Entity Enumeration System (HPOES). HPOES is accessible via the CMS’ Health Insurance Oversight System (HIOS).

Health Plan Identifier (HPID)

Who is required to get a HPID?
- Health plans as defined by 45 CFR 160.103
- Controlling health plan (CHP) vs. Subhealth plan (SHP)

Controlling Health Plan (CHP):
- A CHP means a health plan that controls its own business activities, actions, or policies OR is controlled by an entity that is not a health plan; and
- If it has sub health plan(s) exercises sufficient control over the sub health plan(s) to direct its/their business activities, actions, or policies.

Subhealth Plan (SHP):
- A SHP means a health plan whose business activities, actions, or policies are directed by a controlling health plan.

HPID Compliance Dates

- Plans with health benefit receipts of more than five million dollars ($5M), or “large” health plans,” will need to obtain an HPID by November 5, 2014.
- Plans with health benefit receipts under five million dollars ($5M), also known as “small health plans,” need to obtain an HPID by November 5, 2015.
- Health plans may have to use HPIDs in HIPAA electronic standard transactions by November 7, 2016.

<table>
<thead>
<tr>
<th>Action</th>
<th>Compliance Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Plan Enumerate</td>
<td>11/5/2014</td>
</tr>
<tr>
<td>Small Plan Enumerate</td>
<td>11/5/2015</td>
</tr>
<tr>
<td>Use HPID in transaction</td>
<td>11/7/2016</td>
</tr>
</tbody>
</table>

Current Concerns (1 of 2)

- Industry stakeholders continue to express concern about HPID enumeration and the use of HPID within the HIPAA electronic standard transactions. Specific concerns include routing issues reported years ago have been solved so the use of HPID to address routing issues is not needed, and may result in the creation of unintended consequences, such as privacy breaches, and mis-routed, unprocessed transactions.
- The Centers for Medicare and Medicaid Services (CMS) has not provided written guidance in response to industry stakeholders’ clarification request.
Current Concerns (2 of 2)

Recently, HHS officials offered/signaled:

- **Self-funded:** “Payers are not permitted to complete a HPID application for self-funded (ASO) customers without explicit authorization from the customer.”
- **Fully-insured:** HHS intends to exempt fully-insured group health plans from obtaining a HPID; however, no written guidance has been published.

HHS officials have not reported the number of HPIDs issued; however, it appears only 800+ HPIDs have been issued to date, which is far below estimates.

Many health plans are “holding off” HPID enumeration until HHS offers written guidance.

---

HPII Usage in HIPAA Standard Transactions

**Does the HPID replace the Payer ID used in HIPAA standard transactions?**

The HIPAA Standard transactions are under current review by ASCX12, but our expectation at this time is that the HPID does not replace the Payer ID. The X12 TR3 formerly known as the implementation guides will support the use of the HPID and the Payer ID.

**Note:**
If you do not identify your Controlling Health Plan within your transactions today then you may still continue with the Payer ID usage.
Health Plan vs. Payer

WEDI's HPID Workgroup Announces Release of Issue Brief: "What is the Difference Between a Health Plan and Payer?"

WEDI partnered with ASC X12 to develop this issue brief, which includes definitions of both terms and clarifies the role each plays in standard transactions according to the HPID Final Rule.


Health Insurance Oversight System (HIOS) and Health Plan and Other Entity Enumeration (HPOES) System Data Elements

Controlling Health Plan HPID Application:
- Company Information: Company Name, Federal Employer Identification Number, and Domiciliary Address
- Authorizing Official Information: First and Last Name, Title, Phone Number, and Email Address
- The Health Plan’s NAIC Number or Payer ID used in standard transactions

Subhealth Plan HPID Application Type – Company:
- SHP Company Information of Company Name, Federal Employer Identification Number, and Domiciliary Address
- The Health Plan’s NAIC Number or Payer ID used in standard transactions. If not sending transactions NAIC number may be left blank and “not applicable” is to be place in the Payer ID field.
  - May also be set up as issuer, by product or line of business
HPID FAQ’s (1 of 3)

Q. Does a controlling health plan have to get an HPID?
A. Yes.

Q. How is a controlling health plan determined?
A. In the final rule put out by HHS, the Department suggests these questions to decide if an entity is a CHP:
   1. Does the entity itself provide or pay for medical care?
   2. Does either the entity itself or a non-health plan organization control the business activities, actions, or policies of the entity?
      If the answer to both questions is “yes,” then the entity would meet the definition of CHP.

Q. Is a controlling health plan required to obtain an HPID if it does not directly take part in HIPAA electronic standard transactions?
A. Whether or not a plan engages in standard transactions does not impact whether a plan needs to obtain an HPID.

Q. Does a subhealth plan have to get an HPID? Why would a subhealth plan need an HPID?
A. Subhealth plans are not required to get an HPID (but their controlling health plan may ask or require them to do so). The subhealth plan may choose to obtain an HPID because it is the responsible health plan to be identified to the controlling health plan.

Q. Is the HPID required on the member’s identification card?
A. No, the HPID is not required to be added to a member’s identification card.

Q. Does the HPID replace the payer ID used in HIPAA electronic standard transactions?
A. No. To learn more about the terms of “health plan” and “payer” access the Workgroup for Electronic Data Interchange (WEDI) issued a brief titled “What is the Difference Between a Health Plan and Payer?” available here.

Q. Does using the HPID mean that the HIPAA electronic standard transaction will get routed to the health plan whose HPID is used?
A. No, the HPID is not used for routing purposes.

HPID FAQ’s… (2 of 3)
HPID FAQ’s (3 of 3)

Q. Could a potential penalty be assessed against a controlling health plan that does not obtain an HPID by the respective compliance deadlines?
A. Yes, penalties could be assessed. According to HIPAA’s enforcement provisions there is a tiered structure for minimum penalties range from $100 to $1.5 million for violations of HIPAA with the amount of penalties generally dependent on the determined degree of culpability. Although HIPAA provides for penalties, federal regulators released frequently asked questions about general ACA compliance activities available here that may be helpful to understand their stance. In these early FAQs, the department reaffirms its intention to assist (rather than impose penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law.

Q. Where can I find more information about the HPID?
A. Information from CMS like the final rule, a fact sheet and frequently asked questions can be viewed at:

2014 CMS Updates

Medicare Crossover:
• Bundled Payments for Care Improvement (BPCI) Initiative
• BPCI Model 1 – 4
• Benefits Coordination & Recovery Center (BCRC) [formerly COBC]
• ICD-10 crossover testing

Upcoming CMS Changes/Updates 2015
• Claims filing indicator code change
• Diagnosis Code Set General Equivalence Mappings
• Credited Sources
What is the Bundled Payments for Care Improvement (BPCI) Initiative?

- The Center for Medicare & Medicaid Innovation (CMMI) states, traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings.
- The bundled payment initiative is intended to align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners. This allows these providers to work closely across specialties and settings.
- The initiative is expected to move through a course of three years. During this time CMS will work with the organizations participating to determine whether the models being tested result in improved patient care and lower costs to Medicare.

What is the Bundled Payments for Care Improvement (BPCI) Initiative?

- Model 1 focuses on the acute care inpatient hospitalization. Awardees agree to provide a standard discount to Medicare from the usual Part A hospital inpatient payments. The first set of participants in Model 1 began in April 2013, and additional participants began in January 2014. Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Model 4 involves a prospective bundled payment arrangement, where a lump sum payment is made to a provider (Facility) for the entire episode of care. The first set of participants in Models 2, 3, and 4 were announced in January 2013.
Bundled Payments for Care Improvement (BPCI) Initiative – Model 4

Acute Care Hospital Stay Only

• CMS makes a single prospectively determined bundled payment to the hospital that includes all services furnished during the inpatient stay by the hospital, physicians, and other practitioners.
• Physicians and other practitioners submit “no-pay” claims to Medicare Part B. These providers will be paid by the hospital out of the global bundled payment.
• The payment arrangements include financial and performance corresponding to the episodes of care.
• Related readmissions for 30 days after hospital discharge are included in the bundled payment amount.
• Hospital providers taking part in the program can choose up to 48 different clinical condition episodes.

Bundled Payments for Care Improvement (BPCI) Initiative – Model 4 (Cont’d)

• There are 24 participating sites at this time
• Model 4 will not include Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Home Health and Hospice jurisdiction MACs.
• The Beneficiary must be eligible to take part in the pilot.
  • Eligible for Part A and Part B and has at least 1 utilization day left or 1 Life time reserve day left.
  • Does not have ESRD, is not enrolled in managed care plan, and is not covered under United Mine Workers (UMW), and
  • Medicare must be the primary payer
• Authority: Section 3021 of the Affordable Care Act
BPCI Model 4 – Phases and Effective Dates

<table>
<thead>
<tr>
<th>PHASE</th>
<th>DEFINITION</th>
<th>START DATE</th>
<th>DESCRIPTION OF PHASE</th>
</tr>
</thead>
</table>
| 1     | "No Risk Preparation" Phase | October 2013 | - Participants are expected to become participants in Phase 2  
- *Participants are NOT receiving prospective payments under BPCI Model 4 yet.  
- Participants are learning activities surrounding bundled payments |
| 2     | "Risk – bearing Implementation" Phase | January 2014 | - Participants choose to take financial risk for episodes of care.  
- Period in which Model 4 prospective payments will be made. |

48 Episodes of Care

There are 48 episodes that participants can choose from. These are listed under the section “Episodes of Care” using the following URL:

http://innovation.cms.gov/initiatives/Bundled-Payments

<table>
<thead>
<tr>
<th>EPISODE (1 – 12)</th>
<th>EPISODE (13 – 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint upper extremity</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Amputation</td>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>Cardiac arrhythmia</td>
</tr>
<tr>
<td>Stroke</td>
<td>Cardiac valve</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis/asthma</td>
<td>Other vascular surgery</td>
</tr>
<tr>
<td>Coronary artery bypass graft surgery</td>
<td>Major cardiovascular procedure</td>
</tr>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>Gastrointestinal hemorrhage</td>
</tr>
<tr>
<td>Percutaneous coronary intervention</td>
<td>Major bowel</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>Fractures femur and hip/pelvis</td>
</tr>
<tr>
<td>Cardiac defibrillator</td>
<td>Medical non-infectious orthopedic</td>
</tr>
<tr>
<td>Pacemaker Device replacement or revision</td>
<td>Double joint replacement of the lower extremity</td>
</tr>
<tr>
<td>Automatic implantable cardiac defibrillator generator or lead</td>
<td>Revision of the hip or knee</td>
</tr>
</tbody>
</table>
48 Episodes of Care (Cont’d)

<table>
<thead>
<tr>
<th>EPISODE (25 – 36)</th>
<th>EPISODE (37 – 48)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal fusion (non-Cervical)</td>
<td>Other respiratory</td>
</tr>
<tr>
<td>Hip and femur procedures</td>
<td>Chest pain</td>
</tr>
<tr>
<td>Cervical spinal fusion</td>
<td>Medical peripheral vascular disorders</td>
</tr>
<tr>
<td>Other knee procedures</td>
<td>Atherosclerosis</td>
</tr>
<tr>
<td>Complex non-Cervical spinal fusion</td>
<td>Gastrointestinal obstruction</td>
</tr>
<tr>
<td>Combined anterior posterior spinal fusion</td>
<td>Syncope and collapse</td>
</tr>
<tr>
<td>Back and neck except spinal fusion</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
<td>Nutritional and metabolic disorders</td>
</tr>
<tr>
<td>Removal of orthopedic devices</td>
<td>Cellulitis</td>
</tr>
<tr>
<td>Sepsis</td>
<td>Red blood cell disorders</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Transient ischemia</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
</tr>
</tbody>
</table>

Important Codes on the Model 4 BPCI Institutional Inpatient Claim

<table>
<thead>
<tr>
<th>Code Definition</th>
<th>Code Value</th>
<th>Short Description</th>
<th>HIPAA 837I location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstration Project Id</td>
<td>64</td>
<td>BPCI Demo Code</td>
<td>2300, REF02 when REF01=P4</td>
</tr>
<tr>
<td>Value Code</td>
<td>Y1</td>
<td>Part A Demonstration Payment</td>
<td>2300, qualifier BE</td>
</tr>
<tr>
<td>Value Code</td>
<td>Y2</td>
<td>Part B Demonstration Payment</td>
<td>2300, qualifier BE</td>
</tr>
<tr>
<td>Value Code</td>
<td>Y3</td>
<td>Part B Co-Insurance</td>
<td>2300, qualifier BE</td>
</tr>
<tr>
<td>Value Code</td>
<td>Y4</td>
<td>Conventional Prov Paid Amt</td>
<td>2300, qualifier BE</td>
</tr>
<tr>
<td>Value Code</td>
<td>Y5</td>
<td>Part B Deductible</td>
<td>2300, qualifier BE</td>
</tr>
<tr>
<td>CARC</td>
<td>1</td>
<td>Deductible (Part A)</td>
<td>2320, CAS</td>
</tr>
<tr>
<td>CARC</td>
<td>2</td>
<td>Co-insurance (Part A)</td>
<td>2320, CAS</td>
</tr>
<tr>
<td>CARC</td>
<td>247</td>
<td>Deductible (Part B)</td>
<td>2320, CAS</td>
</tr>
<tr>
<td>CARC</td>
<td>248</td>
<td>Co-insurance (Part B)</td>
<td>2320, CAS</td>
</tr>
<tr>
<td>CARC</td>
<td>253</td>
<td>sequestration reduction</td>
<td>2320, CAS</td>
</tr>
<tr>
<td>Payer Paid</td>
<td></td>
<td>COB Payer Paid Amt</td>
<td>2320, AMT02 when AMT01=D</td>
</tr>
</tbody>
</table>
Important Codes on the No Pay Professional Claim Associated to the Model 4 BPCI Institutional Inpatient Claim

<table>
<thead>
<tr>
<th>Code Definition</th>
<th>Code Value</th>
<th>Short Description</th>
<th>HIPAA 837P location</th>
</tr>
</thead>
<tbody>
<tr>
<td>RARC</td>
<td>N67</td>
<td>Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient’s admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.</td>
<td>2320, MOA ** Also included on the Medicare 835** Used with CARC 234</td>
</tr>
<tr>
<td>CARC</td>
<td>234</td>
<td>This procedure is not paid separately.</td>
<td>2320, CAS ** Also included on the Medicare 835** Used with RARC N67</td>
</tr>
<tr>
<td>Modifier</td>
<td>AO</td>
<td>Prov declined alt pmt method</td>
<td>2400, SV101–3 through SV101–6</td>
</tr>
</tbody>
</table>

Trading Partner Impacts: Claims Adjudication System Processing

If the beneficiary does not meet all of the requirements for the Model 4 Beneficiary eligibility, the following codes will be assigned to the rejected or cancelled Notice Of Admissions (NOAs).

*Please note: Trading Partners would not see these codes on the crossover claim. This is how CMS notifies the providers.*

- Claims Adjustment Reason Code (CARC) B5:
  - Coverage/program guidelines were not met or were exceeded.
- Remittance Advice Remark Code (RARC) N564:
  - This patient did not meet the inclusion criteria for the demonstration project or pilot program

Trading Partner Information:
Claims Adjudication System Processing

- **Demo Code 64**: Code to identify these claims. Pend Claims? (may need manual intervention)
- **CARC codes**:
  - 247–Deductible for professional service rendered in an institutional setting and billed on an institutional claim
  - 248–Coinsurance for professional service rendered in an institutional setting and billed on an Institutional claim
- **RARC codes**: N67–Professional provider services not paid separately
- **Value codes**: Y1 Part A Demo Payment, Y2 Part B Demo Payment, Y3 Part B Coinsurance, Y4 Conventional Prov Pymt Amt non-demo clm, Y5 Part B Deductible
- **Part A Coinsurance and Deductible**: displays in CAS segments as they do today.
- **EDI changes were limited**: Demo Code of “64”, Loop 2300 REF segment that will be submitted on these Crossover 837I claims to backend claims platforms.
- **Claims imaging modifications for 837I Model 4 claims to capture Professional data.**

BPCI Model 4 FAQ

**How is CMS ensuring the professional Part B claims are not being incorrectly paid before the model 4 claims are created?**

**Response:** CMS will be working with its MACs to conduct more targeted education of BPCI facilities to hopefully decrease incidents where NOAs are not properly created prior to claims submission. This will lessen the frequency of Part B physician claims being incorrectly paid and crossed over.

**As CMS describes in their COBVA dated 3/4/14,**
- All participating hospitals within Model 4 BPCI are requested to establish a Notice of Admission (NOA) prior to submitting their BPCI claims (11X TOB).
- If the BPCI facility fails to bill an NOA prior to submitting their BPCI claims to Medicare, the Medicare systems are not able to properly associate Part B physician services with the inpatient episode. This results in the Part B claim being paid and crossed over to Trading Partners.
- When the NOA is established after the Model 4 BPCI claims have already been billed, CWF will identify the Part B claims and alert the Part B contractor to deny through an adjustment action.
- Currently these claims are auto–excluded for crossover. CMS is investigating and hoping to correct the issue so Trading Partners that receive 100% denied monetary adjustments will receive the adjustment to recoup incorrect payments.
Benefits Coordination & Recovery Center (BCRC)  
[Previously known as “GHI”] Responsibilities

- Administers the COBA process for CMS.
- The BCRC is responsible for ensuring that Medicare gets repaid for any conditional payments it makes related to a liability, no-fault, or workers’ compensation claim.
- A conditional payment is a payment Medicare makes for services another payer may be responsible for.
- Medicare makes the conditional payment so the Medicare Beneficiary will not have to use his/her own money to pay the bill.
- The payment is “conditional” because it must be repaid to Medicare when a settlement, judgment, award, or other payment is made.
- Once the BCRC is notified, they will gather information about all of the conditional payments Medicare made related to the case and begin recovery.
- The BCRC will issue a Rights and Responsibilities letter that explains the information needed from the beneficiary and what he/she can expect to receive from the BCRC.

ICD–10

On **October 1, 2015**, the ICD–9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD–10 code sets.

- The transition to ICD–10 is required for everyone covered by the [Health Insurance Portability Accountability Act (HIPAA)](http://www.hhs.gov/hipaa). Please note, the change to ICD–10 does not affect CPT coding for outpatient procedures and physician services.

- **Keep Up to Date on ICD–10**
  
  Visit the CMS [ICD–10 website](http://www.cms.gov/Medicare/Coding/ICD-10) for the latest news and resources to help you prepare for the **October 1, 2015**, compliance date. Sign up for [CMS ICD–10 Industry Email Updates](http://www.cms.gov/Medicare/Coding/ICD-10).
ICD–10

ICD–10 eHealth University Resources

- CMS has launched eHealth University, a new go-to resource to help providers understand, implement, and successfully participate in CMS eHealth programs. eHealth University features a full curriculum of materials and information, all in one location. The education modules are organized by level, from beginner to advanced, and simplify complex information in a variety of formats, including fact sheets, guides, videos, checklists, webinar recordings, and more.

As part of eHealth University, CMS is offering several resources to help you prepare for the October 1, 2015, ICD–10 compliance date. These include:

- **Introduction to ICD–10** – This fact sheet provides an introduction to ICD–10 and explains the key steps for switching to ICD–10.

- **Transition Checklist: Large Practices** and **Transition Checklist: Small and Medium Practices** – These checklists outline tasks and estimated timeframes for important ICD–10 transition activities for small, medium, and large practices.

- **Basics for Small and Rural Practices** – This beginner-level fact sheet provides basics about the ICD–10 transition for small and rural practices, including background on ICD–10, important questions to answer about ICD–10 preparations, and resources to help prepare for the compliance date.

- **Introduction to ICD–10 for Providers** – This in-depth guide for providers explains the background behind ICD–10, why the transition is important, how providers can prepare for ICD–10, and important resources to help transition.
ICD–10 Medicare Crossover Testing

- CMS began its COBA ICD–10 testing effort on February 19, 2014, and is expected to run through June 30, 2015.
- Testing (including negative testing) is available for 837 institutional, 837 professional (non-DMEPOS), and 837 DMEPOS claims.
- The goals of testing are to:
  - Actualize COBA trading partner systems vis-à-vis various ICD–9 and ICD–10 codes given certain date of service/date of discharge scenarios. (NOTE: Plans may modify the test data if necessary but need to apprise CMS and the BCRC of this via their COBA ICD–10 Feedback Form when reporting back results found.)
  - Obtain feedback from COBA trading partners, to ensure no issues, related to code usage, are evidenced.

837I – Institutional claims
- Using Test HICN range 88510xxxxA
- Contractor ID 11201
- COBA ID 87000
- 8 Test scenarios (including Model 4)
- 2 Negative test cases

837P – Professional claims
- Using Test HICN range 88610xxxxA
- Contractor ID 11202
- COBA ID 87000
- 8 Test scenarios
- 2 Negative test cases

837P – DME claims
- Using Test HICN range 88410xxxxA
- Contractor ID 44410
- COBA ID 87000
- 8 Test scenarios (including Model 4)
- 2 Negative test cases

All dates reflected in the ISA, BHT04, and 2330B and/or 2430 DTP*573 of the COBA ICD–10 test claims will be set as if Medicare had processed all of the test claims during February of 2015.
Upcoming CMS Changes 2015

Claim Filing Indicator Code Change

• Definition of the Problem: Through formal channels CMS was made aware that Medicare’s current practice of including the value “ZZ” [mutually defined] in both the 2000B SBR09 and 2320 SBR09 segments of outbound HIPAA 837 coordination of benefits (COB)/crossover claims is contributing to a compliance issue involving the 835 Electronic Remittance Advices (ERAs) created by our COBA trading partners.

• CMS will modify the 2000B SBR09 (Subscriber Information – Claim Filing Indicator Code) segment and 2320 SBR09 (Other Subscriber Information – Claim Filing Indicator Code) segment tied to “other supplemental” payers reported in the 2330B loop (Other Payer Name) on all COBA crossover claims.

• Value will be changed from “ZZ” to “CI”; only Medicaid will remain as “MC.”

• Commercial trading partners that currently ignore the “ZZ” 2000B SBR09 value should continue to ignore the “CI” value that will be transmitted.

• Commercial trading partners will be expected to return values other than “ZZ” (such as 12, 13, or 15) in 2100 CLP06 of their 835 ERAs created when making supplemental payment after Medicare.

Diagnosis Code Set General Equivalence Mappings (GEMS)

Documentation and User’s Guide

• This document accompanies the 2015 release of the National Center for Health Statistics (NCHS/CDC) public domain diagnosis code reference mappings of the International Classification of Diseases 10th Revision Clinical Modification (ICD–10–CM) and the International Classification of Diseases 9th Revision (ICD–9–CM) Volumes 1 & 2. The purpose of this document is to give readers the information they need to understand the structure and relationships contained in the mappings so they can use the information correctly.
GEMs continued...

**Section 1** – is a general interest discussion of mapping as it pertains to the GEMs. It includes a discussion of the difficulties inherent in translating between two coding systems. The specific conventions and terms employed in the GEMs are discussed in more detail.

**Section 2** – contains detailed information on how to use the GEM files for users who will be working directly with applied mappings now or in the future—as coding experts, researchers, claims processing personnel, software developers, etc.

The **Glossary** – provides a reference list of the terms and conventions used—some unique to this document—with their accompanying definitions.

**Appendix A** – contains tables describing the technical details of the file formats, one for each of the two GEM files:
1) ICD–9–CM to ICD–10–CM (I–9 to I–10)
2) ICD–10–CM to ICD–9–CM (I–10 to I–9)

---

Credited Sources

**Slides listing CARC/RARC Codes/definitions credit source:**

**Slides listing Value Codes/definitions credit source:**

**Slide listing Modifier AO credit source:**

**Slides Providing Details on BPCI credit source:**

**Slides Providing Details on ICD–10 credit source:**
Questions ???