Washington State Health Care Authority

Encounter Data Reporting Guide

For

Managed Care Organizations

Qualified Health Home Lead Entities

Regional Support Networks

October 2014

Version 1.5

DOCUMENT CHANGE CONTROL TABLE

Author of Change: HCA	Impact To MCOs	Impact To RSNs	Page	Change	Reason	Date
Division of Systems & Monitoring (DSM); Division of Healthcare Services (DHS); Division of Behavioral Health and Recovery Services (DBHR); Home & Community Services (HCS)	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
DBHR		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
DHS; DSM	X	X	All	Replaces previous version.	Updated for HIPAA 5010 and other edit corrections.	3/30/2012
HCA	X		All	Updated: Encounter Data Reporting including Health Home, Paid Date, Certification Letter, Serviced Based Enhancement,	Health Home & MC Contract	1/1/2014
HCA, DBHR	X	X	All	Updated: Edits added/ disposition changes, NDC Proc Code Added, Address Change for DBHR. New DRG codes for SBEs. Payment Inquiry Section & Form updated. Other updates	Changes to ProviderOne	10/30/2014

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 Health Care Authority created this reporting guide for use in combination with the Standard 837 and National Council for Prescription Drug Programs (NCPDP) Implementation Guides, and the ProviderOne Encounter Data Companion Guides. This reporting guide includes data clarifications derived from specific business rules that apply exclusively to encounter processing for Washington State's ProviderOne payment system. 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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DEFINITIONS

Atypical Provider - Atypical providers are providers who do not provide medical services (ex: non-emergency transportation, case management, or environmental modifications) and are not eligible to receive an NPI.

Billing Provider - The NPI of the provider who billed the Managed Care Organization (MCO).

CNSI - The state contracted systems vendor for ProviderOne.

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

Delivery Case Rate - Payments approved by HCA for MCOs, Federally Qualified Health Center (FQHCs and Rural Health Clinics (RHCs) who perform a delivery of a newborn.

Encounter –The Health Care Authority (HCA) defines an encounter as a single healthcare service, or a period of examination or treatment. HCA requires MCOs/Regional Service Networks (RSNs)/Qualified Health Home (QHH) lead entities to report healthcare services delivered to clients enrolled in managed care, receiving mental health services, or receiving health home services as encounter data.

Encounter Data Transaction - Electronic data files created by MCO/RSN/QHH systems in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) 1.1 Batch format.

Encounter Transaction Results Report (ETRR) - The ETRR is the final edit report from ProviderOne for processed encounters. This is a single electronic document available on the ProviderOne Secure File Transfer Protocol (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 Electronic Data Interchange (EDI) edits. If the correct required information cannot be obtained, HCA 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 Implementation Guide (IG), use the most appropriate value for the situation. *See* 837 Professional and Institutional Encounter Companion Guide (Mapping Documents) for HCA required fields.

Implementation Guide (IG) - The IG has instructions for creating the 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 (NPI) - An NPI is the standard unique health identifier for all health care providers. It was implemented as a requirement of the Health Information Portability & Accountability Act (HIPAA) of 1996 (45 CFR Part 162).

Original Encounter - The first submittal of an encounter record that has not previously been processed through ProviderOne.

ProviderOne - ProviderOne is the primary claims/encounter payment processing system for Washington State.

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

Qualified Health Home –The lead entities contracted with the Health Care Authority to administer, oversee, and report encounters performed by their network of Care Coordination Organizations (CCO) who provide health home services to Medicaid clients.

Referring Provider - The individual provider who referred the client or prescribed ancillary services/items such as Lab, Radiology, Durable Medical Equipment, and disposable medical supplies.

Rendering Or Attending Provider - The individual provider who provided the healthcare service to the client/member.

S-Kicker Payment (or S-Kicker Enhancement) – An additional delivery enhancement payment from HCA made to RHCs and FQHCs if a client is enrolled in BHP+. For more information on S-kicker payments, see the Medicaid Billing instructions for RHCs and FQHCs.

Service Based Enhancement (SBE) - A payment generated for specific encounter services provided to Medicaid managed care enrollees and Fee for Service (FFS) health home beneficiaries.

Standard Transaction - A transaction that complies with an applicable standard and associated operating rules adopted under 45 CFR Part 162.

Taxonomy – Taxonomy is a hierarchical code set designed to categorize the type, classification, and/or specialization of health care providers.

GENERAL INFORMATION SECTION

Introduction

The Health Care Authority (HCA) publishes this Encounter Data Reporting Guide to assist contracted Managed Care Organizations (MCOs), Regional Support Networks (RSNs), and Qualified Health Home (QHH) lead entities in the standard electronic encounter data reporting process.

Use this guide as a reference. It outlines how to transmit managed care, behavioral health, and health home encounter data to HCA.

There are 4 separate sections:

- **General Information Section:** This section includes guidance and instructions for all types of Encounter Data reporting and applies to all reporting entities including MCOs, RSNs, and QHH lead entities.
- **MCO Specific Section:** This section includes specific information and guidance for the MCOs on both medical and pharmacy encounters.
- **QHH Lead Entity Specific Section:** This section includes specific information and guidance for the QHH Lead Entities to report health home services provided to Medicaid fee-for-service (FFS) eligible clients including Dual Medicare and Medicaid eligible clients.
- **RSN Specific Section:** This section includes specific information and guidance for the RSNs.

Standard Formats

Use this guide in conjunction with:

- 837 Healthcare Claim Professional and Institutional Implementation Guides (IG) version 5010. To purchase the IGs contact the Washington Publishing Company at http://www.wpc-edi.com or call 1-800-972-4334.

- NCPDP Telecommunication Standard D.0 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.

- Washington State/CNSI 837 Professional; Institutional and NCPDP Pharmacy Encounter Data Companion Guides at http://www.hca.wa.gov/medicaid/hipaa/

Code Sets

HCA follows National Standards and Code Sets found in:

- Current Procedural Terminology(CPT) – The CPT AMA is available at: https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp
- Health Care Comprehensive Procedure Coding System (HCPCS)– The HCPCS is available at: http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html
- Standard Edition International Classification of Diseases (ICD) - The ICD.9.CM is available at: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/, or http://icd9cm.chrisendres.com/icd9cm/

Other Helpful URLs

- DBHR Mental Health Publications are available at: http://www.dshs.wa.gov/dbhr/mh_information.shtml
- HCA Medicaid Provider Guides, Provider Notices, and Healthy Options links are available at: http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx
- HIPAA 837I and 837P Implementation Guide may be purchased at: www.wpc-edi.com/hipaa/HIPAA_40.asp
- Medi-Span® Master Drug Data Base is available at: http://www.medispan.com
- National Drug Code (Medi-Span® file) is available at: http://www.ncpdp.org/
- National Uniform Billing Committee codes are available at: http://www.nubc.org
- Place of Service code updates are available at: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
- ProviderOne Secure File Transfer Protocol Directory: sftp://ftp.waproviderone.org (Use for both Medical and Pharmacy Encounters)
- Quarterly NDC-HCPCS Crosswalk is available at: https://www.cms.gov/McrPartBDrugAvgSalesPrice/01a18_2011ASPFiles.asp#TopOfPage

- Revenue Code/Procedure Code Grid: Use the grid to help determine which revenue codes require you to include a procedure code. Scroll down to "revenue code grids" and choose the one that applies for the date of service. http://www.hca.wa.gov/medicaid/hospitalpymt/Pages/outpatient.aspx
- Taxonomy Codes are available at: http://www.wpc-edi.com/codes/Codes.asp
- The SFT Tumbleweed (aka: Valicert) server. This SFT server is separate from ProviderOne. HCA uses it to transfer confidential files and information. https://sft.wa.gov/.

Purpose

HCA requires encounter data reporting from contracted MCOs, RSNs, and QHHs. Data reporting must include all healthcare, health home and behavioral health services delivered to eligible clients, or as defined in the RSN or QHH Specific Section. Complete, accurate, and timely encounter reporting is the responsibility of each MCO, RSN and QHH lead entity.

Reporting Frequency

Encounters may be reported as often as daily. Otherwise, use the information in the MCO, RSN or QHH 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

Use the ProviderOne Client ID to report medical, pharmacy and health home services encounter data. For processing encounters also report the client's gender on every encounter record in the Subscriber/Patient Demographic Information segments.

Provider Identifiers

Report the National Provider Identifiers (NPIs) to identify all Billing, Pay-to, Servicing, Attending, Referring, and other required providers in all provider segments.

To identify the MCO/RSN/QHH submitting the encounter claim, follow the instructions in the Encounter Data Companion Guide for 5010 transactions and D.0 for pharmacy transactions.

Remember the ProviderOne provider ID **must** be included in the

- Billing Provider Secondary Identification LOOP 2010BB using REF01 = G2 and REF02 for the 837 Encounter Data Companion Guide for 5010 transactions

- Sender ID 880-K1 field for D.0 for Pharmacy transactions. For additional information, see section "Retail Pharmacy Data Processing".

These ProviderOne IDs must be the specific Medicaid program the client is enrolled in such as: 105010101, 105010102, 105010103, 105010104 etc. as applicable).

Provider NPI Unknown To ProviderOne

- Send the NPI for providers who by definition are required to obtain and use an NPI for standard transactions. *Use the Federal NPI Registry to search for the Provider's NPI at https://nppes.cms.hhs.gov/NPPES/Welcome.do*
- If the NPI is not known to the ProviderOne system the encounter will have an error message post identifying that the provider is not known to the system. ProviderOne will retain the NPI on an error page for further data analysis review.
- 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.

PROVIDERONE ENCOUNTER DATA PROCESSING

Encounter Data Processing

Unless otherwise specified, the following information applies to all encounter types (Medical, Behavioral Health, Health Home, and Pharmacy services).

Only accepted encounters are used for evaluation of rate development, risk adjustment, quality assurance and the generation of Service Based Enhancement payments. ProviderOne processes all encounter files received and checks for HIPAA Level 1 and 2 errors. This process ensures that the file is readable, has all required loops and segments, will be accepted into the system, and is 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 837 and NCPDP syntax, and compliance with specified 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 a code list or table as laid-out in the implementation guide.

For additional standard HIPAA Level edits and 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 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.

For Pharmacy encounter file information, see section "Retail Pharmacy Data Processing"

File Preparation

Separate your files by 837P (Professional) and 837I (Institutional) encounters.

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

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

For Pharmacy encounter file information, see section "Retail Pharmacy Data Processing"

File Naming For Medical 837 Encounters

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)

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 Medical and Pharmacy Batch Encounter files to the SFTP Directory – HIPAA or NCPDP Inbound folder depending on the file type

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

- **NCPDP Inbound,**
- **NCPDP Outbound,**
- **NCPDP Acknowledgment, and**
- **NCPDP Error folders.**

File Acknowledgements For Medical Encounters

Each 837 encounter 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.
- **999 Functional Acknowledgement -** All submitted files having a positive TA1 receive either a positive or negative 999.
  - **Positive 999**: A positive 999 and Custom Report are generated for each file that passes the ST-header and SE-trailer check and the HIPAA Level 1 and 2 editing.
  - **Negative 999**: A negative 999 and Custom Report is generated when HIPAA Level 1 and 2 errors occur in the file.
- **Custom Report -** All submitted files having a positive TA1 will receive a 999 and a Custom Report.

For Pharmacy encounter information, see section "Retail Pharmacy Data Processing"

Table of File Acknowledgments

Submitter Initial Action	System Action	Submitter Requirement	Submitter Action - 2
Encounter file submitted	Submitter receives: Negative TA1 Identifies HIPAA level 1 or 2 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 999 Negative Custom Report Identifies HIPAA level 1 or 2, errors in the file detail	Submitter verifies and corrects detail level errors	File is resubmitted

Submitter Initial Action	System Action	Submitter Requirement	Submitter Action - 2
Encounter file submitted	Submitter receives: Positive TA1 Positive 999 Positive Custom Report Identifies no HIPAA level 1 or 2 at 'ST/SE' envelope or detail levels	File moves forward for encounter record processing (edits)	ETRR is generated

Retrieve your TA1, 999 Acknowledgement, and Custom Reports from your 'HIPAA Ack' or 'NCPDP 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. Correct errors in files with Rejected and Partial acknowledgement statuses.

- Files that have partial acknowledgement statuses 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 partial file. Resending accepted records will cause duplicate errors and will cause a higher error rate.

Please note that any HIPAA 837 files that have partial acknowledgement statuses only need the rejected records resubmitted. For NCPDP pharmacy files that have partial acknowledgement statuses ALL the records need to be resubmitted.

Review each 999 or Custom Report - Always verify the number of file uploads listed in your letter of certification to the number of files returned on the 999 Functional Acknowledgement and Custom Report. *See sample Certification Letter*

Correct all errors in files that are Rejected or Partials for Level 1 and/or 2.

Retransmit files that have rejected or partial acknowledgement statuses at the ProviderOne SFTP Server following the established transmittal procedures listed above.

Review the subsequent 999 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.105XXXX01.20120105.HIPAA.105XXXX01.033120090915.SBE13_IET.dat

Error Report *Powered by Edifecs*

Executed Thursday 20120105 4:31:47 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 Qualifier Mandatory Must Use 2 3 Identifier

VALIDATION PROCESS

The Encounter Transaction Results Report (ETRR)

After your batch file is accepted it is split into encounter records and moved further into the ProviderOne validation processes. HCA validates each Encounter record using HCA defined edits. The Submitter specific ETRR is the final report of the encounter process and identifies ALL encounter services 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.
The ProviderOne ETRR has two parts within a single text file:

Part 1 - The ETRR Summary: This part has two sections. The first section lists the 837 service errors. The second section lists the NCPDP pharmacy 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
- Total number of encounter records processed

Part 2 – The ETRR provides you information to merge the processed encounter records with your submitted files electronically. Matching your unique Submitter's Claim Identifier will allow you to add the ProviderOne TCNs to find the records that rejected/accepted during the encounter record validation process.

- The ETRR includes:
  - 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" or "34"
  - An ETRR Number
  - 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.

- HCA expects errors to be corrected and retransmitted for "replacement" processing in the next submission.

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

- **Review** the ETRR to determine if rejected encounters need corrections or if additional provider/subcontractor education is required.

Remember: Only accepted encounter records are used during the rate setting review process or SBE payment generation.

Encounter Transaction Results Report (ETRR) Layout

The system will produce a summary ETRR report with two sections. The first section will show the total number of 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. 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 Common Business Oriented Language (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		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 by error number positions as illustrated above. Encounter Edit Error Occurrence values will be placed as follows:
   - Positions 1-57 837I and 837P encounter errors
   - Positions 58 through 150 reserved for future use in 837I and 837P encounters
   - Positions 151-171 NCPDP encounter errors
   - Positions 172 through 250 reserved for NCPDP encounter errors

Error code lists for Medical and Pharmacy Encounters

837 Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
1	00005	Missing From Date of Service	Y	Y	Y	Reject	Reject	Reject
2	00010	Billing Date is Before Service Date	Y	Y	Y	Reject	Reject	Reject
3	00045	Missing or Invalid Admit Date	Y	Y	Y	Reject	Reject	Reject
4	00070	Invalid Patient Status	Y	Y	Y	Reject	Reject	Reject
5	00135	Missing Units of Service or Days	Y	Y	Y	Reject	Reject	Reject
6	00190	Claim Past Timely Filing Limitation	Y	Y	Y	Reject	Reject	Reject
7	00265	Original TCN Not of File	Y	Y	Y	Reject	Reject	Reject
8	00455	Invalid Place of Service	Y	Y	N	Reject	Reject	N/A
9	00550	Birth Weight Requires Review	Y	N	N	Accept	N/A	N/A
10	00755	TCN Referenced Has Previously Been Adjusted	Y	Y	Y	Reject	Reject	Reject
11	00760	TCN Referenced is in Process of Being Adjusted	Y	Y	Y	Reject	Reject	Reject

837 Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
12	00825	Invalid Discharge Date	Y	Y	N	Reject	Reject	N/A
13	00835	Unable to Determine Claim Type	Y	N	Y	Reject	N/A	Reject
14	01005	Provider Number Missing	Y	N	Y	Reject	N/A	Reject
15	01010	Claim Contains an Unrecognized Performing Provider NPI	Y	N	Y	Accept	N/A	Accept
16	01015	Claim Contains an Unrecognized Provider NPI	Y	Y	Y	Accept	Reject	Accept
17	01280	Attending Provider Missing or Invalid	Y	Y	Y	Accept	Reject	Accept
18	02110	Client ID Not on File	Y	N	Y	Reject	N/A	Reject
19	02125	Recipient Date of Birth Mismatch	Y	N	Y	Reject	N/A	Reject
20	02145	Client not Enrolled with MCO	Y	N	Y	Reject	N/A	Reject
21	02225	Client not Eligible for all Dates of Service	Y	N	Y	Accept	N/A	Accept

837 Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
22	02230	Claim Spans Eligible and Ineligible Periods of Coverage	Y	N	Y	Reject	N/A	Reject
23	02255	Client not Eligible for This Date of Service	Y	N	Y	Accept	N/A	Accept
24	03000	Missing/Invalid Procedure Code	Y	Y	Y	Reject	Reject	Reject
25	03010	Invalid Primary Procedure	Y	N	N	Reject	N/A	N/A
26	03015	Invalid 2nd Procedure	Y	N	N	Reject	N/A	N/A
27	03055	Primary Diagnosis not Found on the Reference File	Y	Y	Y	Reject	Reject	Reject
28	03065	Diagnosis Not Valid for Client Age	Y	N	Y	Accept	N/A	Accept
29	03100	Diagnosis Not Valid for Client Gender	Y	N	Y	Accept	N/A	Accept
30	03130	Procedure Code not on Reference File	Y	Y	Y	Reject	Reject	Reject

837 Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
31	03145	Service Not Allowed for Client's Age	Y	N	Y	Accept	N/A	Accept
32	03150	Procedure Not Valid for Client Gender	Y	N	Y	Accept	N/A	Accept
33	03175	Invalid Place of Service for Procedure	Y	N	Y	Accept	N/A	Accept
34	03230	Invalid Procedure Code Modifier	Y	N	Y	Accept	N/A	Accept
35	03340	Secondary Diagnosis not Found on the Reference File	Y	Y	Y	Reject	Reject	Reject
36	03555	Revenue Code Billed Not on Reference Table	Y	Y	N	Reject	Reject	N/A
37	03935	Revenue Code Requires Procedure Code	Y	N	N	Reject	N/A	N/A
38	02185	Invalid RSN Association	N	Y	N	N/A	Reject	N/A
39	02265	Invalid Procedure Code for Community Mental Health Center	N	Y	N	N/A	Reject	N/A

837 Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
40	98328	Duplicate HIPAA Billing (Record)	Y	Y	Y	Reject	N/A	Reject
41	01020	Invalid Pay-to-Provider	Y	Y	Y	Accept	Reject	Accept
42	02121	Gender on client file does not Match Submitted Gender	N	N	Y	N/A	N/A	Reject
43	99405	Claim Missing Required HCP Amounts	Y	N	Y	Reject	N/A	Reject
44	99410	Facility Type must be 11 for RSN Encounters	N	Y	N	N/A	Reject	N/A
45	99415	Admission Source must be 2 or 8 for RSN Encounters	N	Y	N	N/A	Reject	N/A
46	99420	Revenue Code must be 0124 for RSN Encounters	N	Y	N	N/A	Reject	N/A
47	03640	Missing or Invalid NDC Number	Y	N	N	Reject	N/A	N/A
48	03645	Procedure Code (HCPCS) Invalid with NDC Number	Y	N	N	Reject	N/A	N/A

837 Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
49	01006	Missing/Invalid Managed Care Program ID	Y	Y	Y	Reject	Reject	Reject
50	00535	First Date of Service More Than 2 or 3 years old	Y	Y	Y	Reject	Reject	Reject
51	12930	Initial visit/outreach Health Home - once in a lifetime	Y	N	Y	N/A	N/A	Reject
52	12931	Procedure Code G9148 must be paid with a Date of Service prior to the payment of Procedure Code G9149 & G9150	Y	N	Y	Accept	N/A	Accept
53	12932	Subsequent Health Home care billed before initial outreach	Y	N	Y	Reject	N/A	Reject
54	00762	Claim was already credited	Y	Y	Y	Reject	Reject	Reject
55	98325	Claim is exact duplicate	Y	Y	Y	Reject	Accept	Reject

837 Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
56	00865	Invalid or Missing Managed Care Paid Date	Y	N	N	Reject	N/A	N/A
57	00870	Encounter was not filed on timely basis	Y	N	N	Accept	N/A	N/A
58 -150		Reserved for Future Medical Encounter Edits	N/A	N/A	N/A	N/A	N/A	N/A

NCPDP Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
151	50 99075	Non-Matched Pharmacy NPI	Y	N/A	N/A	Reject	N/A	N/A
152	52 99077	Non-Matched Cardholder ID	Y	N/A	N/A	Reject	N/A	N/A
153	CB 99147	Missing/Invalid Patient's Last Name	Y	N/A	N/A	Reject	N/A	N/A
154	09 99009	Missing/Invalid Patient's Birth Date	Y	N/A	N/A	Reject	N/A	N/A
155	10 99010	Missing/Invalid Patient's Gender Code	Y	N/A	N/A	Reject	N/A	N/A
156	83 99114	Duplicate paid/captured claim	Y	N/A	N/A	Reject	N/A	N/A
157	21 99023	NDC Not on File - Missing/Invalid Product Service ID	Y	N/A	N/A	Reject	N/A	N/A
158	67 99094	Fill Date Prior to Client's Managed Care Enrollment	Y	N/A	N/A	Reject	N/A	N/A
159	68 99095	Fill Date after client's Managed Care Enrollment Ended	Y	N/A	N/A	Reject	N/A	N/A

NCPDP Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
160	70 99099	NDC Product/Service Not Covered (Client is not Enrolled in the MCO that submitted the encounter)	Y	N/A	N/A	Reject	N/A	N/A
161	81 99112	Claim Too Old (over 365 days)	Y	N/A	N/A	Reject	N/A	N/A
162	82 99113	Claim is Post-Dated	Y	N/A	N/A	Reject	N/A	N/A
163	69 99096	Filled After Coverage Terminated (Client's Eligibility Terminated but Client was Previously MCO Enrolled)	Y	N/A	N/A	Reject	N/A	N/A
164	84 99115	Claim Has Not Been Paid/Captured	Y	N/A	N/A	Reject	N/A	N/A
165	77 99106	Discontinued Product/Service ID Number	Y	N/A	N/A	Reject	N/A	N/A
166	28 99030	Missing/Invalid Date Prescription Written	Y	N/A	N/A	Reject	N/A	N/A
167	E7 99188	Missing/Invalid Quantity Dispensed	Y	N/A	N/A	Reject	N/A	N/A
168	EE 99195	Missing/Invalid Compound Ingredient Drug Cost	Y	N/A	N/A	Reject	N/A	N/A

NCPDP Encounter Error Codes and Positions								
Sequence Number	**Error Code**	**Error Description**	**Applies to MCOs? Y/N**	**Applies to RSNs? Y/N**	**Applies to QHHs? Y/N**	**Managed Care Disposition**	**Mental Health Disposition**	**Health Home Disposition**
169	UE 99286	Missing/Invalid Compound Ingredient Basis of Cost Determination	Y	N/A	N/A	Reject	N/A	N/A
170	DN 99170	Missing/Invalid Basis of Cost Determination	Y	N/A	N/A	Reject	N/A	N/A

Large ETRRs

When an MCO/RSN/QHH has over 300,000 encounters within a given cycle, the ETRRs will be split to contain no more than 200,000 encounters. This will result in the possibility of receiving multiple ETRRs for a given cycle/week.

Example: If an MCO/RSN/QHH has 800,000 encounters that are in final disposition at the time of ETRR generation – The MCO/RSN/QHH will receive 4 ETRRs each containing the results for 200,000 encounters.

Original 837 Encounters

Original Encounter – Submitted directly to ProviderOne: all ProviderOne original encounters will be assigned an 18-digit TCN, e.g. 330914920034234000.

837 Encounter records that have not previously processed through HCA defined encounter edits are original encounters. This includes encounters:

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

Corrected 837 Encounters

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

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.

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." For MCOs and QHHs, duplicate encounters will reject with edits 98325 and 98328. For RSNs, the encounters will not reject but have the edit 98325 posted if a duplicate. All corrected or resubmitted 837 records must have an "Original/previous TCN" reported in the correct data element.

To prevent a high error rate due to duplicate records, do not retransmit encounter records that were previously accepted through ProviderOne processing systems; this includes records within 837 files that have partial acknowledgement statuses.

HCA recommends that MCOs/RSNs/QHHs 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.

Certification of Encounter Data

To comply with 42 CFR 438.606, MCOs, RSNs and QHHs must certify the accuracy and completeness of encounter data or other required data submission concurrently with each 837 or NCPDP file upload. The Chief Executive Officer, Chief Financial Officer, or MCO/RSN/QHH authorized designated staff must certify the data.
Each time you upload a file, send an email notification to: ENCOUNTERDATA@hca.wa.gov. This email will be the concurrent certification of the accuracy and completeness of the encounter data file at the time of submission.

In the **Subject** line of the email type the following:

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

Include the number of batch files and total encounter records and services submitted in the email and the following certification statement:

*To the best of my knowledge, information and belief as of the date indicated, I certify that the encounter data and the corresponding financial summary, or other required data, reported by **[MCO/RSN/QHH Name]** to the State of Washington in the submission is accurate, complete, truthful and is in accordance with 42 CFR 438.606 and the current Managed Care/RSN/QHH lead entity Contract in effect.*
Example:

Batch#	Date Submitted	# of Records	Services
HIPAA.123123123.082020140116.837P.dat	08/01/2014	133	208
HIPAA. 123123125.082020140121.837P.dat	08/05/2014	4644	9111
HIPAA. 123123121.082020140122.837I.dat	08/05/2014	13	66
HIPAA. 123123126.082020140125.837I.dat	08/14/2014	2500	14121
NCPDP.123123124.082020140126.NCPDP01.dat	08/14/2014	88	88

NCPDP.123123122.082020140128.NCPDP02.dat	08/26/2014	5000	5000
NCPDP.123123123.082020140128.NCPDP03.dat	08/26/2014	5000	5000
Total		17,378	33,594

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. This includes files that have rejected and partial acknowledgement statuses. Please indicate with an (R) if a file was rejected or with a (P) for partial file statuses. If a file has a rejected or partial acknowledgement status, please change the name of the file when resubmitting the corrected encounters. Each file submitted should have its own unique file name.

1.

MCOs/QHHs - Send the signed original letter of Certification to:

Health Care Authority
HCS/QCM
P.O. Box 45530
Olympia, WA 98504-5530

RSNs – Send the signed original letter of Certification to:

DSHS/DBHR
Attn: RSN Oversight Unit
PO Box 45330
Olympia, WA 98504- 45330

2.

Include all of the following information in <u>each</u> email and signed Certification Letter :

- Date the batch files are uploaded to ProviderOne;
- Batch name of each file transmitted; and
- Number of encounter records and services in each batch file.
- MCOs: Certify the transmitted files as "MCO Proprietary Data."
- The following Certification statement:

To the best of my knowledge, information and belief as of the date indicated, I certify that the encounter data and the corresponding financial summary, or other required data, reported by **[MCO/RSN/QHH Name]** to the State of Washington in the submission is accurate, complete, truthful and is in accordance with 42 CFR 438.606 and the current Managed Care/RSN/QHH lead entity Contract in effect.

Sample – Certification Letter

TO: HCA/HCS or DSHS/DBHR

[TODAYS DATE]

RE: Certification of the Encounter Data Files

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

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

MCOs and QHHs 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/QHH Name]** were uploaded to ProviderOne on the following dates during the transmittal period:

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

Sincerely,

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

MCO SPECIFIC SECTION

Claim Types and Format

Ensure billing providers submit all information required for payment of the claim and your claim system maintains all information required to report your encounter data.
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 HCA; e.g. data must not be stripped, or split from the service provider's original claim.

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.)
- Transportation services

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.

All accepted encounters are used for evaluation of rate development, risk adjustment, and quality assurance. HCA uses MCO Encounter data to:

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

- Obtain Medicaid Drug Rebates

Reporting Frequency

At a minimum report encounters monthly, no later than 30 days from the end of the month in which the MCO paid the financial liability; i.e. MCO processed claim during January, data is due to HCA no later than March 1. HCA verifies timely submissions through file upload dates and system review and analysis.

Client Identifiers for MCOs

MCOs must use the ProviderOne Client ID on all encounter claim records. The client Date of Birth and Gender must be on every encounter record in the Subscriber/Patient Demographic Information segments.

When submitting encounter data for newborns please utilize the newborn's ProviderOne Client ID. In the instance where the ID is not known please utilize the 270 benefit inquiry to get their client ID.

Once you have the ID, please submit the newborns encounter claims on their own ID. If there are problems with the encounters you are submitting once the newborn has a client ID, submit the information on a MC Premium Payment and Other Inquiry Form as "other inquiry". The MC Premium Payment and Other Inquiry Form is in the Premium Payment and Other Inquiry section of this guide.

If the newborn doesn't have an ID, after 6 months, please submit an inquiry on the MC Payment and Other Inquiry Form.

If you are waiting on information from HCA for newborns and you are limited in time to submit the encounter claim, submit the encounter for the newborn on the mom's ID with the special indicator of B. Only use B if you have to submit Encounter data before the baby gets enrolled or in the case where no ID is available.

Provider Identifiers for MCOs

Report the NPI and Taxonomy codes for the Billing Provider as instructed in the Encounter Data Companion Guides (Loops 2000A PRV and 2010AA NM for 837 files). This must always be the provider that billed the MCO for the services. For pharmacy files, report the servicing provider NPI.

Use the 9-digit ProviderOne Provider ID for each line of business in the Secondary Identifier LOOP 2010BB of the 837 Billing Provider/Payer Name as well as in the NCPDP Sender ID segments. This is how the system identifies which MCO submitted the encounter data. Please note that if the Billing Provideror the NCPDP Sender ID on the file doesn't

match the ID of the program that the client is enrolled in at the time of service, the encounter will reject for "client not enrolled in MCO".

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.

All of the MCOs contracted providers must have a signed Core Provider Agreement with HCA. A provider may enroll with HCA as a "non-billing" provider if he or she does not wish to serve fee-for-service Medicaid clients, but the provider must have an active NPI number registered with HCA.

Reporting Atypical Non-NPI Providers

Atypical (non-NPI) providers usually provide services to,WMIP, and QHH clients. When MCOs or QHHs pay for services provided by non-NPI required providers, use the HCA standard Atypical Provider ID (API) of 5108005500. When using this API you must also report all the demographic information required by the HIPAA Standard Implementation 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 HCA on a regular basis.

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. Reporting denied service lines are acceptable but do not report encounters where all lines are denied.

- **Use the specified denial codes** listed in the 837 Encounter Companion Guide and as directed in the sub-section below.
- **Report mixed** (Denied line, Paid line, and Capitated line) outcomes in HCP 2400 and identify each line separately in HCP 2400 for 837 Encounters but use HCP 2300 to report the total Amount Paid for the entire claim. Please refer to the 'Amount Paid' sub-section.

- **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 the 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, HCA created a default Procedure code for the 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.

The Paid Date

HCA requires the MCOs to report the paid date for each medical and health home service encounter effective April 1, 2014.
For 837 Professional and 837 Institutional Encounters submit Paid Date in Loop 2300 DTP – DATE – REPRICER RECEIVED DATE as follows:

- **DTP01** (Date/Time Qualifier) – submit code '**050'**
- **DTP02** (Date Time Period Format Qualifier) – submit **'D8'**
- **DTP03** (Date Time Period) – submit the date the claim was paid in 'CCYYMMDD' format.

Example: Managed Care Organization Paid claim on 10/01/2013 – ***DTP*050*D8*20131001~***

See edits 00870 and 00865 for errors that post related to paid date.

The Amount Paid

HCA requires MCOs to report the amount paid for each medical, pharmacy and health home service 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 fee-for-service or in a capitated payment arrangement, or denied, use the HCP segments as shown in the table of scenarios and examples.

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 = 1530 (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
SCENARIO	**2300 HCP**	**2400 HCP (Examples)**
Entire Claim Paid by MCO fee-for-service	HCP 01 = '02' and HCP 02 = 2805 (Total $ 'Amount Paid' to Provider)	Each Line Item will have own value: 1. HCP 01 = '02' HCP 02 = 1530 2. HCP 01 = '02' HCP 02 = 1275
Entire Claim Paid by Capitation arrangement	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 = 1530 (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 Implementation Guide.

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

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.'

Rejected encounters should be replaced or voided. When resubmitting a previously rejected encounter, make sure to use Claim Frequency Type Code '7' or '8'. If the encounter is submitted with a Claim Frequency Type Code '1', the system may reject the encounter as a duplicate.

National Drug Codes (NDC)

HCA requires all MCOs to report the NDC of drugs provided in outpatient settings when the following occurs or the ProviderOne system will reject the encounter with error/edit code 03640 (missing or invalid NDC).

1. Physician and Med Vendor claims (837P) we need the NDC with the following HCPCS codes: J0120-J3489, J3491-J9999, Q0136-Q0187, Q0515, Q3025-Q3026, S0012-S0198, S4989-S5014, S5550-S5553, S5570-S5571, 90281-90399, 1112J, Q4079, Q4082-Q4084 unless the provider is 340b exempt.

2. Kidney centers – we need NDCs if revenue code is 0634, 0635, or 0636 AND procedure code is 90281-90399; A4706-A4709; A4720-A4728; A4765, A4766, A4802, J0120-J3488; J3500-J9626; Q0136-Q0187; Q0479, Q0515, Q3025, Q3026, Q4081, Q4083, Q4084, S0012-S0198; S4989-S5014; S5550-S5553; S5570, S5571

3. Hospital Outpatient or OPPS claims – we need NDC if revenue code is 0634, 0635, 0636, 0637 AND procedure code is NOT 90400-90749

EXCEPTION: Provider is 340b exempt; the bundled indicator is "yes" on the line.

Service Based Enhancements

HCA pays MCOs and FQHCs/RHCs a Delivery Case Rate (DCR) as a Service Based Enhancement (SBE). The MCO and FQHC/RHC must incur the expense related to the delivery of a newborn.

For HH SBE payment information, please refer to the Health Home Specific Section.

Effective for dates of service on or after September 1, 2014, HCA will no longer make DCR and S-kicker payments to FQHCs and RHCs and will not require the Managed Care plans to pay them either. The Managed Care plans will continue to pay FQHCs and RHCs for maternity services as they are currently.

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. When a client is also enrolled with the MCO associated FQHC/RHC one SBE is paid to the MCO and one is paid to the FQHC/RHC that provided the delivery service. In order for this automatic payment to be triggered, the same NPI must be:
   - Used by the FQHC/RHC when billing deliveries to the MCO(s);
   - Used by the MCO(s) on the monthly enhancement file sent to the FQHC/RHC manager at HCA; and
   - Submitted by the MCO(s) to HCA in the managed care encounter data.
2. The last time HCA paid an SBE for the client - only one SBE per pregnancy within a nine-month period is paid.
3. For inpatient hospital encounters an admission date must be present to generate the SBE. The eligibility for payment of the SBE is based on the hospital "admission" date. The system uses APR-DRG (V31.0) to derive a valid DRG code for payment of the SBE.
4. For outpatient hospital delivery services the encounter must include the statement 'From-To' date to generate the SBE.
5. For professional encounters, the admission date field (not required) should not be used for any other date than the admission date, when reported.
6. ProviderOne must receive the original encounter within 365 days of the date of admission or delivery.

7. 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 SBE payments
- The subscriber/patient is male
- The claim was paid by a "Primary Insurance Carrier" other than the MCO
- The encounter record is rejected by an edit. The encounter must be fully accepted to generate the SBE payment.
- The MCO on an encounter does not match the MCO the client is enrolled in on the date of admission. Please note that the admission date, when present, also applies to professional claims.

HCA Will Review:

- Encounter records for females under the age of 12 years and over the age of 60 years.

HCA will recoup SBE payments when:

- An MCO voids the encounter which generated the SBE.
- 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.

MATERNITY CODES THAT WILL TRIGGER AN SBE

HOSPITAL – 837 INSTITUTIONAL

DRG CODES	540 – Cesarean delivery 541 – Vaginal delivery w sterilization/ or D and C 542 – Vaginal delivery w complicating procedures exc sterilization/ or D and C 560 – Vaginal delivery
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 codes.
DIAGNOSIS CODES	Labor and Delivery, and other indications for care in pregnancy. The **Primary** ICD9 diagnosis code **must** be between 644.00 – 669.94
CLAIM TYPE	Claim Type = Inpatient Hospital with Type of Bill 11x. Outpatient OPPS Payment claim with Procedure Codes listed above.

PHYSICIAN – 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 PAYMENT AND OTHER INQUIRY

Managed Care Premium Payment and Other Inquiry Form

Purpose: The Managed Care Premium Payment and Other Inquiry Form (PPOIF), formerly known as PARF form, is designed as a general purpose form for use by MCOs to request assistance regarding regular premium, new born premium, SBE payment and other inquiries. The MCO must complete all actions available; including but not limited to correcting rejected encounters and reviewing all audit files, to resolve the issue before submitting a form for HCA to research. If still unable to resolve the issue, submit a PPOIF using the encounter Secure File Transfer – SFT Tumbleweed server at https://sft.wa.gov/ (encounter data directory) and notify the MMIS help desk (MMISHelp@hca.wa.gov) when a document is uploaded.

Request Access: To request user access to https://sft.wa.gov/ send an email to MMISHelp@hca.wa.gov. Include all of the following in your email request:

- SUBJECT line: Encounter SFT Server Access for Managed Care Inquiries
- In the message body include; MCO name; individual's name; phone number; and email address.

After your access is approved you will receive two separate emails from HCA – one with your User ID and the second with your temporary 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.

Use this form to submit inquiries for:

- **Newborns** - Premiums not paid for the months in which the first 21 days of life occurred – Submit inquiries if after 180 days from DOB the newborn premium has not been paid and the newborn doesn't have a client ID.
- **DCRs/SBEs** - Payments not received 30 days after the Encounter Transaction Results Report (ETRR) shows the encounter claim was accepted without errors. Form submission should only include SBE inquires.
- **Other inquiries** - Includes verification of address, name, HOH, date of birth, death, verification of SSN, Newborns that have client ID but encounter claim still rejecting for "Client not enrolled in MCO".

File 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 (MMDDYYY); PPOIF.

SAMPLE Naming Convention: Sequence Number_PlanName_SubmitDate_PPOIF.doc

Example: 12-001_MHC_06152010_PPOIF.doc

Follow-Up: Wait 30 days before sending questions regarding the status of issues. Submit your questions by email to MMISHelp@hca.wa.gov

Use this form to submit inquiries for:

- **Regular Premium inquiries -** When the MCO reconciles the electronic benefit enrollment file with the premium payment information and finds differences for resolution within sixty (60) calendar days of the first day of the subject month

Submit these forms to the managed care directory of the SFTP site with a notification email to MCprograms@hca.wa.gov

Naming convention: DELIVERABLE: (MCO) (month) reconciliation report

Follow up: Wait 30 days before sending questions regarding the status of issues. Submit your questions by email to MCprograms@hca.wa.gov

Below are two examples of the Managed Care Premium Payment and Other Inquiry Form (PPOIF) depending on the type of inquiry. Please submit inquiries in this format and in a printer friendly version. Any non-printer friendly versions will be returned to be corrected. Inquiry types should be grouped together on the same PPOIF form. Any forms with multiple inquiry types on one form will be returned to be corrected and resubmitted.

Managed Care Premium Payment and Other Inquiry Form (PPOIF)

Date: 03/11/2014 MCO Name: Any Medicaid Health Plan ProviderOne Provider ID: 10105xxxx

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

Inquiry Type -Regular Premium Inquiry -Newborn (NB) Inquiry -Delivery Case Rate (DCR/SBE) Inquiry -Other Inquiry	ProviderOne Client ID If baby has ID, list here. If not, list mom's ID	Transaction Number (TCN)	Date/Month of Service	Enrollee Name Last Name First Name Middle Initial	Enrollee Date of Birth	Comments Baby Name Mom Name Mom ID	HCA Response
Newborn Inquiry	111222333WA	N/A	Aug 2013	White, Snow	09/25/2013	Baby: Snow White Mom: Angelina Jolie White Mom ID: 123444555WA	
Newborn Inquiry	666555777WA	N/A	Feb 2014	Duck, BabyGirl	2/01/2014	Baby: BabyGirl Duck Mom: Daisy Duck Mom ID: 666555777WA	

Instructions: The Managed Care Premium Payment and Other Inquiry Form (PPOIF) is designed as a general purpose form to be used by Managed Care Organizations (MCOs). The form will be used by HCA staff to research information provided and determine the issue and/or resolution. Submit the PPOIF electronically to HCA SFT Tumbleweed site: https://sft.wa.gov/. There is no limit on the number of rows submitted per file. Please use a file naming convention that includes a Sequence Number (YY-001; YY-002; YY-003….) The MCO Name, Date Submitted Followed by PPOIF for ease of recognition. Example: 14-001-MHC-07012014_PPOIF.doc.

Managed Care Premium Payment and Other Inquiry Form (PPOIF)

Date: **03/11/2014** MCO Name: **Any Medicaid Health Plan** ProviderOne Provider ID: **10105xxxx**

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

Inquiry Type -Regular Premium Inquiry -Newborn (NB) Inquiry -Delivery Case Rate (DCR/SBE) Inquiry -Other Inquiry	ProviderOne Client ID Mom ID	Transaction Number (TCN) 837 Number Encounter Data (ED) Number	Date/Month of Service	Enrollee Name Mom: Last Name First Name Middle Initial	Enrollee Date of Birth Mom Date of birth	Comments	HCA Response
DCR/SBE Inquiry	111222111WA	330835055992001000	7/13/2014	Roberts, Michela	05/25/1976	Encounter data was submitted and accepted without errors on 8/10/2014. Payment for DCR/SBE not yet received. Please research.	
DCR/SBE Inquiry	111222555WA	330935056662031000	09/21/2013	Smith, Angela	12/06/1984	Clm#111111111111, paid 10/7/2013. HCA originally paid DCR in Nov 2013 but recouped the payment in June 2014. Please explain why since we paid the hospital claim and the DRG is 372	

Instructions: The Managed Care Premium Payment and Other Inquiry Form (PPOIF) is designed as a general purpose form to be used by Managed Care Organizations (MCOs). The form will be used by HCA staff to research information provided and determine the issue and/or resolution. Submit the PPOIF electronically to HCA SFT Tumbleweed site: https://sft.wa.gov/. There is no limit on the number of rows submitted per file. Please use a file naming convention that includes a sequence number (YY-001; YY-002; YY-003….) The MCO Name, Date Submitted Followed by PPOIF for ease of recognition. Example: 14-001-MHC-07012014_PPOIF.doc.

RETAIL PHARMACY DATA PROCESSING

HCA 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 -** HCA'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 HCA'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.

HCA 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** - The 'AMOUNT PAID' field (430-DU field name) 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.

- **Paid date** – The prescription fill date on NCPDP pharmacy encounters is designated by HCA as the paid date. Pharmacy encounters will be considered "untimely" if they are submitted to ProviderOne 75 days after the prescription fill date.

- **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 HCA POS system as encounter records, only if the file is compliant with NCPDP transaction standards.
Do Not 'GAP' Fill Situational Fields in your 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 D.0 format.

Do NOT zip/compress your pharmacy encounter files

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

Any NCPDP 1.1 Batch file that has a partial acknowledgement status will need to be fully resubmitted.

File Acknowledgments

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

999s ARE NOT GENERATED FOR PHARMACY ENCOUNTERS

You will receive a 999-*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 NCPDP Outbound folder.

The NCPDP Acknowledgment is similar in format to the 837 Custom Report generated with the 999 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 Pharmacy 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.

Washington State Health Care Authority

HEALTH HOME SPECIFIC SECTION

Qualified Health Home Lead Entity Encounter Reporting

Qualified Health Home (QHH) Lead Entities contracted with HCA to deliver Health Home services to Fee-for-Service (FFS) Medicaid eligible beneficiaries must provide the required care coordination services before payment can be made. Payment for health home care coordination services is based on a monthly encounter claim submission to HCA that generates a Service Based Enhancement payment to the QHH lead entity.

MCOs provide the care coordination services to health home beneficiaries enrolled with the MCO, and are not eligible for a separate Service Based Enhancement (SBE) payment. The Health Home care coordination service payment is incorporated into each MCO's monthly premium payment rate. This is also true for MCOs who elected not to become a Qualified Health Home Lead Entity, but delegated the services for their MCO beneficiaries to another QHH Lead Entity.

MCOs must report health home care coordination services using the procedure codes listed below with their normal encounter data reporting described in this guide. Only one service per month per beneficiary is reported and must include the amount paid to the subcontracted Care Coordination Organization or Delegated Qualified Health Home Lead Entity.

The QHH Lead Entities must use their assigned ProviderOne provider/submitter ID number on Health Home encounter services as the billing provider, with the taxonomy code of 251B0000X. The standard ICD-9 diagnosis code to us for Health Home encounter claims is V6540.

The appropriate Health Home encounter procedure code must be used aas well as, all the other standard beneficiary specific data field information, one would routinely submit with any claim or encounter. Please see the Encounter Data Companion Guide for specific information not found in this guide.

Health Home Encounter Service/Procedure Codes

The three (3) service/procedure codes are outlined in the table below.

Encounter/Procedure Code	Encounter Code Description	Encounter Reporting Frequency
G9148	**Tier One** - Outreach, engagement and Health Action Plan development.	Once per lifetime per beneficiary enrolled in the Health Home program.
G9149	**Tier Two** - Intensive Health Home care coordination.	Once a month per beneficiary

G9150	**Tier Three** - Low-level Health Home care coordination.	Once a month per beneficiary.

Only one G code can be submitted for a client during any calendar month

G9148 - Tier One – Outreach, Engagement and Health Action Plan development:

- Once the outreach, engagement and Health Action Plan have been developed, the Care Coordination Organization submits a Tier One encounter code of G9148 claim to the QHH lead entity or MCO if the beneficiary is a managed care enrollee for payment.
- In turn the QHH lead entity and/or MCO submits the electronic encounter data transaction in the standard 837P format to HCA.
- This code is paid only once in a beneficiaries lifetime and must be completed before any other codes can be paid.

G9149 - Tier Two – Intensive Health Home care coordination

- This service is the highest level of care coordination.
- At a minimum, Tier Two includes one face-to-face visit with the beneficiary every month.
- At least one qualified Health Home Service must be provided by the Care Coordination Organization prior to submitting a claim for the Tier Two encounter code of G9149 to the QHH lead entity or MCO for payment.
- In turn the QHH lead entity and/or MCO submits the electronic encounter data transaction in the standard 837P format to HCA.
- This code is only paid once during any given month of service provided per beneficiary.

G9150 - Tier Three – Low level Health Home care coordination

- The maintenance of the beneficiary's self-management skills with periodic home visits and telephone calls to reassess health care needs with fewer contacts.
- At Tier Three the review of the HAP must occur minimally at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.
- At least one qualified Health Home Service must be provided by the Care Coordination Organization prior to submitting a claim for the Tier Three encounter code of G9150 to the QHH lead entity or MCO for payment.
- In turn the QHH lead entity and/or MCO submits the electronic encounter data transaction in the standard 837P format to HCA.

Unsuccessful Outreach:

Despite multiple attempts to contact a beneficiary in person, by phone and by mail, the care coordinator has been unable to engage the beneficiary. Document the attempted contacts in the beneficiary's record.

When a beneficiary is not actively participating in the Health Home program an encounter using the G9148, G9149, or G9150 cannot be submitted to reflect the outreach attempts.

Any questions the QHH lead entity and/or MCO has regarding SBE payments and Health Home services can send an email to: healthhomes@hca.wa.gov.

RSN SPECIFIC SECTION

Reporting Claim Types

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

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

Client Identifiers for RSNs

- If a client is a Medicaid client use the ProviderOne Client ID.
- If the client is Non-Medicaid but eligible for services, use the RSN Unique Consumer ID.
- Report the Client Date of Birth if known. If unknown refer to the instructions located in the 837 Professional and Institutional Encounter Data 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 their contract requirements.

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.101721502.122620132100.200000001.dat
(This name example is 42 characters)

RSN Appendices

RSN Data Dictionary:

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

Find the Data dictionary at:
http://www.dshs.wa.gov/pdf/dbhr/mh/mhrsndatadictionary2011.pdf

RSN Service Encounter Reporting Instructions (SERI):

SERI Provides RSNs with guidance on coding of encounters based on State Plan modalities and provider types. The latest document can be found at:

http://www.dshs.wa.gov/dbhr/sericptinformation.shtml