Encounter Data Reporting Guide

For Managed Care Organizations and
Regional Support Networks

Department of Social & Health Services

State of Washington

Version 1.0

MAY 2009

Document Change Control Table

Author of Change: DSHS	Impact To MCOs	Impact To RSNs	Page	Change	Reason	Date
Division of Systems & Monitoring; Division of Healthcare Services; Mental Health Division; Home & Community Services	X	X	All	Merged MCO guide to include RSN and PACE for the new DSHS ProviderOne payment / reporting system	Change to ProviderOne reporting system	5/28/2009
MHD		X		Page 4; Corrected URL for Mental Health Publications	Incorrect URL	6/1/2009

This data reporting guide is subject to updates based on changes in state or federal rules, policies, contracts, or in the processing systems.

Washington State Department of Social & Health Services (DSHS) created this reporting guide for use in combination with the Standard Implementation Guides for X12N 837, NCPDP and the ProviderOne Encounter Companion Guides. This reporting guide is not a replacement for the Implementation Guides, but should be used as an additional source of information. This reporting guide includes data clarifications derived from specific business rules that apply exclusively to encounter processing for Washington State DSHS ProviderOne.

The information in this data reporting guide is not intended to change or alter the meaning or intent of any implementation specifications in the standard Implementation Guides.

TABLE OF CONTENTS

MCO SPECIFIC SECTION (NEW)

RSN SPECIFIC SECTION (NEW)

DEFINITIONS

ATYPICAL PROVIDER: A service provider who does not qualify for an NPI and is not enrolled in ProviderOne, or the Provider NPI is unknown to ProviderOne system.

BILLING PROVIDER: For encounter data reporting only the Billing Provider will always be the ProviderOne ID number of the MCO/RSN.

CNSI: The DSHS contracted systems vendor for ProviderOne.

CORRECTED ENCOUNTER: These are encounter records corrected by the organization after error rejection from the DSHS/HRSA Encounter Edit process. The organization resubmits these corrected records to DSHS to replace the previously rejected encounter record.

ENCOUNTER: DSHS defines an encounter as a single healthcare service, or a period of examination or treatment. DSHS requires MCOs/RSNs to report healthcare services delivered to clients enrolled in managed care, or receiving mental health services as encounter data.

ENCOUNTER DATA TRANSACTION (EDT): Electronic EDT files created by MCO/RSN systems in the X12N 837 format and the NCPDP 1.1 Batch format (pharmaceutical services).

ENCOUNTER TRANSACTION RESULTS REPORT (ETRR): The final edit report from ProviderOne for processed encounters. This is a single electronic document returned to the MCO/RSN and includes a summary and details of all encounters that were processed during the previous week.

ETRR NUMBER: This represents the ProviderOne ETRR Reference number that will be assigned to each unique encounter file produced.

"GAP" FILLING: Default coding to pass Level 1 and Level 2 EDI edits. If the correct required information cannot be obtained, DSHS allows 'filling' the required fields with values consistent to pass the ProviderOne Portal syntax. If the field requires specific information from a list in the IG, use the most appropriate value for the situation. *See* 837 Professional and Institutional Encounter Companion Guide (Mapping Documents) for DSHS required fields.

IMPLEMENTATION GUIDE (IG): Instructions for creating the X12N 837 Health Care Claim/Encounter transaction sets and the NCPDP Batch Standard. The Implementation Guides are available from the Washington Publishing Company at:
www.wpc-edi.com/hipaa/HIPAA_40.asp.

NATIONAL PROVIDER IDENTIFIER (NPI): The unique standardized provider identifier. Issued to each physician, supplier, and other healthcare provider conducting HIPAA standard electronic transactions.

ORIGINAL ENCOUNTERS: The first submittal of Encounter records that have not previously been processed through DSHS/HRSA encounter edit process.

PAY-TO OR SERVICE PROVIDER: For encounter data reporting the Pay-to or Service Provider is the provider who billed the MCO/RSN for services.

ProviderOne: ProviderOne is the primary provider claims/encounter payment processing system for DSHS.

ProviderOne SFTP BATCH FILE DIRECTORY: The official DSHS ProviderOne Web Interface Portal for reporting batch encounter files via the Secure File Transfer Protocol (SFTP) Directory – sftp://ftp.waproviderone.org

REFERRING PROVIDER: Identifies the individual provider who referred the client or prescribed Ancillary services/items such as Lab, Radiology and Durable Medical Equipment (DME) and disposable medical supplies.

RENDERING OR ATTENDING PROVIDER: The Rendering/Attending Provider (performing) identifies the individual provider who provided the healthcare service to the DSHS client/member .

SERVICE BASED ENHANCEMENT (SBE): A payment made in addition to the regular capitation premium amount. An example is the Delivery Case Rate (DCR) payments.

COMMON USAGE SECTION

INTRODUCTION

DSHS publishes this Encounter Data Reporting Guide to assist the contracted Managed Care Organizations (MCOs) and Mental Health Regional Support Networks (RSNs) in the ProviderOne encounter reporting process. This guide is a reference for Washington State contracted MCOs and RSNs. It outlines how to transmit managed care and mental health encounter data to DSHS. This guide has 3 separate sections:

- Common Usage Section: The Common Usage section has guidance and instructions for all types of Encounter Data reporting.
- MCO Specific Section: This section includes specific information, guidance and attachments for only the MCOs for both X12N 837 and NCPDP encounters.
- RSN Specific Section: This section includes specific information, guidance and attachments for only the RSNs.

THIS IS NOT A STAND ALONE GUIDE

Use of the additional documents and publications listed below are required in conjunction with this Reporting Guide.

STANDARD FORMATS - Use this guide in conjunction with:

- 837 HEALTHCARE CLAIM PROFESSIONAL AND INSTITUTIONAL IMPLEMENTATION GUIDES (IG) version 4010A including Addenda. To purchase the IGs contact the Washington Publishing Company at http://www.wpc-edi.com or call 1-800-972-4334
- NCPDP TELECOMMUNICATION STANDARD 5.1 WITH NCPDP BATCH TRANSACTION STANDARD 1.1. Obtain the Standard from the National Council for Prescription Drug Programs at http://www.ncpdp.org/ , call (480) 477-1000, or Fax your request to (480) 767-1042
- DSHS/CNSI 837 and NCPDP Encounter Data Companion Guides at http://hrsa.dshs.wa.gov/dshshipaa/
- DSHS/HRSA Mental Health Division external publications at https://fortress.wa.gov/dshs/hrsamhd/mhdscripts/asp/general/MHC_Entry_Page.asp Login with your account, then navigate to "Headquarters > Publications".
- DSHS/HRSA Provider Publications, such as Billing Instructions and Numbered Memos may be downloaded at http://hrsa.wa.gov/dshs/maa/download/

CODE SETS

DSHS/HRSA follows National Standards and Code Sets found in:

- Current Procedural Terminology (CPT) (AMA) https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp
- Health Care Comprehensive Procedure Coding System (HCPCS) http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/
- Standard Edition International Classification of Diseases (ICD.9.CM) http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/ , or http://icd9cm.chrisendres.com/icd9cm/
- Medi-Span® Master Drug Data Base (MDDB) http://www.medispan.com
- National Drug Code (NDC) (Medi-Span® file) http://www.ncpdp.org/
- National Uniform Billing Committee (NUBC) codes http://www.nubc.org
- Current Dental Terminology (CDT) http://www.ada.org
- Place of Service (POS) code updates: http://www.cms.hhs.gov/PlaceofServiceCodes

OTHER HELPFUL URLS

- DSHS/HRSA Provider Publications and Healthy Options Managed Care Program: http://hrsa.dshs.wa.gov/
- HIPAA 837I and 837P Implementation Guide may be purchased at: www.wpc-edi.com/hipaa/HIPAA_40.asp
- MENTAL HEALTH DIVISION can be found at: http://www.dshs.wa.gov/Mentalhealth/publications.shtml
- ProviderOne Secure File Transfer Protocol (SFTP) Directory: Use this site for both X12N 837 Encounters and NCPDP Pharmacy Encounters: sftp://ftp.waproviderone.org
- Valicert SFT server: This is the current SFT server used by DSHS to transfer confidential files/information. HRSA will let you know when to use this server - https://sft.wa.gov/

PURPOSE

DSHS requires encounter data reporting from contracted MCOs and RSNs. Data reporting must include all healthcare and mental health services delivered to eligible clients, or as defined in the RSN Specific Section. Complete, accurate and timely encounter reporting is the responsibility of each MCO and RSN, and is critical to the success of the managed care healthcare delivery system for DSHS clients.

REPORTING FREQUENCY

All types of Encounters may be reported as often as daily. Otherwise, use the information in the MCO or RSN Specific Sections as your reporting frequency guide.

For X12N 837 encounters:
The ProviderOne system has an automatic 365 day billing limitation. Encounters with dates of service over 365 days will be rejected.

ProviderOne IDENTIFIERS

CLIENT IDENTIFIERS - The Patient Identification Code (PIC) Is Replaced

ProviderOne will generate unique ProviderOne Client IDs for all clients. The new Client ID must be used for reporting encounter data.

The client Date of Birth and Gender must be on every encounter record in the Subscriber/Patient Demographic Information segments.

- MCOs must use this new Client ID when resubmitting corrected encounters that were submitted prior to the ProviderOne implementation date.
- RSN encounters for clients who are not known to ProviderOne will be accepted with a default ProviderOne Client ID.

ProviderOne Will Reject ALL
Encounter Records
Submitted With a Legacy PIC

Refer to the 837and NCPDP Encounter Data Companion Guides for detailed instructions.

PROVIDER IDENTIFIERS

Where applicable, report NPIs as the Provider Identifier in all provider fields.

Exception – For the 837 Billing Provider and the NCPDP Sender ID report the appropriate ProviderOne assigned Identifier (TPA/Submitter ID). *MCOs - See the MCO Specific Section for additional information.*

NPI PROVIDER IDS UNKNOWN TO ProviderOne

- Send the NPI for providers who by definition are required to obtain and use an NPI. *If you have access, use the Federal NPI Registry to search for the Provider's NPI.*

- If the NPI is not known to the ProviderOne system the encounter will be accepted and an error message will post identifying that the provider is not known to the system. ProviderOne will retain the NPI on an error page for further research through the Federal NPI Registry.

- The ProviderOne file validation process distinguishes the difference between an NPI that is invalid and an NPI that is not known to the system through a "Check Digit" process.

- A check digit edit process is run during file validation. If an NPI fails the check digit edit (a Level 2 HIPAA error) the complete file will be rejected, the organization will need to find and correct the problem, and retransmit the file.

For additional reporting instructions of Providers and Atypical Providers see the Encounter Data Companion Guides and the MCO Specific Section.

ProviderOne ENCOUNTER DATA PROCESSING

The following information applies to all encounter types (Medical, Mental Health and Pharmacy) unless otherwise specified.

Ensure that encounters are reported according to DSHS requirements. Only accepted encounters are used for evaluation of rate development, risk adjustment and quality assurance.

ProviderOne processes all encounter files received and checks for HIPAA Level 1, Level 2 and Level 7 errors. This process ensures that the file is readable, has all required loops and segments, will be accepted into the system and ready for encounter processing. The following information describes the HIPAA Level edits:

- Level 1: Integrity editing – verifies the EDI file for valid segments, segment order, element attributes, edits for numeric values in numeric data elements, validates X12N/NCPDP syntax, and compliance with X12N/NCPDP rules.

- Level 2: Requirement editing – verifies for HIPAA implementation-guide-specific syntax requirements, such as repeat counts, used and not used codes, elements and segments, required or intra-segment situational data elements. Edits for non-medical code sets and values via an X12/NCPDP code list or table as laid out in the implementation guide.

- Level 7: State of Washington DSHS Companion Guide Compliance - verifies DSHS specific Companion Guide requirements.

For additional HIPAA Level information refer to the HIPAA/NCPDP Implementation Guides.

Use an integrity testing program
prior to uploading your encounter files to
reduce the number of rejected files
at the ProviderOne SFTP Directory.

FILE SIZE

Batch file transmission size is limited based on the following factors:

- Number of Segments/Records allowed by X12N 837 HIPAA IG standards. HIPAA IG Standards limits the ST-SE envelope to a maximum of 5000 CLM segments; and

- DSHS file size limitations (for all encounter files). The DSHS ProviderOne SFTP Directory limits the batch file size to 100 MB.

The DSHS ProviderOne SFTP Directory is capable of handling large files up to 100 MB as long as each ST/SE segment within the file does not contain more than 5000 claims.

- You may choose to combine several ST/SE segments of 5000 claims each into one large file and upload the file as long as the single file does not exceed 100 MB.

- Finding the HIPAA Level errors in large files can be time consuming - It is much easier to separate the files and send 50+ files with 5000 claims each, rather than to send 5 files with 50,000 claims.

FILE PREPARATION

Separate files by X12N 837P and X12N 837I encounters.

Enter the appropriate identifiers in the header ISA and REF segments:

- The Submitter ID must be reported by the MCO, RSN, or Clearinghouse in the Submitter segments. Your ProviderOne 9-digit Provider ID is your Submitter ID.

- Do not use an NPI in the Billing Provider segments.

For more specific information, please refer to the Encounter Companion Guides and the MCO Specific Section.

FILE NAMING FOR X12N 837

Name your files correctly by following the file naming standard below. Use no more than 50 characters:

HIPAA.<TPID>.<datetimestamp>.<originalfilename>.<dat>

- <TPID> is the Trading Partner ID (same as the 9-digit ProviderOne Provider ID).
- <datetimestamp> is the Date and Timestamp
- <originalfilename> is the original file name derived by the trading partner.

Example of file name: HIPAA.101721502.122620072100.myfile1.dat
(This name example is 40 characters)

RSNs - please refer to the naming convention information located within the RSN Specific Section of this document.

TRANSMITTING FILES

There is a single SFTP directory for uploading all encounter types.

Use this URL: sftp://ftp.waproviderone.org to upload X12N 837, Mental Health and NCPDP Batch Encounter files to the SFTP Directory - HIPAA Inbound folder.

Batch files must be uploaded to the ProviderOne SFTP Directory. You will find duplicative sets (2) of folders in your Trading Partner Directory - 1 set used for Production and 1 set used for testing.

Refer to the Companion Guides for the SFTP Directory Naming Convention of the:

- *HIPAA Inbound;*
- *HIPAA Outbound;*
- *HIPAA Acknowledgment; and*
- *HIPAA Error folders.*

FILE ACKNOWLEDGEMENTS FOR X12N 837

Each X12N 837 file successfully received by the ProviderOne system generates all of the following acknowledgments:

- TA1 Envelope Acknowledgment. All submitted files receive a TA1. If an error occurs in the envelope, the file is not processed further. The submitter must correct the error and resubmit the file for further processing.

- 997 Functional Acknowledgement. All submitted files having a positive TA1 receive either a positive or negative 997.

  - Positive 997: A positive 997 and Custom Report are generated for each file that passes the header and trailer check and the HIPAA Level 1, 2 and 7 editing.

  - Negative 997: A negative 997 and Custom Report is generated when HIPAA Level 1, 2 and 7 errors occur in the file.

- Custom Report - All submitted files having a positive TA1 and 997 will receive a Custom Report.

Refer to the
"Types of File Acknowledgements" table
For examples of when each
File Acknowledgment will be generated

Types of File Acknowledgments

Submitter Initial Action	System Action	Submitter Requirement	Submitter Action - 2
Encounter file submitted	Submitter receives: ▪ Negative TA1 Identifies HIPAA level 1, 2, or 7 errors in the envelope (Header and/or Trailer)	Submitter verifies and corrects envelope level errors	File is resubmitted
Encounter file submitted	Submitter receives: ▪ Positive TA1 ▪ Negative 997 ▪ Negative Custom Report Identifies HIPAA level 1, 2, or 7 errors in the file detail	Submitter verifies and corrects detail level errors	File is resubmitted
Encounter file submitted	Submitter receives: ▪ Positive TA1 ▪ Positive 997 ▪ Positive Custom Report Identifies no HIPAA level 1, 2, or 7 at envelope or detail levels	File moves forward for encounter record processing (edits)	ETRR is generated

The Submitter retrieves their ETRR from ProviderOne HIPAA Outbound directory and reviews the report for DSHS edit errors.

For further information, see the ETRR section.

Retrieve and review your TA1, 997 Acknowledgement and Custom Reports from your 'HIPAA Ack' folder in the SFTP Directory. These items should be ready for you within 24 hours after uploading your file.

If your file was not HIPAA compliant, or is not recognized by ProviderOne, it will be moved to the HIPAA Error folder in the SFTP Directory.

If appropriate, correct the errors for Rejected and Partially Rejected files;

- Files that are partially rejected should be retransmitted starting with the first corrected ST/SE segment error forward to end of file.
- Do not resend the accepted records of a partially accepted file. Resending accepted records will cause duplicate errors and will cause a higher error rate.

For additional help refer to the X12N 837 Encounter Data Companion Guide.
Please see the 837 HIPAA IGs for additional information about the response coding.

It is important to:

Review each 997 or Custom Report - Always verify the number of accepted file uploads listed in your letter of certification to the number of files returned on the 997 Functional Acknowledgement and Custom Report. *See sample Certification Letter.*

Correct all errors in files that are Rejected or Partially Rejected for Level 1, 2 or 7.

Retransmit files rejected or partially accepted at the ProviderOne SFTP Server following the established transmittal procedures listed above.

Review the subsequent 997 and Custom Report with your resubmitted data file to find if it was accepted.

Retrieve your ETRR (Encounter Transaction Results Report) the ProviderOne SFTP Directory, HIPAA Outbound Folder.

SAMPLE - CUSTOM REPORT ACKNOWLEDGMENT

ProviderOne For Assistance Call - 1-800-562-3022

File name:

HIPAA.105XXXX01.20090428092706.HIPAA.105XXXX01.033120090915.SBE13_IET.dat

Error Report *Powered by Edifecs*

Executed Tuesday April 28, 20094:31:47 PM (GMT)

This report shows the results of a submitted data file validated against a guideline. If there are errors, you must fix the application that created the data file and then generate and submit a new data file.

Report Summary	Error Severity Summary		File Information	
Failed **1 Error(s)**	Rejecting	Normal: 2	Interchange Received: Interchange Accepted:	1 0

1 Interchange

Interchange Status: Rejected

FunctionalGroup Received: 1
FunctionalGroup Accepted: 0

Sender ID: 105XXXX01
Receiver ID: 77045
Control Number: 000000021
Date: 090331

Sender Qualifier: ZZ
Receiver Qualifier: ZZ
Version: 00401
Time: 1439

1.1 FunctionalGroup

FunctionalGroup Status: Rejected

TransactionSets Received: 1
TransactionSets Accepted: 0

SenderID 105XXXX01
Control Number 207143919
Date: 20090331

Receiver ID: 77045
Version: 004010X096A1
Time: 1439

1.1.1 Transaction

Transaction Status: Rejected *Control Number 207143919* *Transaction ID: 837*

#	ErrorID	Error	Error Data	SNIP Type	Severity	Guideline Properties	
1	0x8220001	Qualifier' is incorrect; Expected Value is either "EI" or "SY". Business Message: An error was reported from a JavaScript rule.	REF* **sy** *327665314	7	Normal	ID: IID: Name: Standard Option: User Option: Min Length: Max Length: Type:	128 7776 Reference Identification Qualifer Mandatory Must Use 2 3 Identifier

VALIDATION PROCESSES

THE ENCOUNTER TRANSACTION RESULTS REPORT (ETRR)

After your file is accepted it is split into encounter records and moved further into the ProviderOne process. DSHS validates each Encounter record using DSHS defined edits. The ETRR is the final outcome report of the encounter edits processing.

Check your record counts on the ETRR summary to make sure everything you submit is processed. After the encounter records are validated, an ETRR is available as often as weekly in your Trading Partner HIPAA Outbound folder of the SFTP Directory.
The ProviderOne ETRR has 2 parts within a single text file:

Part 1 - Within the weekly processing of encounters the Encounter Summary has one section for the X12N 837 errors and a second section for the NCPDP errors. The ETRR summary lists the following information:

- Edit Code Number;
- Description of the error code;
- Total number of errors for that Edit code; and
- Total number of encounter records processed.

Part 2 – This part of the ETRR may be used to electronically merge with your electronic encounter records. It will allow you to add the DSHS TCNs that match your unique internal Claim Number (Patient Account Number) and to find which records were rejected during the encounter record validation.

- The submitter specific ETRR identifies all encounters processed by DSHS.
- The ETRR includes the organization's Patient Account Number (the organization's unique internal Claim Number), the ProviderOne 18-character Transaction Control Number (TCN), (Encounter TCNs begin with "33" for reference.) and an ETRR Number and the error flags in sequence order.
- The rejected encounter records are listed in the ETRR with an Error Flag (e.g. '000Y'). The TCN will be listed for Claim level rejected errors. The TCN, with a suffix that includes the Service Line number, will be listed under the Claim Level TCN. Errors are to be corrected and retransmitted for "replacement" processing by the MCO in the next transmittal.
- All Encounter Records will show either accepted or rejected. DSHS recommends review of the ETRR to determine if case corrections and/or additional provider/subcontractor education is required.

ENCOUNTER TRANSACTION RESULTS REPORT (ETRR) LAYOUT

The following information is the Record Layout for the downloadable electronic layout/structure of the ETRR for use with your copy of the files/data records.

1. Copybook (COBOL) for the layout of the ETRR details

Revised Copybook for ProviderOne ETRR format

01		ETRR-TRANSACTION-RECORD.	
05		ETRR-SUMMARY-REPORT-LINE	PIC X(1086).
10		ETRR-REPORT LINE	PIC X(132).
10		FILLER	PIC X(954).
05		ETRR-TRANSACTION-DETAIL-LINE REDFINES ETRR-SUMMARY-REPORT-LINE	PIC X(1086).
10		PATIENT-ACCOUNT-NUMBER	PIC X (38).
10		PATIENT-MEDICAL-RECORD-NUMBER	PIC X (30).
10		TRANSACTION-CONTROL-NUMBER.	
	15	INPUT-MEDIUM-INDICATOR	PIC 9(1).
	15	TCN-CATEGORY	PIC 9(1).
	15	BATCH-DATE	PIC 9(5).
	15	ADJUSTMENT-INDICATOR	PIC 9(1).
	15	SEQUENCE-NUMBER	PIC 9(7).
	15	LINE-NUMBER	PIC 9(3).
10		X12N 837-ERROR-FLAGS-OCCURS 150 TIMES.	
	15	FILLER	PIC 9(3).
	15	ERROR FLAG	PIC X(1).
10		NCPDP-ERROR-FLAGS-OCCURS 100 TIMES.	
	15	FILLER	PIC 9(3).
	15	ERROR FLAG	PIC X(1).

2. Encounter Errors are recorded positionally by error number as illustrated in Error! Reference source not found. Encounter Edit Error Occurrence values will be placed as follows:
   - Positions 1-40 X12N 837 Encounter Errors
   - Positions 41 through 150 Reserved for future use in X12N 837 Encounters
   - Positions 151-160 NCPDP Encounter Errors
   - Positions 161 through 250 Reserved for NCPDP Encounter Errors

3. At the beginning of the ETRR the system will produce a summary report with two sections. The first section will show the total number of X12N 837 encounters and the total number of errors by position for errors in positions 1 to 150. The second section will show the total number of NCPDP encounters and the total number of errors by position for errors in positions 151 to 250.

EDIT/ERROR CODE LIST for X12N 837 and NCPDP

X12N 837						
Sequence Number	**Error Code**	**Edit Description**	**MCO Y/N**	**RSN Y/N**	**Managed Care Disposition**	**Mental Health Disposition**
1	00005	Missing From Date of Service	Y	Y	If missing - file rejected, HIPAA Level 1, 2, or 7 If invalid – Encounter Rejected	If missing - file rejected, HIPAA Level 1, 2, or 7 If invalid - Encounter Rejected
2	00010	DOS Greater than Batch Date-Claim Dates of Service	Y	Y	Encounter Rejected	Encounter Rejected
3	00045	Missing or Invalid Date of Admission	Y	Y	Encounter Rejected	Encounter Rejected
4	00070	Invalid Patient Status	Y	Y	Encounter Rejected	Encounter Rejected
5	00135	Missing Units of Service or Days	Y	Y	If missing - file rejected, HIPAA Level 1, 2, or 7 If invalid – Encounter Rejected	If missing - file rejected, HIPAA Level 1, 2, or 7 If invalid - Encounter Rejected
6	00190	Claim Past Timely Filing Limitation	Y	Y	Encounter Rejected	Encounter Rejected
7	00265	No Match Found in History for TCN	Y	Y	Encounter Rejected	Encounter Rejected
8	00455	Invalid Place of Service	Y	Y	Encounter Rejected	Encounter Rejected
9	00550	Birth Weight Missing or Invalid	Y	N	Encounter Rejected Previously – Info flag only	N/A
10	00755	Claim was Already Credited	Y	Y	Encounter Rejected	Encounter Rejected
11	00760	Adjustment Already in Process	Y	Y	Encounter Rejected	Encounter Rejected
12	00825	Invalid Discharge Date	Y	Y	Encounter Rejected	Encounter Rejected
13	00835	Unable to Determine Claim Type	Y	N	Encounter Rejected	N/A
14	01005	Provider Number Missing	Y	N	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid - Encounter Rejected	N/A
15	01010	Performing Provider Number Not Found	Y	N	Encounter Rejected	N/A
16	01015	No Provider Master Record on File	Y	Y	Encounter Rejected	Encounter Rejected

X12N 837						
Sequence Number	**Error Code**	**Edit Description**	**MCO Y/N**	**RSN Y/N**	**Managed Care Disposition**	**Mental Health Disposition**
17	01280	Attending Provider Missing or Invalid	**Y**	**Y**	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid – Encounter Rejected	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid - Encounter Rejected
18	02110	Recipient not on Eligibility File	**Y**	N	Encounter Rejected	N/A
19	02125	Recipient Date of Birth Mismatch	**Y**	N	Encounter Rejected	N/A
20	02145	HMO Provider Error	**Y**	N	Encounter Rejected	N/A
21	02225	Institutional Claim and Client not Eligible for all dates of service	**Y**	N	Encounter Rejected; MCO correction is not required.	N/A
22	02230	Detail Service Dates not Eligible	**Y**	N	Encounter Rejected Previously – Info Flag only	N/A
23	02255	Recipient not Eligible for Date of Service	**Y**	N	Encounter Accepted Previously – Info Flag only	N/A
24	03000	Missing Procedure Code	**Y**	**Y**	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid – Encounter Rejected	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid - Encounter Rejected
25	03010	Invalid Primary Procedure	**Y**	N	Encounter Rejected	N/A
26	03015	Invalid 2nd Procedure	**Y**	N	Encounter Rejected	N/A
27	03055	Primary Diagnosis not Found on the Reference File	**Y**	**Y**	Encounter Rejected	Encounter Rejected
28	03065	Invalid Recipient Age to Diagnosis	**Y**	N	Encounter Rejected - unless BOMID is noted on encounter Previously – Info Flag only	N/A
29	03100	Invalid Recipient Sex to Diagnosis	**Y**	N	Encounter Rejected - unless BOMID is noted on encounter Previously – Info Flag only	N/A
30	03130	Procedure Code not on Reference File	**Y**	**Y**	Encounter Rejected	Encounter Rejected

X12N 837						
Sequence Number	**Error Code**	**Edit Description**	**MCO Y/N**	**RSN Y/N**	**Managed Care Disposition**	**Mental Health Disposition**
31	03145	Invalid Recipient Age for Procedure	**Y**	N	Encounter Rejected - unless BOMID is noted on encounter Previously – Info Flag only	N/A
32	03150	Invalid Recipient Sex for Procedure	**Y**	N	Encounter Rejected - unless BOMID is noted on encounter Previously – Info Flag only	N/A
33	03175	Invalid Place of Service for Procedure	**Y**	N	Encounter Rejected	N/A
34	03230	Invalid Procedure Code Modifier	**Y**	N	Encounter Rejected	N/A
35	03340	Secondary Diagnosis not Found on the Reference File	**Y**	**Y**	Encounter Rejected	Encounter Rejected
36	03555	Revenue Code Billed Not on Reference Table	**Y**	**Y**	Encounter Rejected	Encounter Rejected
37	03935	Revenue Code Requires HCPC	**Y**	N	Encounter Rejected	N/A
38	02185	Invalid RSN Association	N	**Y**	N/A	Encounter Rejected
39	02265	Invalid Procedure Code for Community Mental Health Center	N	**Y**	N/A	Encounter Rejected
40	98328	Duplicate HIPAA Billing (Record)	**Y**	**Y**	Encounter Rejected	Encounter Rejected
41-150		Reserved for Future X12N837 Edits	N/A	N/A	N/A	N/A

NCPDP						
Sequence Number	**Error Code**	**Edit Description**	**MCO Y/N**	**RSN Y/N**	**Managed Care Disposition**	**Mental Health Disposition**
151	50	Non-Matched Pharmacy NPI	Y	N/A	Encounter Rejected	N/A
152	52	Non-Matched Cardholder ID	Y	N/A	Encounter Rejected	N/A
153	CB	Missing/Invalid Patient's Last Name	Y	N/A	Encounter Rejected	N/A
154	09	Missing/Invalid Patient's Birth Date	Y	N/A	Encounter Rejected	N/A
155	10	Missing/Invalid Patient's Gender Code	Y	N/A	Encounter Rejected	N/A
156	83	Duplicate paid/captured claim	Y	N/A	Encounter Rejected	N/A
157	21	NDC Not on File	Y	N/A	Encounter Rejected	N/A
158	TE	Compound NDC Not on File	Y	N/A	Encounter Rejected	N/A
159	67	Coverage effective xx/xx/xx - Fill prior to enrollment	Y	N/A	Encounter Rejected	N/A
160	68	Coverage effective xx/xx/xx - Fill after enrollment	Y	N/A	Encounter Rejected	N/A
161-250		Reserved for Future NCPDP Edits	N/A	N/A	N/A	N/A

ORIGINAL X12N 837 ENCOUNTERS

Original Medical Encounter records are X12N 837 encounters not previously processed through DSHS encounter edits. The file may include encounters reported for the first time, or retransmitted after being rejected during the HIPAA Level 1, 2, or 7 edit process.

CORRECTED X12N 837 ENCOUNTERS

Corrected Medical Encounter records include X12N 837 encounters previously rejected by the ProviderOne Encounter Edit/Audit process. If resubmitted, these encounters must include the Original/previous TCN. If rejected the specific Edit Code(s) for each TCN is listed on the ETRR. A description of the edit code is listed in the Encounter Summary part of the ETRR. *See ETRR Layout*

Except for encounter records rejected as "duplicate", DSHS will review all rejected encounter data records and verify when corrections and/or resubmissions are complete. If you have rejected encounters that do not require corrections send an email to EncounterData@dshs.wa.gov to tell us how many errors will not be resubmitted and why.

DUPLICATE ENCOUNTER RECORDS

For encounter records a duplicate is defined as "all fields alike except for the DSHS TCNs and the Claim Submitter's Identifier, or Transaction Code, e.g. - "Patient Account Number".

Duplicate encounter records are rejected as errors by DSHS.

After an encounter file passes the SFTP Server validation, each record is validated in ProviderOne against historical data for duplicate encounter records. If a duplicate occurs the encounter record is rejected. X12N 837 must have an "Original TCN" reported in the correct data element.

To prevent a high error rate due to duplicate records, do not retransmit clean encounter records that were previously accepted through ProviderOne processing systems. DSHS recommends that MCOs/RSNs check their batch files for duplicate historical records prior to transmitting.

For additional information on reporting corrected/adjusted encounters see the:

- *837 Encounter Data Companion Guide; and*
- *Retail Pharmacy information in the MCO Specific Section.*

CERTIFICATION OF ENCOUNTER DATA

To comply with 42 CFR 438.606 MCOs/RSNs must certify the accuracy and completeness of encounter data or other required data submission concurrently with each medical and pharmacy file upload. The Chief Executive Officer (CEO), Chief Financial Officer (CFO), or MCO/RSN authorized staff must certify the data.

Each time you upload a file, send an email notification to: ENCOUNTERDATA@dshs.wa.gov. This email will be the concurrent certification to the accuracy and completeness of the encounter data file. Include the number of batch files and total encounter records submitted in the email.

On the last business day of the month, send a signed original Certification letter and include a list of all files submitted during the month to the address below:

INSTRUCTIONS FOR SENDING CERTIFICATION OF ENCOUNTER DATA

Send the signed original letter of certification the address below:

1.	For MCOs and RSNs: Encounter Data Coordinator For the Office of Quality & Care Management Health & Recovery Services Administration P.O. Box 45564 Olympia, WA 98504-5564
2.	Include the following information in each email and signed Certification Letter (*See Sample Letter):* - Date the batch files are uploaded to DSHS; - Batch name of each file transmitted; and - Number of encounters in each batch file. - MCOs: Certify the transmitted files as MCO Proprietary Data

SAMPLE

CERTIFICATION LETTER

Encounter Data Coordinator
For [Name DSHS Office]
Health & Recovery Services Administration
PO Box 45564
Olympia, WA 98504-5564

RE: Certification of the Encounter Data Files

For: [TRANSMITTAL DATE]

To the best of my knowledge I certify that the encounter data, or other required data, reported by [MCO/RSN Name] to the State of Washington is complete, accurate and truthful in accordance with 42 CFR 438.606 and the current Managed Care/RSN Contract in effect.

MCOs ADD: I also certify that any claims cost information within the submitted encounter data is proprietary in nature and assert that it is protected from public disclosure under Revised Code of Washington 42.56.270(11).

The following electronic data files for [MCO/RSN Name] were uploaded to DSHS on the following dates during the month of [Month/Year].

Sincerely,

Signature
Authorized Signature (CEO, CFO or Authorized Designee)
Title

MCO SPECIFIC SECTION (NEW)

REPORTING

Ensure the billing claim comes to you in the appropriate claim format so you can correctly report the encounter. Use the following lists as a guide for claim types:

CLAIM TYPES

X12N 837P – Includes any professional or medical healthcare service that could be billed on the standard "1500 Health Insurance Claim" form. Professional services usually include:

- Ambulatory surgery centers,
- Anesthesia services,
- Durable medical equipment (DME) and medical supplies,
- Laboratory and radiology interpretation,
- Physician visits,
- Physician-based surgical services,
- Therapy (i.e., Speech, P.T., O.T.), and
- Transportation services.

X12N 837I – Includes any institutional services and facility charges that would be billed on the standard "UB-04 Claim" form. These services usually include:

- Inpatient hospital stays,
- Outpatient hospital services,
- Evaluation & Treatment Centers,
- Home Health and Hospice services,
- Kidney Centers,
- Skilled Nursing Facility stays.

NCPDP Batch 1.1 Format – Includes all retail pharmacy services for prescription medicines and covered over-the-counter medicines.

For specific information refer to the MCO - Pharmacy Encounter Section.

The information on each reported encounter record must include all data billed/transmitted for payment from your service provider or sub-contractor.

Do not alter paid claim data when reporting encounters to DSHS; e.g. data must not be stripped, or split from the service provider's original claim.

All accepted encounters are used for evaluation of rate development, risk adjustment and quality assurance. (The Exception is the 365 Day rule, see Common Usage Section.)

DSHS uses MCO Encounter data to:

- Develop and establish capitation rates;
- Evaluate health care quality;
- Evaluate contractor performance; and
- Use data for health care service utilization

REPORTING FREQUENCY

Report encounters monthly, no later than 60 days from the end of the month in which the MCO paid the claim; i.e. MCO processed claim during January, data is due to DSHS no later than April 1st.

To ensure receipt of data HRSA verifies monthly through file upload dates and system review and analysis.

PROVIDER IDENTIFIERS

Report the NPI and Taxonomy codes for only the Pay-To Provider as instructed in the Encounter Data Companion Guides.

For the X12N 837 Billing Provider and the NCPDP Sender ID segments, report each line of business separately using the 9-digit ProviderOne Provider ID.

DSHS no longer provides the weekly Provider List, formerly placed on the Valicert SFTP site.

PACE and WMIP - Reporting Atypical Non-NPI Providers

Provider ID fields are required anytime you report a provider.

Report ALL of the Demographic information required by the HIPAA IG and the 837 Encounter Data Companion Guide.

Find an atypical (Non-NPI) provider who is not enrolled in ProviderOne:

- Access ProviderOne Provider ID information and search the DSHS Provider Number Reference Website at https://hrsa.dshs.wa.gov/pnrmaa/ .

DSHS is working with the systems contractor to develop an Atypical Provider Identifier (API) that will correctly pass through the DSHS system processes.

Instructions for this section will be updated when the API is available.

NPI Provider IDs Unknown To ProviderOne

When all NPIs within a file pass the check digit edit, the file will be accepted even if the NPI is not known to ProviderOne. The NPI information will be retained.

DO NOT USE Medicaid 7-digit provider IDs. **ProviderOne does not recognize them**.

Using Legacy Medicaid Provider Identifiers will result in rejected encounters on the ETRR.

The non-participating provider ID '8999070' is no longer valid. If used, your encounter will be rejected. Use the ProviderOne default ID only as appropriate.

USING THE 'NTE' (CLAIM NOTE) SEGMENTS

The 'NTE' segment is no longer valid for reporting MCO Service Line Denials.

NEW – MCOs now use the NTE to report Newborn Baby services using Mom's ProviderOne Client ID.

For specific information refer to 'Reporting Denied Service Lines' in this MCO Specific Section and the 837 Encounter Companion Guide.

MEDICARE OR COB DATA

When MCOs receive payment from any other payer, including Medicare, the Amount Paid must be reported in the COB segment as required by the 837 and NCPDP Encounter Companion Guides. This includes MCOs serving Dual Eligible Medicare/Medicaid clients, or clients with other primary insurance coverage.

DENIED SERVICE LINES

Reporting denied service lines allows you to report encounters without changing the claim. It will also balance the 'Total Charges' reported at the claim level with the total charges reported for each service line.

- Use the specified codes listed in the 837 Encounter Companion Guide and as directed in the sub-section below.
- Use HCP 2300 to report the total Amount Paid for the entire claim. Please refer to the 'Amount Paid' sub-section.
- Please report mixed (Denied line, Paid line, and Capitated line) outcomes in HCP 2400. Identify each line separately in HCP 2400.
- Service Lines denied by the MCO will bypass the edits during the encounter processes.

DO NOT REPORT an encounter if the entire claim was denied.

Denied Service Lines and Missing Codes

Denied service lines that are missing codes will cause your batch file to fail the ProviderOne SFTP server process. Professional and Institutional Service Line code fields are required and if missing, are considered to be HIPAA Level 1 or Level 2 errors.

Do not split or alter a paid claim that is missing Procedure or Diagnosis codes. Exception is correcting a Provider's NPI

To avoid having to split a paid claim, make sure the 'Total Claim Charges' and the summed total of all 'Service Line' billed charges balance.

To prevent rejected batch files, DSHS created a default Procedure code for the X12N 837 Professional and Outpatient Institutional encounters. Use this code on partially denied, paid encounters when a Service Line is missing the Procedure code - '12345'.

If you have a Missing Diagnosis Code Pointer, make sure the HCP line shows "denied" and point to any other diagnosis listed at claim level.

THE AMOUNT PAID

DSHS requires the MCOs to report the Amount Paid for each Medical and Pharmacy encounter.
For NCPDP specific information, please refer to the Pharmacy Encounter Section.

"Amount Paid" data is considered MCO proprietary information and protected from public disclosure under RCW 42.56.270 (11).

The HCP segments were added to the 837 Encounter Companion Guides to provide an area to report the 'Amount Paid' as well as to report the Denied Service Lines of a Paid claim.

If any part of a claim was either Paid (by MCO or Capitated Payment), or Denied we expect to see use of the HCP segments at the:

- Claim (2300) level for the 'Total Amount Paid'; and
- Service Line (2400) level payment amounts.

Do not report claims that are entirely denied.

Scenarios/Examples for how to use the HCP segments:

SCENARIO	2300 HCP	2400 HCP (Examples)
Claim Partially Denied by MCO	HCP 01 = '02' and HCP 02 = Total $ 'Amount Paid' to Provider	Each Line Item will have own value: 1. HCP 01 = '02' HCP 02 = 1530 2. HCP 01 = '00' HCP 02 = 0
Entire Claim Paid by MCO	HCP 01 = '02' and HCP 02 = Total $ 'Amount Paid' to Provider For DRG Hospital encounters only: it is okay to report at 2300 HCP and not report 'Amount Paid' at Line level.	Each Line Item will have own value: 1. HCP 01 = '02' HCP 02 = 1530 2. HCP 01 = '00' HCP 02 = 1275
Entire Claim Paid by Capitation	HCP 01 = 07 HCP 02 = 0	Line itemization not required if unable to report 'Amount Paid' due to Capitation.
Claim Partially Paid by Capitation and Partially Paid by MCO directly to Provider	HCP 01 = '02' and HCP 02 = Total $ 'Amount Paid' to Provider	Each Line Item will have own values: 1. HCP 01 = '07' HCP 02 = 0 2. HCP 01 = '02' HCP 02 = 1530

For formatting specifics, also refer to the
837 Encounter Data Companion Guide and the HIPAA IG

CORRECTING AND RESUBMITTING ENCOUNTER RECORDS

Use the Original or Former TCN - When correcting an error, a post payment revision, or adjusting a provider's claim after it was reported to DSHS, always report the "Original/Former TCN" in the correct X12N 837 field. *For specific information see the X12N 837 Encounter Data Companion Guide.*

ProviderOne uses the HIPAA IG format for correcting claims or encounter records. You must first submit a "void" record with the original/former TCN. Then submit the record with the corrected/replaced information.

ProviderOne uses a reference table to identify converted Legacy ICNs.

- When you void an original 17-digit Legacy ICN you must add '9' for the prefix and '000' for the suffix to the original Legacy 17-digit ICN; it should look like this: '990835055992000001000'.

- Report only the newest, former record as the void, and if applicable, the newly adjusted/corrected record as the replacement.

Do not re-report the record if there is a time-span of 3 years, or more.

SERVICE BASED ENHANCEMENTS (SBE)

DSHS pays MCOs and FQHCs/RHCs a delivery case rate (DCR) whenever the MCO and FQHC/RHC incur expenses related to the delivery of a newborn. ProviderOne will generate these Service Based Enhancement payments after receiving and processing the encounter data (with 'Amount Paid' information) for the service.

The MCO responsible for the payment of the delivery service, based on the encounter reported, will receive the payment. The ProviderOne system will "flag" encounters with any of the codes listed in the "Codes That Will Trigger an SBE" table. The ProviderOne system will then verify the following information:

1. The client's eligibility and enrollment.

2. The client's enrollment to an FQHC/RHC (one DCR paid to the MCO and one paid to the FQHC/RHC clinic.

3. Last time DSHS paid a DCR for the client (only one DCR per pregnancy within a nin-month period).

4. For inpatient hospital encounters an admission date must be present to generate a DCR payment.

5. For outpatient hospital delivery services the encounter must include the statement 'From-To' date to generate the DCR.

6. DSHS must receive the original encounter within 365 days of the date of delivery.

The FQHC/RHC NPI and Taxonomy codes must be present on the encounter claim so that ProviderOne can generate a DCR to the FQH/RHC. Use the following taxonomy codes as applicable: FQHC = 261QF0400X; or RHC = 261QR1300X.

MCOs will not receive a DCR Payment for the following reasons:

- An abortion or miscarriage;
- Multiple births do not justify multiple DCR payments;
- The subscriber/patient is male;
- The encounter record is rejected by an edit.

HRSA Will Review:

- Records having females under the age of 12 years and over the age of 60 years.
- An MCO that submits the encounter which generates a DCR, but does not match the listed MCO of the client for that date of service (delivery date)

HRSA will recoup DCR payments when:

- An MCO voids the encounter which generated the DCR and there are no other services that qualify.
- The MCO voids the encounter which generated the DCR and there are other encounters which qualify, the DCR will be recouped and regenerated from one of the other qualifying encounters.
- The MCO Voids and Replaces an encounter which previously generated a DCR. The DCR will be recouped and regenerated from the replacement encounter.
- When a DCR was generated to FQHC/RHC 'Clinic A' and the client's association for the date of delivery is changed to FQHC/RHC 'Clinic B', the original DCR will be recouped from FQHC/RHC 'Clinic A' and paid to FQHC/RHC 'Clinic B'.
- If the female client is Fee-For-Service at the time of admit, no DCR is paid. In this case, HRSA is considered fiscally responsible for all charges through discharge and the MCO is not eligible for the DCR.

CODES THAT WILL TRIGGER A SBE

Hospital –X12N 837 Institutional

MATERNITY CATEGORY	DRG CODES	PROCEDURE CODES	REVENUE CODES	DIAGNOSIS CODES	CLAIM TYPE
Code set to trigger SBE	370 - Cesarean section w CC; 371- Cesarean section w/o CC; 372 - Vaginal delivery w/complicating diagnoses; 373 - Vaginal delivery w/o complicating diagnoses; 374 - Vaginal delivery w sterilization &/or D&C; 375 - Vaginal delivery w/O.R. procedure except sterilization	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	Will not generate enhancements using Revenue Codes because the applicable claim will have one of the identified DRG and procedure codes.	Normal delivery, and other indications for care in pregnancy, labor and delivery 650 - 659	Claim Type = UB - 04

Physician – X12N 837 Professional

MATERNITY CATEGORY	DRG CODES	PROCEDURE CODES	REVENUE CODES	DIAGNOSIS CODES	CLAIM TYPE
Code set to trigger SBE	N/A	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	N/A	N/A	Claim Type = 1500 Health Insurance Claim Form

RETAIL PHARMACY DATA PROCESSING

There are new and subtle differences between the old Legacy system and the new ProviderOne system for NCPDP Pharmacy Encounters. *Refer to the Pharmacy Encounter Companion Guide and the DSHS Prescription Drug Program billing instructions.*

DSHS requires the following:

- The standard NCPDP Batch 1.1 file format for transmitting all Retail Pharmacy encounter records that were paid by the MCOs.

- Medi-Span® NDC File - HRSA's drug file is maintained by Medi-Span® (a drug file contractor). Manufacturers must report their products to Medi-Span® for them to be included in HRSA's drug file for potential coverage and reimbursement. If an NDC is not listed in Medi-Span®, DSHS will reject the encounter. Verify with your Pharmacy Benefit Manager to ensure that they can submit their data using the Medi-Span® NDCs.

DSHS has found that most pharmacies in the State of Washington do not have a problem using the Medi-Span® file. Other NDC contractor files are okay to use, but they are updated at different times; this may cause your encounter to reject.

- Amount Paid - With the implementation of ProviderOne the 'AMOUNT PAID' field is a requirement for pharmacy encounters. The Amount Paid is the amount the MCO paid to the servicing Pharmacy.

  For specific placement refer to the Pharmacy Encounter Companion Guide.

- Required layout - Your fields must be in the specified order as listed in the Pharmacy Encounter Companion Guide. Follow this Companion Guide exactly. Your file will be rejected if it is formatted incorrectly.

- Unzipped batch files – The ProviderOne SFTP Server will not accept zipped or compressed batch files.

Do Not 'Gap' Fill Situational Fields in your NCPDP files unless indicated in the Pharmacy Encounter Companion Guide.

Except as indicated in the Pharmacy Encounter Companion Guide, do not include Situational Fields when there is no data to report in the field. That data will cause your file to reject at the SFTP Server.

If the field is situational and you have nothing to report - leave it out.

The NCPDP files received at the SFTP Directory are validated for compliance using Edifecs and passed to the DSHS Point-of-Sale (POS) system as encounter records only if the file is compliant for HIPAA Level 1, 2 & 7 edits.

Refer to the Pharmacy Encounter Companion Guide for specific layout information.

NAMING STANDARD (new for pharmacy)

Name your files correctly by following the file naming standard below. Use no more than 50 characters:

<NCPDP.SubmitterID>.<DateTimeStamp>.<OriginalFileName>.dat

Example: NCPDP.123456700.020520091101.NCPDPFile.dat
(This name example has 42 characters total)

PHARMACY ENCOUNTER PROCESSING

To submit your NCPDP 1.1 Batch encounter data files:

Create encounter pharmacy files in the NCPDP 1.1 Batch file format. Each encounter record will be in NCPDP 5.1 format. *(Refer to NCPDP 1.1 Batch Implementation Guide and the Pharmacy Encounter Companion Guide.)*

DO NOT ZIP/COMPRESS YOUR PHARMACY ENCOUNTER FILES

Upload your NCPDP 1.1 Batch Encounter files to the ProviderOne SFTP Directory HIPAA Inbound folder.

FILE ACKNOWLEDGMENTS

The ProviderOne Encounter system searches frequently for new files and forwards those to begin the encounter data processing.

997s ARE NOT GENERATED FOR PHARMACY ENCOUNTERS

You will receive a 997-LIKE NCPDP Acknowledgment within 24 hours of uploading your files. Collect them at the ProviderOne SFTP Directory in the HIPAA Outbound folder.

The NCPDP Acknowledgment is similar in format to the 837 Custom Report generated with the 997 acknowledgment. Refer to the sample Custom Report in the Common Section.

ORIGINAL PHARMACY ENCOUNTERS

The NCPDP 1.1 Batch file includes encounters reported for the first time or retransmitted after being rejected on the ETRR during the SXC POS.

CORRECTED PHARMACY ENCOUNTERS

Corrected Encounter records include NCPDP Pharmacy encounters that were previously rejected through the POS edit process (not the HIPAA/NCPDP file edits). If a record is rejected, the Edit Code for each TCN is listed on the ETRR that was returned to the MCO via the Trading Partner folder on the SFTP Server. These records should be corrected and resubmitted with your next file transfer, as per the table below.

The NCPDP format does not allow you to report Original TCNs for encounters that were rejected during POS edit processing (ETRR). The ProviderOne systems will find, void and replace the original record using the Transaction Code field value.

Corrected/adjusted/reversed encounters will be rejected as duplicates unless an appropriate qualifier (as listed below) is reported.

Follow the NCPDP standard for reversals. Use any one of the following methods:

Listed below are your options to void/replace/adjust a previously reported encounter record:	
1.	B1 – B2 (Encounter followed by Reversal)
2.	B1 – B2 – B1 (Encounter, Reversal, Encounter)
3.	B1 – B3 (Encounter, Reversal and Rebill, which is the same as B1 – B2 – B1)

For additional information on submitting reversals, refer to the NCPDP Standard.

DSHS uses the Medi-Span® file for reporting NDCs on Pharmacy encounters to DSHS.

RSN SPECIFIC SECTION (NEW)

USING THE NTE (CLAIM NOTE) SEGMENTS

RSNs Mental Health - enter the Provider Type in the 2400 NTE segments according to the list in the Mental Health Data Dictionary. *(See MHD Data Dictionary.)*

REPORTING FREQUENCY

RSNs: Report encounters according to contract.

NAMING CONVENTION FOR RSNs

File names must be under 50 characters total and named using the following format:

HIPAA.<TPID>.<datetimestamp>.<originalfilename>.<dat>

- <TPID> is the Trading Partner ID (same as the 9-digit ProviderOne Provider ID).
- <datetimestamp> is the Date and Timestamp
- <originalfilename> is the sequential number that begins with '2000000' and must be the same as the number derived for Loop 'ISA' , Segment '13'.

  Example of file name: HIPAA.101721502.122620072100.2000001.dat
  (This name example is 42 characters)

EXCEPTION REPORT

For RSN encounter reporting, in addition to the ETRR, additional edits will apply and will be returned on an 'Exception report'. Encounters accepted into ProviderOne will be copied to the MHD CIS system for further processing. MHD CIS will return errors via the legacy "exception report." That report will be available in the RSN's directory on MHD's own SFTP server.

To correct any encounters that RSNs previously had successfully accepted into the MHD CIS system prior to ProviderOne going live, RSNs must send those changes and deletes to MHD CIS in the legacy 837-like format, rather than to the ProviderOne system.

Any encounters not successfully accepted by the MHD CIS system by the time ProviderOne "goes live" should be submitted to ProviderOne using the current EDI formats documented in the guides.

RSN APPENDICES

MHD Data Dictionary:

Provides RSNs with guidance on sending non-encounter data directly to MHC CIS system.

MHD Service Encounter Reporting Instructions:

Provides RSNs with guidance on coding of encounters based on State Plan modalities and provider types.

https://fortress.wa.gov/dshs/hrsamhd/mhdscripts/asp/general/MHC_Entry_Page.asp
Login with your account, then navigate to "Headquarters > Publications".

Updated Appendices will be
Published in this reporting guide as
MHD makes them available