Detroit Area Agency on Aging – Data Management RFQ
Responses due by August 29, 2025

Introduction and Background

The Detroit Area Agency on Aging (DAAA) is soliciting quotes from qualified vendors to design, develop, and manage a secure data management infrastructure that enables robust exchange of member data with contracted healthcare payors. DAAA maintains multiple payor relationships and is required to receive, ingest, standardize, transform, transmit, and report data across numerous file types and formats. The objective of this procurement is to obtain a reliable solution with proven capabilities in data integration, secure file exchange, data warehousing, and reporting.

We are also attaching our desired data flows, payor exchange, specifications, and current payor reporting requirements to provide additional technical details.

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2. Scope of Work

2.1 Data Ingestion & Integration
• Ingest structured and unstructured data across multiple formats (e.g., HL7, EDI, CSV, JSON, ADT feeds), including eligibility, claims, encounter, and quality files. Capability to ingest data in real-time
• Support a **modern interoperability framework**, including SFTP, RESTful APIs, and event-based messaging to enable real-time bi-directional data exchange with healthcare payors and internal systems.
• Provide a **whole-person data aggregation capability** that consolidates clinical, social, and operational data sources into a unified data layer.
2.2 Data Warehouse/Data Lake Development
• Design, develop, and maintain a secure data warehouse or data lake to store structured and unstructured data.
• Include automated data refresh, indexing, and archival processes.
• Ensure system maintains full audit trails and supports HIPAA-compliant, Soc 2 Type II architecture.
2.3 Data Transformation and Enhancement
• Extract required data elements from our CM solution (CIMs Compass) and map to relevant outbound interfaces.
• Incorporate and append plan-specific data points as required.
• Transform data to meet healthcare payor file interface specifications.
2.4 Interface Management
• Submit, process, and maintain all inbound and outbound file interfaces in accordance with each payor's frequency and technical format (daily, weekly, monthly, etc).
• Monitor interface activity; identify and remediate data or transmission errors.
• Coordinate interface changes and updates with DAAA and payor partners.

2.5 Reporting & Dashboards
• Develop dashboards and standard (“canned”) reports that align with contractual requirements and key operational needs.
• Provide ad hoc querying and reporting capability for DAAA staff.
• Reporting should include utilization trends, data quality metrics, processing status, transmission status, and error alerts.
2.6 Performance Metrics and Problem Identification
• Support DAAA key performance metrics to allow DAAA to identify potential data issues, interface delays, and service delivery problems.
• Provide proactive alerts and notifications when agreed-upon thresholds are exceeded. • Report Attestation – Allow DAAA to review and approve reports prior to submission
• Enable DAAA to configure custom alert rules based on operational priorities.
2.7 Expansion Capabilities
• Capability to connect to interoperability networks (TEFCA framework)
• Provide a platform for the addition of other proprietary datasets
• OCR-capability to extract data from PDFs

Share data back with DAAA – DAAA owns the data and should have the ability to migrate as necessary

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3. Vendor Qualifications

Vendors should demonstrate the following:

- Proven experience supporting healthcare data integration, transformation, and interface management with Medicaid managed care plans, Medicare plans, and/or Provider Networks.
- Expertise in designing and maintaining secure data warehouse environments compliant with HIPAA and other applicable data security standards. Vendor must maintain a Hitech Certification (Soc 2 Type II, HiTrust, ISO 27001, etc)
- Onshore Resources (PHI cannot be offshored)
- Experience integrating with Compass or other case management systems (preferred but not required).
- Availability of dedicated staff to support implementation and ongoing maintenance.

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4. Submission Requirements

Interested vendors should provide the following information in their quote:

Requirement	Description
Company Overview	Brief background and description of relevant experience

Requirement	Description
Technical Solution	Description of the proposed architecture, functionality, and approach
Implementation Plan	High-level timeline with key milestones and deliverables. *We are looking at a 1/1/26 go-live date with time for testing pre go-live.* Please detail assumptions needed to meet our timeline
Staffing Plan	Description of key team members and roles
Pricing	Breakdown of implementation costs, ongoing maintenance/support fees, and any optional services. Include hourly rates by staff role to be utilized in any change orders. Please include any assumptions (ie; number of reports, number of interfaces, etc)

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5. Submission Instructions

Quotes must be submitted via email to **hedgepeths@daaa1a.org** no later than **August 29, 2025**. Please include "Data Management RFQ Response – [Vendor Name]" in the email subject line.

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6. Anticipated Procurement Timeline

Milestone	Date
RFQ Released	August 19, 2025
Vendor Questions Due	August 25, 2025
Responses to Questions Issued	August 26, 2025
RFQ Responses Due	August 29, 2025
Vendor Review and Evaluation	August 30 – September 3, 2025
Vendor Selection Notification	September 4, 2025
Contract Start Date (Target)	September 15, 2025

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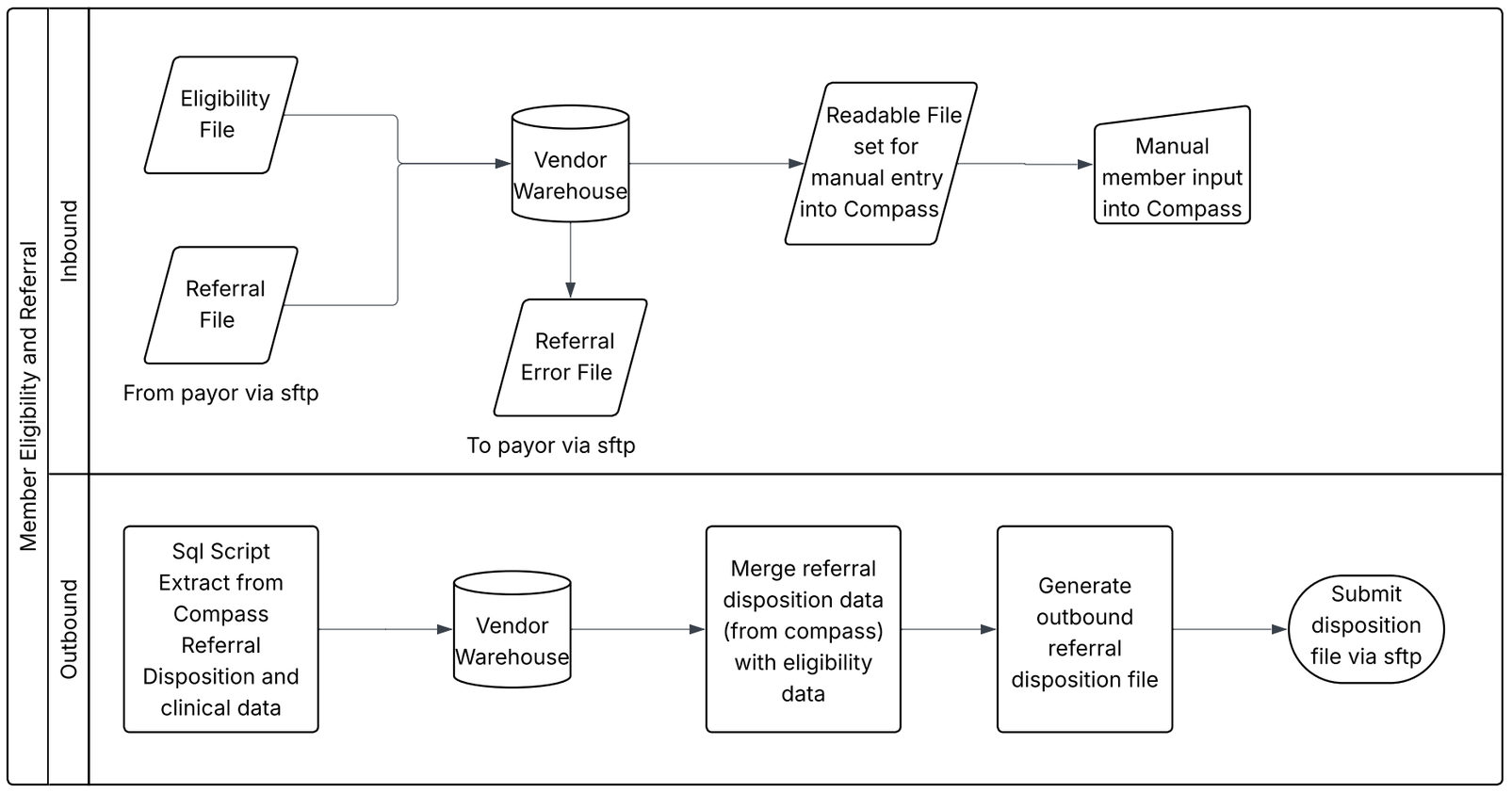
7. Evaluation Criteria

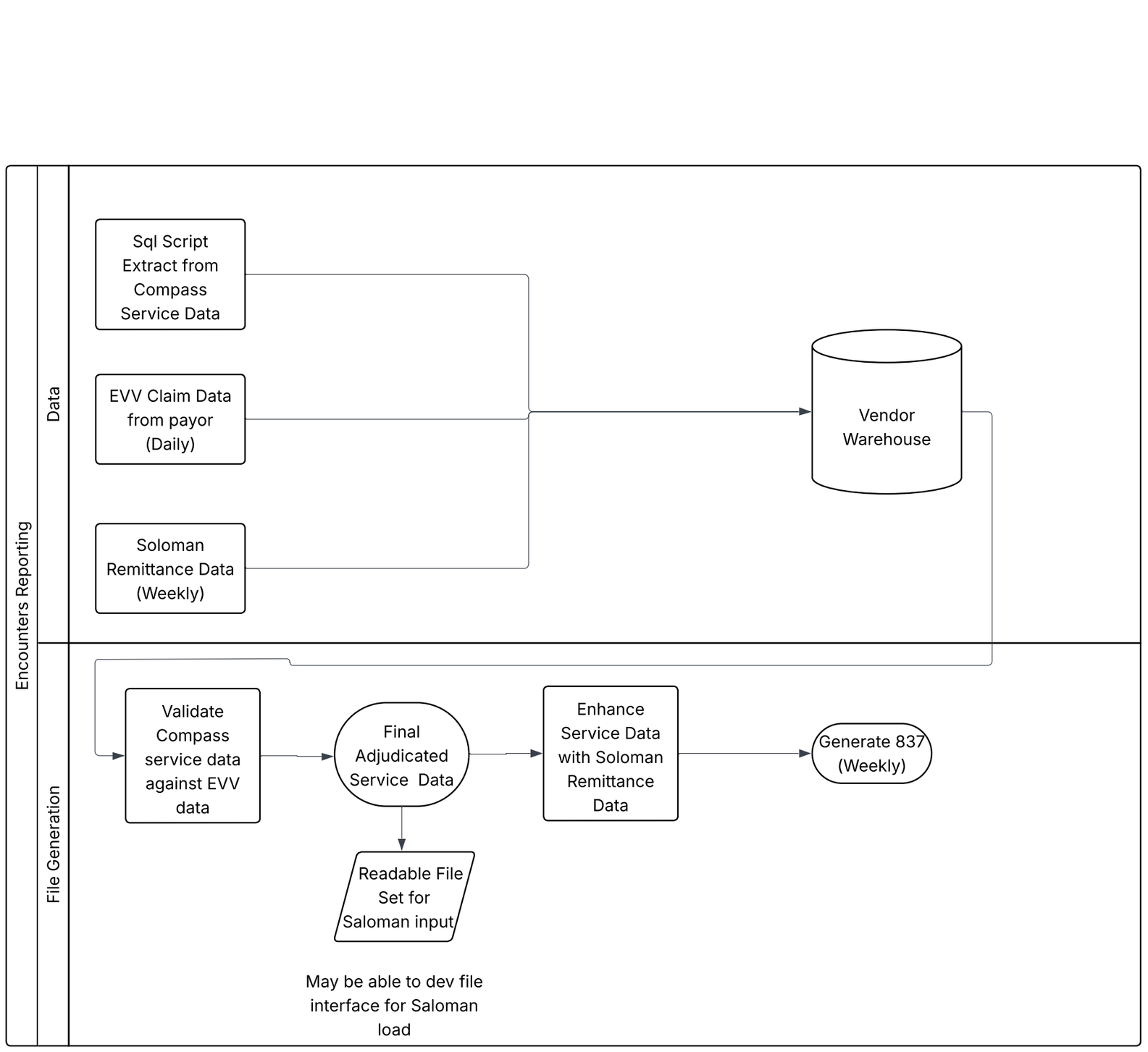
DAAA will evaluate responses based on the following criteria:

Criterion	Description
Technical Capability	Alignment of proposed solution with RFQ requirements
Relevant Experience	Demonstrated track record with similar clients/scope
Implementation Approach	Clarity, feasibility, and timeliness of the proposed workplan
Staffing	Experience and qualifications of proposed team members
Cost	Overall cost and cost-effectiveness of proposed services

DAAA reserves the right to select the vendor that provides the “best value” based on the experience, readiness, approach and cost.

File Names	
Inbound	Outbound
Payor • AAA Eligibility (from plan • Referral File • EVV File **Compass** • Referral Disposition Data • Clinical Data - assessment dates • Service Data **Soloman** • Remittance Data	**DAAA** • Member Demographic and Referral Detail File (manual input into Compass) • Adjudicated Service Data (Manual input for payments) **Payor** • Referral Disposition File • 837 Encounters





AAA Medicaid Eligibility Template

File Format:	Pipe delimited .txt		
File Naming convention:	AAA_{Payor}_YYYY_MM_DD AAATest_{Payor}_YYYY_MM_DD		
Frequency:	Daily Change Mon-Sun @10:00am EST Monthly Full 1st Monday of Every Month @ 10am		
Note:	**All columns must be included even if there is no data.** **First row should always be the header with column names as below.** Trailer - CCYYMMDD######## where # is the record count		
Required Header	**Description**	**Required**	**Special Notes**
Participant_Case_ID	Member Id	Y	Payor Member ID, (Hxxxxxxxx)
MBR_Last_Name	Member Last Name	Y	
MBR_First_Name	Member First Name	Y	
Effective_Start_Date	Format: MMDDYYYY	Y	Payor Effective Date
Medicaid Enrollment_Effective Date	Format: MMDDYYYY	Y	?
Medicaid Effective_End_Date	Format: MMDDYYYY	C	Conditional- **Required** when member coverage terms Humana Termination Date
Group_Id	6 digit Group#	Y	Payor Group Number (Program)
BSN	3 digit Benefit Sequence Number	Y	Payor BSN Sub-type(Sub-Type)
Medicare_Number	Member Medicare Beneficiary ID (MBI)	C	Conditional- **Required** for Medicare Coverage --Medicare ID
Medicaid_Number	Member Medicaid Number	Y	Medicaid ID Number
Member_Waiver	Member Waiver	C	Conditional- **Required** when member wavier coverage
Member_Waiver_Effective_Date	Format: MMDDYYYY	C	Conditional- **Required** when member wavier coverage
Member_Waiver_End _Date	Format: MMDDYYYY	C	Conditional- **Required** when member wavier coverage terms

Interface Control Document (EXAMPLE)

A guide to hCAT coding guidelines for:

State Data to hCAT

Version 2 (Updates from PCE)

Target Release: 2026

General Overview

The purpose of this ICD is to document and track the necessary information required for consumption by hCAT:

- State Referral Outgoing File

This Interface Control is created during the Planning and Design Phases of the project. Its Intended audience is the project manager, project team, development team, and stakeholders Interested in interfacing with the system. This ICD helps ensure compatibility between system segments and components.

Transmission Details

Referral Data File

Protocol	FTP
File Type	Uncompressed data
File Format	Pipe Delimited {"|"}
Headers	Yes
File Name	DELEGATE_DATA _MMDDYYYY.txt
File Rules	• File name to include state, date and file type/name. • First row is count of records. • Second Row is header row. • All additional rows are one record per line with fields tab delimited. • No empty rows. • If more than one file is to be passed, then file name is to be different by putting a different day in the file name.
Frequency	Daily, EOD
Location for pickup	TBD
Interface Availability	Should be available 24/7
Humana At Home Support team contact	TBD

Clinical Data File Layout
NOTE: First row will be record count for file.
Second row is column/field headers

Attribute Name	Type / Format	Description	Null Values Allowed	DAAA Notes/ Questions
TRANSACTION_ID	VARCHAR2(16)	Transaction ID for this row, used to reference dispositions and outgoing files.	No	
IDCARD_ID	VARCHAR2(20)	Cardholder number used to identify the beneficiary as assigned by Humana, also known as the H-number.	No	
FIRST_NAME	VARCHAR2(50)	First name of the beneficiary.	Yes	
LAST_NAME	VARCHAR2(50)	Last name of the beneficiary.	Yes	
DOB	Date (MMDDYYYY)	Date of Birth of the beneficiary.	No	
MCR_ID	VARCHAR2(20)	Medicare ID	No	
MCD_ID	VARCHAR2(20)	Medicaid ID	No	
MBR_GENDER	CHAR	Gender of Member	No	
MBR_ADDRESS	VARCHAR2(64)	Member Address	No	
MBR_PHONE	VARCHAR2(12)	Phone Number	No	
CARE_COORD_NAME	VARCHAR2(30)	Humana Care Coordinator Name	No	Will be Humana CC
CARE_COORD_PHONE	VARCHAR2(12)	Humana Care Coordinator Contact Phone	No	Will be Humana CC
PROG_ID	VARCHAR2(16)	ID of the Auth/Referral	Yes	Unique by referral
PROG_CD	VARCHAR2(300)	Program/Waiver Code	No	Seen at bottom of doc

PROG_CREATE_DT	Date (MMDDYYYY)	Date of the Referral Creation	No	
PROG_EFF_DT	Date (MMDDYYYY)	Start Date of Associated Program	No	Start Date of CM
PROG_END_DT	Date (MMDDYYYY)	End Date of Associated Program	No	Null
PROG_ENROLL_REASON	VARCHAR2(50)	Reason the Program was Initiated	No	Allowable Values?
PROG_END_REASON	VARCHAR2(50)	Reason program was ended/terminated. NULL if in progress or new.	Yes	Allowable Values?
PROG_SRC_TRIGGER	VARCHAR2(1)	What triggered the program's enrollment (HRA, State-Defined, etc.)	No	Allowable Values?
PROG_SRC_DATE	DATE(MMDDYYYY)	Date the Program was Triggered	No	
PROG_SRC_SUPPL	VARCHAR2(300)	Supplemental data for program source (HRA Question that triggered if available, etc.)	Yes	Allowable Values?
WAIVER_DT	Date (MMDDYYYY)	Original data of Waiver that generated Referral, if applicable.	Yes	
MBMR_ACK	VARCHAR2(8)	Yes/No if the Member has been communicated in regards to Program. Yes/No/UTC	No	DAAA to populate

Post-Interaction Actions and/or Results

Errors and Error Handling

In case of error during Data Feed Transmission CDM will send a failure email to the following:

1. If error occurs during the processing of the file – HCAT SRE will be notified.
2. Error details should be included in the email description so that Humana teams can access it directly & start working on it.
3. CDM and HCAT IT will have to work to correct the issues and push the feed as per process applicable.

Notes and Issues

None

Revision and Approval History

REVISION HISTORY			
Version #	**Version Date**	**Revision Description**	**Version Author**
1	05/29/2025	EXAMPLE PROVIDED	Kevin Devroy
2	06/02/2025	Updates requested from PCE Added.	Taylor Hans

Waiver	Program/Reason
HCBS	MI Coordinated Health and receiving Home and Community Based Services
HOSW	MI Coordinated Health receiving Home and Community Based Services and receiving Hospice services at home
HOSN	MI Coordinated Health receiving Hospice in a Nursing Facility (not CMCF)
NFAC	MI Coordinated Health residing in Nursing Facility (not CMCF)
HOSR	MI Coordinated Health receiving Hospice in a Hospice Residence Facility
CMCF	MI Coordinated Health residing in County Medical Care Facility
HOSC	MI Coordinated Health receiving Hospice in CMCF
COMM	MI Coordinated Health and living in the community
HOSH	MI Coordinated Health receiving Hospice at home

Interface Control Document (EXAMPLE)

A guide to hCAT coding guidelines for:

State Dispositions to hCAT

Version 1

Target Release: 2026

General Overview

The purpose of this ICD is to document and track the necessary information required for consumption by hCAT:

- State Disposition Incoming File

This Interface Control is created during the Planning and Design Phases of the project. Its Intended audience is the project manager, project team, development team, and stakeholders Interested in interfacing with the system. This ICD helps ensure compatibility between system segments and components.

Transmission Details

Payor Data File

Protocol	FTP
File Type	Uncompressed data
File Format	Pipe Delimited {"|"}
Headers	Yes
File Name	REFERRAL_DISPOSITIONS _MMDDYYYY.txt
File Rules	• File name to include state, date and file type/name. • First row is count of records. • Second Row is header row. • All additional rows are one record per line with fields tab delimited. • No empty rows.

	• If more than one file is to be passed, then file name is to be different by putting a different day in the file name.
Frequency	Daily, EOD
Location for pickup	TBD
Interface Availability	Should be available 24/7
At Home Support team contact	TBD

Clinical Data File Layout

NOTE: First row will be record count for file.

Second row is column/field headers

Error Return:

Attribute Name	Type / Format	Description	Null Values Allowed
TRANSACTION_ID	VARCHAR2(16)	Transaction ID for this row, used to reference dispositions and outgoing files.	No
STATUS	VARCHAR2(20)	ACCEPTED, ERROR	No

ERROR_MESSAGE	VARCHAR2(16)	Details on the error message	Yes

Disposition

Attribute Name	Type / Format	Description	Null Values Allowed	DAAA Field
TRANSACTION_ID	VARCHAR2(16)	Transaction ID for this row, used to reference dispositions and outgoing files.	No	
IDCARD_ID	VARCHAR2(20)	Cardholder number used to identify the beneficiary as assigned by Payor.	No	
FIRST_NAME	VARCHAR2(50)	First name of the beneficiary.	No	
LAST_NAME	VARCHAR2(50)	Last name of the beneficiary.	No	
DOB	Date (MMDDYYYY)	Date of Birth of the beneficiary.	Yes	
MCR_ID	VARCHAR2(20)	Medicare ID	No	
MCD_ID	VARCHAR2(20)	Medicaid ID	No	
AAA_IDENTIFIER	CHAR(12)	AAA's Beneficiary ID	No	
AAA_CARE_COORDINATOR_NAME	VARCHAR(64)	Name of the LTSS Care Coordinator	Yes	
AAA_CARE_COORDINATOR_PHONE	VARCHAR(25)	Phone number of the LTSS Care Coordinator	Yes	
AAA_CARE_COORDINATOR_AGENCY	VARCHAR(64)	Name of the agency responsible for LTSS Care Coordination	Yes	

AAA_CONTACT_ATTEMPT_1	DATE	First date that the LTSS attempted contact.	Yes	
AAA_CONTACT_ATTEMPT_2	DATE	Second date that the LTSS attempted contact.	Yes	
AAA_CONTACT_ATTEMPT_1	DATE	Third date that the LTSS attempted contact.	Yes	
AAA_CLINICAL_SUMMARY	VARCHAR(30000)	AAA's clinical summary narrative	Yes	From assessment
AAA_SCREENING_DATE	DATE	Date that the AAA's LTSS Screening was performed	Yes	From eligibility assessment date – all members
AAA_ASSESSMENT_DATE	DATE	Date of the AAA's LTSS Assessment (inter-ria)	Yes	From assessment
AAA_DISPOSITION	CHAR(1)	AAA's disposition for the beneficiary	No	From eligibility assessment date – all members – will need to add in compass
AAA_DISPOSITION_REASON	CHAR(2)	Reason for the AAA's disposition	Yes	Standarized values needed
AAA_ACUITY	CHAR(1)	Acuity of the beneficiary (E = Emergent, N = Normal, U = Urgent)	Yes	Add to eligibility screening assessment
AAA_LTSS_SERVICES_REQUIRED	CHAR(1)	LTSS services are required (Y = Yes, N = No)	Yes	From eligibility screening
AAA_MEDICATION_SUMMARY	VARCHAR(8000)	AAA's summary of beneficiary's medications	Yes	From Inter-RAI assessment

AAA_ASSESSMENT_SCORE	INTEGER	Most recent LTSS Assessment Score	Yes	From inter-RAI
AAA_WAIVER	VARCHAR(100)	LTSS Waiver Name	Yes	
AAA_WAIVER_DATE	DATE	LTSS Waiver Date	Yes	Member status update – will have to match program with start date shown

Post-Interaction Actions and/or Results

Errors and Error Handling

In case of error during Data Feed Transmission CDM will send a failure email to the following:

1. If error occurs during the processing of the file – CGX SRE will be notified.
2. Error details should be included in the email description so that Humana teams can access it directly & start working on it.
3. CGX IT will have to work to correct the issues and push the feed as per process applicable.

Notes and Issues

None

Revision and Approval History

REVISION HISTORY			
Version #	**Version Date**	**Revision Description**	**Version Author**
1	08/08/2025	Proposed file format	Altaf Syed

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

837 – ANSI X12 Version 005010X222A1 Delegated Professional Encounters

Companion Guide Version Number: [10.0] [March 1, 2016]

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.

- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

1.3 Document Purpose

The purpose of the Humana Inc. Companion Guide is to define (for its directly connected trading partners) the required values for submission of 837 ANSI X12 Health Care Claim: Professional Version 005010X222A1 transaction(s) to Humana, Inc. Humana's companion guide(s) supplement the HIPAA Implementation Guides and should be used in conjunction with the published HIPAA Implementation Guides. This document is not intended to convey information that in any way exceeds the requirements or uses of data expressed in the Implementation Guide. This supplement is solely for the purpose of clarification and facilitation if implementing 837 transaction with Humana Inc.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
[005010X222A1	Health Care Claim; Professional (837)]

3 Instruction Tables

3.1 ISA

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
Interchange	ISA	Interchange Control Header		
	ISA05	Interchange ID Qualifier	14	"14" (SENDER'S) DUNS Number plus Suffix
	ISA08	Interchange Receiver ID	0499441430000	Humana DUNS number

3.1 Interchange Control Header

Example

ISA*00* *00* *14*1234567890000 *14*0499441430000
*110111*1001*^*00501*000000905*0*P:~

Note: If submitting directly to Availity then you must use Availity's companion guide

3.2 GS segment

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
Functional Group	GS	Functional Group Header		
	GS02	Application Sender's Code	61105	Humana requires this value to represent Delegated Encounters
	GS03	Application Receiver's Code	0499441430000	Humana DUNS number

3.2 Functional Group Header

Example

GS * HC*61105*0499441430000*20111107*0850*47234227*X*005010X222A1~

3.3 Submitter Information

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments	
1000A	NM1	**Submitter Information**			
	NM109	Humana Submitter ID		This submitter id will contain. a 5 byte alpha numeric value.	Please provide?

3.3 Submitter Information

Humana assigned submitter id should be used in this segment.

Example

NM1*41*2*THE CLEARINGHOUSE*****46*ABC98~

3.4 Subscriber Information

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments	
2010BA	NM1	**Subscriber Information**			
	NM109	Subscriber ID		Humana requires use of member ID	DAAA to create with minimum 9 characters (ie; H123456789)

3.4 Subscriber Information

Example

NM1*IL*1*DOE*JOHN*T**JR*MI*123456789***~

3.5 Claim Information

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments	
2300	CLM	**Claim Information**			
	CLM01	Claim Submitter's Identifier		delegate claim number	DAAA created claim ID

3.5 Claim Information

Humana requires the delegate claim number to be submitted in this segment.

Example

CLM*ABC123456*275***81::1*Y*A*Y*Y*C~

3.6 Check Information

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments	
2300	NTE	**Line Note**		**ONLY APPLICABLE IF AGREED UPON BY IPA**	
	NTE01	Note Reference Code	ADD		
	NTE02	Description: Check Number		Humana requires the check numbers of paid dates if they are provided, to be submitted in this segment. The format below is how it needs to be sent; *CHECK xxxxx CCYYMMDD. See Example.	? Do we do this currently

3.6 Check Information

The check number needs to be formatted as seen below related to the claim payment being reported.

Example

NTE*ADD*CHECK 62025 20120918~

3.7 HCP Line Pricing/Repricing Information

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
2400	HCP	**HCP Line Pricing/Repricing Information**		
	HCP01	Pricing Methodology	10	Humana requires 10 to be used in this field.
	HCP02	Description		Humana requires Allowed amount in this field. See Example.

3.8 Line Pricing/Reporting Information

Example

HCP*10*61.95~ (with decimal)
HCP*10*70~ (without decimal)

3.8 SVD Line Adjudication Information

005010X222A2 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
2430	SVD	**Line Adjudication Information**		
	SVD01	Identification Code		Humana requires the use of 61105 in this field.
	SVD02	Monetary Amount		Humana requires the amount that has been paid for this service line.
	SVD03-1	Product/Service ID Qualifier		Humana requires the procedure code/service code qualifier.
	SVD03-2	Product/Service ID		Humana requires the procedure code/service code that processed in this segment.
	SVD05	Quantity		The quantity paid should be sent in this segment.

3.8 SVD Line Adjudication Information

Humana requires the paid amount at the service line to be reported in the SVD segment.

Example

SVD*61105*104.64*HC:A5500:LT:RT**2~

(CAS*CO*24*amount – due to HIPAA syntax requirements, the CAS segment also needs to be sent when SVD present.)

3.9 Member Out Of Pocket/MOOP

005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
2430	CAS	Line Adjudication		
	CAS01	Claim Adjustment Group Code	PR	Humana requires the use of PR to indicate patient responsibility.
	CAS02	Claim Adjustment Reason Code	1= Deductible 2 =Coinsurance 3 = Copayment	Codes identify reason for adjustment
	CAS03	Monetary Amount		Amount of adjustment

3.10 Member Out Of Pocket/MOOP

Humana requires these values when submitting the MOOP data in the CAS segment.

Example

CAS*PR*1*10.50**2*11.99**3*25~

NOTE: If No Patient Responsibility is reported (PR), Then you Do Not need to send the SVD and CAS segments in **3.8 SVD Line Adjudication Information.**

3.10 BHT Segment

BHT✻0019✻00✻44445✻20040213✻0345✻RP~

BHT01Hierach Struct BHT02 TS purpose code BHT03 Reference Ident BHT04 date BHT05 Time BHT06 Transaction Type code

RP Reporting 397 Use RP when the entire ST-SE envelope contains only capitated encounters. Use RP when the transaction is being sent to an entity (usually not a payer or a normal provider payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes

3.11 Chart Review

Effective for dates of service beginning January 1, 2012, CMS is requiring all health plans to submit HIPAA compliant 837 claims transactions to CMS for Medicare Risk Adjustment. Through at least 2013, health plans are required to continue to submit RAPS data in parallel with the 837 transactions. During this transition time, health plans will continue to be reimbursed under the RAPS submission model.

What's Different?

- Effective with January 1, 2012 dates of service and forward, we are required to submit encounter data within 13 months.
- Previously, the CMS reporting period was approximately 25 months.

Why I Care

- Chart reviews are done to ensure that health plans and our provider partners are fully documenting the disease conditions of the Medicare Advantage members
- Today, Humana is unable to differentiate diagnosis codes from a chart review from those submitted via claims or encounters
- Humana is developing system specifications for our provider partners that will enable us to recognize those encounters that are submitted as a result of a chart reviews and thus enable our provider partners to submit chart review data for the entire CMS reporting period

What I Need to Do

- Beginning July 1, 2013, on Encounters you submit to Humana that are generated from a Chart Review, please populate the following segments :PWK01=09, PWK02=AA, CPT=99499, Charge=.00

Example:

PWK*09*AA~

SV1*HC:99499:::::CHART REVIEW*0*UN*1***1**Y~

- If you have additional questions, please contact your Market Contracting Representative.

4 TI Additional Information

4.1 Business Scenarios

Example

005010X222A1 (837)

4.2 Other Resources

- **ACS X12 TR3 Implementation Guides**

  http://store.x12.org

5TI Change Summary

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