ProviderOne
Washington's Social and Health Services Provider Payment System

Encounter Data Reporting Guide

A Resource For:

Managed Care Organizations

& Regional Support Networks

Version 1.2

APRIL 2010

Washington State Department of Social & Health Services

DOCUMENT CHANGE CONTROL TABLE

Author of Change: HRSA	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 ProviderOne payment / reporting system	Change to ProviderOne reporting system	5/28/2009
MHD		X		Page 3 & 4; Corrected URLs for Mental Health Publications	Incorrect URLs	6/1/2009
DSM; DHS; DBHR; HCS	X	X	All	Multiple changes	New System implemented; ProviderOne	4/30/2010

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

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MCO SPECIFIC SECTION

RSN SPECIFIC SECTION

DEFINITIONS

Atypical Provider - A service provider who does not qualify for an NPI.

Billing Provider - Different from Fee-For-Service - encounter data reporting requires the Billing Provider to always be the Program specific ProviderOne Provider ID of the MCO/RSN.

CNSI - The DSHS contracted systems vendor for ProviderOne.

Corrected Encounter - These are encounter records corrected by the organization after an error rejected it during the ProviderOne Encounter Edit process. The organization resubmits corrected records to replace the previously rejected encounter record.

Encounter - HRSA defines an encounter as a single healthcare service, or a period of examination or treatment. HRSA 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 - Electronic data files created by MCO/RSN systems in the X12N 837 format and the NCPDP 1.1 Batch format.

Encounter Transaction Results Report - The ETRR is the final edit report from ProviderOne for processed encounters. This is a single electronic document available on the ProviderOne SFTP site and includes a summary and details of encounters processed.

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

"GAP" Filling - Default coding formatted to pass Level 1, 2, and 7 EDI edits. If the correct required information cannot be obtained, HRSA 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 HRSA required fields.

Implementation Guide - The IG has instructions for creating the X12N 837 Health Care Claim/Encounter transaction sets and the NCPDP Batch Standard. The IGs are available from the Washington Publishing Company at:
www.wpc-edi.com/hipaa/HIPAA_40.asp.

National Provider Identifier - The NPI is a federal system for uniquely identifying all providers of healthcare services.

Original Encounters - The first submittal of Encounter records that have not previously been processed through the ProviderOne 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 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 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 - A SBE payment is made in addition to the regular capitation premium amount. An example is the Delivery Case Rate payments.

COMMON USAGE SECTION

Introduction

HRSA 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.

Use this guide as a reference. It outlines how to transmit managed care and mental health encounter data to HRSA.

There are 3 separate sections:

- **Common Usage Section:** This section includes 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 in this section are required in conjunction with this Reporting Guide.

Standard Formats

Use this guide in conjunction with:

- 837 HEALTHCARE CLAIM PROFESSIONAL AND INSTITUTIONAL IMPLEMENTATION GUIDES 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://maa.dshs.wa.gov/dshshipaa/

- DSHS/HRSA DBHR external publications at http://www.dshs.wa.gov/Mentalhealth/publications.shtml

- DSHS/HRSA Provider Publications, such as Billing Instructions and Numbered Memos may be downloaded at http://hrsa.wa.gov//maa/download/

Code Sets

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

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

Other Helpful URLs

- DSHS/HRSA Provider Publications Billing Instructions and Managed Care Program links: http://hrsa.dshs.wa.gov/

- HIPAA 837I and 837P Implementation Guide may be purchased at: www.wpc-edi.com/hipaa/HIPAA_40.asp

- DBHR Mental Health Publications can be found at: http://www.dshs.wa.gov/Mentalhealth/publications.shtml

- ProviderOne Secure File Transfer Protocol Directory: Use this production SFTP site for both X12N 837 Encounters and NCPDP Pharmacy Encounters: sftp://ftp.waproviderone.org

- Revenue Code/Procedure Code Grid: Use this grid to help determine which revenue codes require you to include procedure code. http://hrsa.dshs.wa.gov/HospitalPymt/Outpatient/ - then scroll down to "revenue code grids" and choose the one that applies for the date of service.

- The SFT Tumbleweed (aka: Valicert) server: This SFT server is separate from ProviderOne and used by HRSA to transfer confidential files/information: https://sft.wa.gov/

- Taxonomy Codes can be found at: http://www.wpc-edi.com/codes/Codes.asp

Purpose

HRSA 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

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

The ProviderOne system has an automatic 365 day reporting limitation. Encounters with dates of service over 365 days will be rejected.

ProviderOne IDENTIFIERS

Client Identifiers

The ProviderOne Client ID is used for reporting encounter data. Report the ProviderOne Client ID if the Client is known.

ProviderOne will reject Encounter records submitted with a Legacy PIC.
The client Gender must be reported on every encounter record in the Subscriber/Patient Demographic Information segments.

For specific reporting information refer to the MCO and RSN Specific sections and the 837and NCPDP Encounter Data Companion Guides.

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).

See the MCO Specific Section for additional information.

NPI Provider ID Unknown To ProviderOne

- Send the NPI for providers who by definition are required to obtain and use an NPI. *Use the Federal NPI Registry to search for the Provider's NPI* - *https://nppes.cms.hhs.gov/NPPES/Welcome.do*

- If the NPI is not known to the ProviderOne system the encounter will be accepted, but 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 the EDI 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 HRSA specific Companion Guide requirements.

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

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
- File size limitation is for all encounter files. The ProviderOne SFTP Directory limits the batch file size to 100 MB.

The 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 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 ST-header and SE-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 will receive a 997 and 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 (ST-Header and/or SE-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 'ST/SE' envelope or detail levels	File moves forward for encounter record processing (edits)	ETRR is generated

For further information, see the ETRR section

Retrieve 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.

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: 1 Interchange Accepted: 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

After your batch file is accepted it is split into encounter records and moved further into the ProviderOne validation processes. HRSA validates each Encounter record using HRSA defined edits. The Submitter specific ETRR is the final report of the encounter process and identifies all encounters processed by ProviderOne during the previous week.

The weekly production ETRR is available on Mondays and is located in ProviderOne as a text file. Retrieve your ETRR directly from the ProviderOne system under the Managed Care View ETRR link. Review the report for edit errors, correct encounters and resubmit as needed.

HRSA recommends that you:

- **Check** your record counts on the ETRR summary to make sure everything you submit is processed; and

- **Review** the ETRR to determine if case corrections and/or additional provider/subcontractor education is required.

The ProviderOne ETRR has 2 parts within a single text file:

Part 1 - The ETRR Summary: This part has 2 sections. The first section lists the X12N 837 errors. The second section lists the NCPDP errors. The summary lists all of 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 - may be useful to electronically merge with your electronic encounter records. Matching your unique Submitter's Claim Identifier will allow you to add the ProviderOne TCNs and to find the records that rejected/accepted during the encounter record validation process.

- The ETRR includes all of the following:
  - The organization's unique Submitter's Claim Identifier – aka: Patient Account Number;
  - ProviderOne 18-character Transaction Control Number - for reference, Encounter TCNs begin with "33";
  - An ETRR Number; and
  - The Error flags in sequential order.
- All Encounter Records will be listed with either accepted - 000N, or rejected – 000Y.
- The rejected encounter records are listed in sequential order with an Error Flag. The TCN will be listed for Claim level rejected errors. The TCN for each Service Line is listed under each Claim Level TCN.
- HRSA expects errors to be corrected and retransmitted for "replacement" processing in the next transmittal.

ETRR Layout

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

1. The table below shows the COBOL Copybook for the layout of the ETRR details.

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 above. Encounter Edit Error Occurrence values will be placed as follows:

   - Positions 1-42 X12N 837 Encounter Errors
   - Positions 43 through 150 Reserved for future use in X12N 837 Encounters
   - Positions 151-169 NCPDP Encounter Errors
   - Positions 170 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.

ERROR CODE LISTS for X12N 837 and NCPDP

X12N 837 – ERROR CODES

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	Billing Date Is Before Service Date	**Y**	**Y**	Encounter Rejected	Encounter Rejected
3	00045	Missing or Invalid Admit Date	**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	Original TCN Not On File	**Y**	**Y**	Encounter Rejected	Encounter Rejected
8	00455	Invalid Place of Service	**Y**	**Y**	Encounter Rejected	Encounter Rejected
9	00550	Birth Weight Less Than 100 Grams	**Y**	N	Encounter Rejected Previously – Info flag only	N/A
10	00755	TCN Referenced Has Previously Been Adjusted	**Y**	**Y**	Encounter Rejected	Encounter Rejected
11	00760	TCN Referenced Is In Process Of Being Adjusted	**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	Claim Contains An Unrecognized Performing Provider NPI	**Y**	N	If missing - file rejected, HIPAA Level 1, 2, or 7: Encounter Accepted	N/A

X12N 837 – ERROR CODES

Sequence Number	Error Code	Edit Description	MCO Y/N	RSN Y/N	Managed Care Disposition	Mental Health Disposition
16	01015	Claim Contains An Unrecognized Provider NPI	**Y**	**Y**	Encounter Rejected	Encounter Rejected
17	01280	Attending Provider Missing or Invalid	**Y**	**Y**	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid – Encounter Accepted	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid - Encounter Rejected
18	02110	Client ID Not On File	**Y**	N	Encounter Rejected	N/A
19	02125	Recipient Date of Birth Mismatch	**Y**	N	Encounter Rejected	N/A
20	02145	Client Not Enrolled With MCO	**Y**	N	Encounter Rejected	N/A
21	02225	Client not Eligible for all dates of service	**Y**	N	Encounter Rejected; MCO correction is not required.	N/A
22	02230	Claim Spans Eligible and Ineligible Periods of Coverage	**Y**	N	Encounter Rejected Previously – Info Flag only	N/A
23	02255	Client not Eligible for All Dates of Service	**Y**	N	Encounter Accepted Previously – Info Flag only	N/A
24	03000	Missing/Invalid 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	Diagnosis Not Valid For Client Age	**Y**	N	Encounter Rejected - unless BOMID is noted on encounter Previously – Info Flag only	N/A
29	03100	Diagnosis Not Valid For Client Gender	**Y**	N	Encounter Rejected - unless BOMID is noted on encounter Previously – Info Flag only	N/A

X12N 837 – ERROR CODES

Sequence Number	Error Code	Edit Description	MCO Y/N	RSN Y/N	Managed Care Disposition	Mental Health Disposition
30	03130	Procedure Code not on Reference File	**Y**	**Y**	If missing - file rejected, HIPAA Level 1, 2, or 7: If invalid – Encounter Rejected	Encounter Rejected
31	03145	Service Not Allowed For Client's Age	**Y**	N	Encounter Rejected - unless SCI = B is noted on encounter Previously – Info Flag only	N/A
32	03150	Procedure Not Valid For Client Gender	**Y**	N	Encounter Rejected - unless SCI = B 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 Procedure Code	**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 – Record Suspended
41	01020	Invalid Pay-to-Provider	**Y**	**Y**	Encounter Accepted	Encounter Rejected
~~42~~	~~02120~~	~~Gender On Client File Does Not Match Submitted Gender~~	~~**Y**~~	~~N~~	**Temporarily Suspended 6 Months** ~~Encounter Rejected~~	~~N/A~~
42	02121	Recipient Gender Missing or Invalid	**Y**	N	**Encounter Rejected Temporarily used 6 Months**	N/A
43 - 150		Reserved for Future X12N837 Edits	N/A	N/A	N/A	N/A

NCPDP – ERROR CODES						
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
159	67	Coverage effective xx/xx/xx – Fill prior to enrollment (fill date prior to client's MC enrollment plan)	**Y**	N/A	Encounter Rejected	N/A
160	68	Coverage effective xx/xx/xx – Fill after enrollment (fill date after client's MC enrollment ended)	**Y**	N/A	Encounter Rejected	N/A
161	70	Client not enrolled with HMO (Client eligibility terminated and not previously Managed Care enrolled.	**Y**	N/A	Encounter Rejected	N/A
162	81	Claim too old (over 365 days)	**Y**	N/A	Encounter Rejected	N/A
163	82	Claim is post-dated	**Y**	N/A	Encounter Rejected	N/A
165	69	Filled After Coverage Terminated (Client's eligibility terminated but was previously MCO enrolled)	**Y**	N/A	Encounter Rejected	N/A

NCPDP – ERROR CODES						
Sequence Number	**Error Code**	**Edit Description**	**MCO Y/N**	**RSN Y/N**	**Managed Care Disposition**	**Mental Health Disposition**
166	84	Claim Has Not Been Paid/Captured	**Y**	N/A	Encounter Rejected	N/A
167	77	Discontinued Product/Service ID Number	**Y**	N/A	Encounter Rejected	N/A
168	28	Missing/Invalid Date Prescription Written	**Y**	**N/A**	Encounter Rejected	N/A
169	E7	Missing/Invalid Quantity Dispensed	**Y**	**N/A**	Encounter Rejected (Federal Limitation)	N/A
170-250		Reserved for Future NCPDP Edits.	N/A	N/A	N/A	N/A

Although ProviderOne POS was thoroughly tested additional error codes could post on the ETRR for NCPDP Encounters.

If you receive a rejected encounter on the ETRR summary without an Error code notify ProviderOne Help with the encounter TCN.

Original X12N 837 Encounters

Original Encounter – Submitted directly to ProviderOne: any non-converted ProviderOne original encounter will be assigned an 18-digit TCN, e.g. 300914920034234000.

X12N 837 Encounter records that have not previously processed through HRSA defined encounter edits are original encounters.

This may include encounters:

- Reported for the first time; or
- Retransmitted after the batch file is rejected during the ProviderOne HIPAA Level 1, 2, or 7 edit process.

Corrected X12N 837 Encounters

Corrected X12N 837 Encounter records are encounters previously rejected by the ProviderOne Encounter Edit/Audit process, corrected by the MCO or RSN and resubmitted to HRSA.

All corrected, resubmitted encounters must include the original/previous Transaction Control Number - TCN.

To identify a rejected encounter review the description of each posted edit code listed in the Encounter Summary part of the ETRR. *See ETRR Layout.*

If rejected the Edit Code(s) for each TCN or Line Item is noted on the ETRR with a 000Y. The columns in the ETRR are in the same sequence number column shown in the Edit List.

HRSA reviews rejected encounter data records to verify corrections and/or resubmissions. Encounter records rejected as "duplicate" are not included in this review.

If you have rejected encounters that do not require correction send an email to EncounterData@dshs.wa.gov to tell us how many errors will not be resubmitted and why.

1. **MCOs, refer to the MCO Section** for additional information - Historic or converted encounters that were previously processed through the Legacy system and the TCN is formatted differently than the ProviderOne TCN.
2. **RSNs – refer to the RSN Specific Section** for additional information on correcting encounters previously reported to DBHR CIS.

Duplicate Encounter Records

A duplicate encounter record is defined as "all fields alike except for the ProviderOne TCNs and the Claim Submitter's Identifier or Transaction Reference Number, e.g. - Patient Account Number".

Duplicate encounter records are handled differently for MCOs and RSNs. They are:

- Rejected as errors for MCOs; and
- Suspended for review for RSNs.

After an encounter batch file passes the EDI Level 1, 2 or 7 validations, each record is validated in ProviderOne against historical data for duplicate encounter records. If a duplicate occurs the encounter record is rejected.

All corrected or resubmitted X12N 837 records must have an "Original/previous TCN" reported in the correct data element.

If the Original/previous TCN is missing the record will reject for MCOs and suspend for RSNs.

To prevent a high error rate due to duplicate records, do not retransmit clean encounter records that were previously accepted through ProviderOne processing systems; this includes records within partially accepted batch files.

HRSA recommends that MCOs/RSNs check their batch files for duplicate records prior to transmitting. Historically, many duplicates that were submitted were unintentional and lacked the Original TCN in order to void and replace a record.

For additional information on reporting corrected/adjusted encounters refer to 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 and 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, Chief Financial Officer, or MCO/RSN authorized staff must certify the data.

Instructions For Sending Certification Of Encounter 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.

In the **Subject** line of the e-mail type the following:

[**RSN**] or [**MCO**] 837/Rx Batch File Upload [**Organization name or initials**]

Examples:

- For King RSN the subject line should read:
  RSN 837 Batch File Upload – KRSN or King RSN.

- For Molina MCO the subject line should read:
  MCO Rx Batch File Upload – MHC or Molina

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

How To Mail The Letter Of Certification

MCOs and RSNs

1.	**Send** the signed original letter of Certification to this address: Encounter Data Coordinator For DHS/OQCM or DBHR Health & Recovery Services Administration P.O. Box 45564 Olympia, WA 98504-5564
2.	**Include** all of the following information in <u>each</u> email and signed Certification Letter (*See Sample Letter):* - Date the batch files are uploaded to ProviderOne; - 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 of HRSA Office OQCM or DBHR]**
Health & Recovery Services Administration
PO Box 45564
Olympia, WA 98504-5564

[TODAYS DATE]

RE: Certification of the Encounter Data Files

For: **[TRANSMITTAL PERIOD – Month and Year]**

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 ProviderOne on the following dates during the transmittal period:

Batch Number	Date Submitted (mm/dd/yyyy)	Number of Records

Sincerely,

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

MCO SPECIFIC SECTION

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 and all services given during the stay,
- 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 Section - Pharmacy Encounters and the RSN 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 HRSA; 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*.

HRSA 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

At a minimum 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 HRSA no later than April 1st.

HRSA verifies timely submissions through file upload dates and system review and analysis.

ProviderOne IDENTIFIERS

Client Identifiers for MCOs

- MCOs must use the ProviderOne Client ID on all records.
- Use the ProviderOne Client ID when resubmitting corrected encounters that were submitted prior to the ProviderOne implementation date.
- The client Date of Birth and Gender must be on every encounter record in the Subscriber/Patient Demographic Information segments.

Provider Identifiers for MCOs

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

Use the 9-digit ProviderOne Provider ID for each line of business in the X12N 837 Billing Provider and the NCPDP Sender ID segments.

Validate provider's NPI at the Federal NPI website:
https://nppes.cms.hhs.gov/NPPES/Welcome.do

NPI Provider IDs Unknown To ProviderOne

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

Reporting Atypical Non-NPI Providers

This section is under construction

Please do not report encounters having Atypical Providers until you receive the Atypical NPI from HRSA.

HRSA is currently developing an assigned NPI-like API that will be accepted through systems.

Atypical Non-NPI Providers usually provide services to PACE and WMIP clients.

- Provider ID fields are always required.
- Report ALL of the Demographic information required by the HIPAA IG and the 837 Encounter Data Companion Guide.
- Use of an API will be allowed **only** for providers who **do not** qualify for an NPI.
- Correct use of the API will be measured by HRSA on a regular basis.
- The non-participating provider ID '8999070' is no longer valid. If used, your encounter will be rejected.

Using The 837 'NTE' Claim / Billing Note Segments

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

For specific information on reporting denied lines refer to 'Denied Service Lines' below and the 837 Encounter Companion Guide.

NEW – If baby does not have a Client ID MCOs may use "**SCI=B"** in the NTE segments to report Newborn Baby medical services with Mom's ProviderOne Client ID. You may use this only when the baby has not yet been issued a Client ID by The Department.

Refer to the instructions included in the new ProviderOne Billing and Resource Guide found at: http://hrsa.dshs.wa.gov/download/Index.htm **.**

Or follow the instructions in the numbered memorandum 10-18 found at:
http://hrsa.dshs.wa.gov/download/Memos/2010Memos/10-18%20Re-issued.pdf

There is no provision to report pharmacy services for a baby on Mom's Client ID.

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.
- **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.

Denied Service Lines And Missing Codes

Missing Procedure Codes and Diagnosis Pointers will cause a X12N 837 batch file to fail the ProviderOne SFTP server process. Service Line code fields are required and if missing, are considered to be HIPAA Level 1 or Level 2 errors.

To prevent rejected batch files, HRSA created a default Procedure code for the X12N 837 Professional and Outpatient Institutional encounters.

- Use this code on MCO partially denied, paid encounters only when a Service Line is missing the Procedure code - '12345'.
- Make sure you correctly report this denied line in the 2400 HCP segment with a '00'.

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.

Do not split or alter a paid claim that is missing Procedure or Diagnosis codes in denied lines. The exception to altering a paid claim 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.

The Amount Paid

HRSA 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. Report the line level "Amount Paid" even if it is '0'.

Do not report encounters 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	Each Line Item will have own value: HCP 01 = '07' HCP 02 = 0
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

A corrected encounter may be either a ProviderOne encounter, or a ProviderOne converted Legacy MCO encounter.

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 HRSA, always report the "Original/Former TCN" in the correct X12N 837 field.

For more information see the X12N 837 Encounter Data Companion Guide.

Send the replacement encounter that includes the TCN of the original/former record that is to be replaced and use Claim Frequency Type Code '7'.

When there is no replacement/corrected encounter to send and you need to void a previously reported encounter use Claim Frequency Type Code '8'.

Legacy converted Encounters – all encounters converted into ProviderOne were assigned a **21-digit** TCN. To make a correction/adjustment the former record must be correctly identified in 2300 REF02 as per the information below:

- When you void an original 17-digit Legacy ICN you must first make into a ProviderOne TCN. Add **'9'** for the prefix and **'000'** for the suffix to the original Legacy 17-digit ICN making it **21** digits; it should look like this: '**9**908350559920000010**00**'.
- Report only the newest, former record as the void, and if applicable, the newly adjusted/corrected record as the replacement.

The 21-digit TCN will never be on the ETRR. The Companion Guide Comments field shows 21-digits are used for **reporting** the Original TCN in 2300 REF02. For clarification here is the ProviderOne logic for TCNs:

- Any new non-converted claim/encounter submitted directly to ProviderOne will receive and be identified using an 18-digit TCN that begins with '**3**', e.g. 331008900020585000;
- Any claim/encounter converted from Legacy into ProviderOne will receive and be identified using a 21-digit TCN and begins with '99'.

Service Based Enhancements

HRSA pays MCOs and FQHCs/RHCs a Delivery Case Rate as a Service Based Enhancement - SBE. The MCO and FQHC/RHC must incur expenses related to the delivery of a newborn. Using the 'Amount Paid' information ProviderOne will generate SBE payments after receiving and processing the encounter data for the service.

The ProviderOne system will "flag" encounters with any of the codes listed in the "Codes That Will Trigger an SBE" table. The ProviderOne SBE process will verify the following:

1. The client's eligibility and enrollment with the MCO.

   The client's enrollment to an FQHC/RHC - one SBE is paid to the MCO and one is paid to the FQHC/RHC clinic. If the appropriate requirements are met, the delivery enhancement will be paid directly to the center. In order for this automatic payment to be triggered, the same NPI must be:

   - Used by the center when billing deliveries to the MCO(s);
   - Used by the MCO(s) on the monthly enhancement file sent to the Department; and
   - Submitted by the MCO(s) to the Department in the managed care encounter data.

If delivery enhancements appear to be missing or incorrect, please contact the appropriate MCO.

2. The last time HRSA paid an SBE for the client - *only one SBE per pregnancy within a nine-month period.*

3. For inpatient hospital encounters an admission date must be present to generate the SBE.

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

5. ProviderOne 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 SBE to the FQHC/RHC. Use the following taxonomy codes as applicable:

- FQHC = **261QF0400X**; or
- RHC = **261QR1300X**.

MCOs will not receive SBE payments 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:

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

HRSA will recoup SBE payments when:

- An MCO voids the encounter which generated the SBE and there are no other services that qualify.
- The MCO voids the encounter which generated the SBE and there are other encounters which qualify - the first SBE will be recouped and a new SBE will be generated from one of the other qualifying encounters.
- The MCO Voids and Replaces an encounter which previously generated a SBE. The first SBE will be recouped and a new SBE will be generated from the replacement encounter.
- FQHC/RHC ‘Clinic A’ received a SBE and the client’s association for the date of delivery is changed to FQHC/RHC ‘Clinic B’. The original SBE will be recouped from ‘Clinic A’ and paid to ‘Clinic B’.

MATERNITY CODES THAT WILL TRIGGER A SBE

HOSPITAL – X12N 837 INSTITUTIONAL	
DRG CODES	370 - Cesarean section w/CC; 371- Cesarean section w/o CC; 373 - Vaginal delivery w/o complicating diagnoses; 374 - Vaginal delivery w/sterilization &/or D&C; 375 - Vaginal delivery w/O.R. procedure except sterilization; 650 – High risk Cesarean section w/CC; 651 – High risk Cesarean section w/o CC; 652 – High risk Vaginal delivery w/sterilization and/or D&C
PROCEDURE CODES	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622
REVENUE CODES	Will not generate enhancements using Revenue Codes because the applicable claim will have one of the identified DRG and procedure codes.
DIAGNOSIS CODES	Normal delivery, and other indications for care in pregnancy, labor and delivery 650 - 659
CLAIM TYPE	Claim Type = UB - 04

PHYSICIAN – X12N 837 PROFESSIONAL	
DRG CODES	N/A
PROCEDURE CODES	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622
REVENUE CODES	N/A
DIAGNOSIS CODES	N/A
CLAIM TYPE	Claim Type = 1500 Health Insurance Claim Form

Premium and Adjustment Request Form

Purpose: The Premium Payment and Adjustment Request form is designed as a general purpose form to be used by MCOs after the ProviderOne payment system is implemented. DSHS/HRSA staff will use this PARF form to research information you provide and determine payment or adjustments due.

This form replaces CMS 1500 Claim Form and DSHS Form 13-715 Adjustment Request.

Use this form to request payment for:

1. Delivery Case Rate/Service Based Enhancement payments not received 60 days after the Encounter Transaction Results Report (ETRR) shows the encounter claim was accepted.
2. Newborn Premiums not paid for the first 21 days of life - The MCO must wait 180 days from DOB to report the baby using MOM's ProviderOne Client ID.

For additional information on reporting baby with Mom's ID refer to Using the 837 NTE Segment.

Request Access: To request user access to the Encounter SFT Tumbleweed server, https://sft.wa.gov/ send an Email a request to MMISHelp@dshs.wa.gov . This generates a Helpdesk ticket. Include all of the following in your Email request:

- In the subject put: Encounter SFT Server Access for PARF – Encounter Data Coordinator.
- In the message body include the:
  - Name of your MCO; and
  - User name; and
  - Phone number; and
  - Email address.

After your access is approved you will receive two separate Emails from HRSA – one with your User ID and the second with your Password. This is a temporary password of 8 alpha/numeric characters. To avoid lockout it is recommended that you keep a similar pattern for your permanent password.

Submission Requirements: Use MS Excel or a Spreadsheet format for your form. Transfer your PARF to the HRSA Encounter SFT Tumbleweed server at https://sft.wa.gov/ . This is the same site HRSA used to transfer Legacy encounter data and reports.

Record Limits: There is no limit on the number of records per file. HRSA/MMIS Services will download your files, at minimum, on a weekly basis.

Naming Convention: The file naming convention includes all of the following elements:

- Sequence Number, e.g. YY-001; YY-002; YY-003;
- MCO Abbreviation;
- Date Submitted;
- PARF.

SAMPLE Naming Convention: Sequence Number_PlanName_SubmitDate_PARF.doc

Example: 10-001_MHC_06152010_PARF.doc

Follow-Up: Wait 30 days before sending questions regarding the status of PARF issues. Submit your questions by email to MMISHelp@dshs.wa.gov. Always include the "PARF" file name in the email Subject.

Refer to the Sample Managed Care Payment or Adjustment Request form for the required information and format.

Managed Care Payment or Adjustment Request Form

Date: **03/11/2010** MCO Name: **DisneyWorld Health Plan** ProviderOne Provider ID: **10105xxxx**

Contact Person: **Mickey Mouse** Contact Phone Number: **1-800-DISNEY9**

Request for Payment=P Adjustment =A	Premium Type Regular Premium Newborn Premium Delivery Case Rate (DCR)/SBE	ProviderOne Client ID	Transaction Number (TCN) 834 Number Encounter Data (ED) Number	Date/Month of Service	Enrollee Name Last Name First Name Middle Initial	Enrollee Date of Birth	Comments
P	DCR	111222333WA	ED - 990835055992000001000	09/25/2009	White, Snow	09/25/2009	Encounter data was submitted on 12/10/2009. Payment for DCR not yet received. Please research.
P	Newborn Premium	None	None	12/01/2009	Duck, BabyGirl	12/06/2009	BabyGirl Duck was born to our enrollee Daisy Duck on 12/06/2009. We paid the hospital delivery charges and received the DCR for the event. We have not received any newborn premiums for Baby Girl Duck. To date (06/06/2010) the baby has not been enrolled in our plan. Please research and pay newborn premium for BabyGirl Duck

Format table using MS Excel or another Spreadsheet type of software

RETAIL PHARMACY DATA PROCESSING

There are new and subtle differences between the old Legacy system and the new ProviderOne Point-Of-Sale system for NCPDP Pharmacy Encounters.

Refer to the Pharmacy Encounter Companion Guide and the Prescription Drug Program billing instructions.

HRSA 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 the drug file contractor Medi-Span®. 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®, ProviderOne will reject the encounter. Verify with your Pharmacy Benefit Manager to ensure that they can submit their data using the Medi-Span® NDCs.

HRSA 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.

The NCPDP files received at the ProviderOne SFTP Directory are validated for compliance using EDIFECS and passed to the HRSA 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 more specific layout information.

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

Do not include Situational Fields when there is no data to report. That data will cause your file to reject at the SFTP Server.

Naming Standard 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.

DO NOT ZIP/COMPRESS YOUR PHARMACY ENCOUNTER FILES

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

Refer to NCPDP 1.1 Batch Implementation Guide and the Pharmacy Encounter Companion Guide.

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 in addition to a Load Report. 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 may include encounters reported for the first time or retransmitted after being rejected on the ETRR during the SXC POS edit process.

Corrected Pharmacy Encounters

Corrected Encounter records include NCPDP Pharmacy encounters that were previously rejected through the POS record edit process. If a record is rejected, the Edit Code for each TCN is listed on the ETRR that was picked-up by the MCO via the Trading Partner folder on the SFTP Server. These records should be corrected and resubmitted with your next file transfer, using the void/replace process listed in the table below.

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

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

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)

Refer to the NCPDP Standard for additional information on submitting Pharmacy reversals.

RSN SPECIFIC SECTION

Reporting Claim Types

X12N 837P – Includes any professional healthcare service described in the "Encounter Data Reporting Instructions."

X12N 837I – Includes institutional services, specifically - Evaluation & Treatment Centers

Client Identifiers for RSNs

- If a client is known use the ProviderOne Client ID.
- Report the RSN Unique Consumer ID if the client is not known and there is no ProviderOne Client ID.
- Report the Client Date of Birth if known. If unknown refer to the instructions located in the Encounter Companion Guide

Using The 'NTE' Claim/Billing 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 „200000000" and must be the same as the number derived for Loop „ISA" , Segment „13".

Example: HIPAA.101721502.122620072100.200000001.dat
(This name example is 42 characters)

Reporting Corrected RSN Encounters

Any encounters that were previously successfully accepted into the DBHR CIS system prior to ProviderOne Go-live may be corrected by doing the following:

- **Use** the Legacy 837-like format;
- **Send** changes and deletes to CIS

Submit any encounters **not** successfully accepted by CIS by the time ProviderOne **"**goes live" 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 the DBHR CIS system.

Find the Data dictionary at:
http://www..wa.gov/pdf/hrsa/mh/_HRSA_CIS_Data_2009_Dictionary.pdf

MHD Service Encounter Reporting Instructions:

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

SERI: http://www..wa.gov/pdf/hrsa/mh/Service_Encounter_Rptng_Instructions.pdf