Encounter Data Reporting Guide:

- **Managed Care Organizations (MCO)**
- **Qualified Health Home Lead Entities (QHH)**
- **Behavioral Health Organizations (BHO)**

April 1, 2016

Washington State Health Care Authority

About this guide

This supersedes all previously published Agency Encounter Data Reporting Guides.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
All	Fixed broken links	Housekeeping
New Programs	Adding definition for Fully Integrated Managed Care (FIMC) and Behavioral Health Services Only (BHSO)	New managed care services that are integrating medical, mental health and substance use disorder benefits in Southwest Washington.
New Programs	Added FIMC and BHSO section under MCO Specific Section	New managed care services that are integrating medical, mental health and substance use disorder benefits
Add Definitions	Added Managed Care Organization (MCO) definition	Left out previously.
NDC Section	Removed bullets and code list in section as NDCs are a requirement when provided during outpatient and professional services.	Listing codes contradicted first paragraph requirement.
BHO Change	Regional Support Networks being phased out for Behavioral Health Organizations (BHO). Removed RSN definition and added BHO definition.	Per legislative mandate.
WISe SBE	Added Wraparound Intensive Service (WISe) Service Based Enhancement (SBE) information	Added WISe information to MCO section.

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.

Table of Contents

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Definitions

This section defines terms and abbreviations, including acronyms, used in this guide. Please refer to the Medicaid agency's online Medical Assistance Glossary for a more complete list of definitions.

Atypical Provider – Providers who don't provide medical services (e.g., non-emergency transportation, case management, or environmental modifications) and are not eligible to receive a NPI.

Behavioral Health Organization (BHO) – Contracted single entity that assumes responsibility and financial risk for providing substance use disorder (SUD) treatment, and mental health services.

Behavioral Health Services Only (BHSO) – Managed care program under which an MCO provides mental health and substance use disorder services.

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

CNSI – The contracted vendor for Washington State's Medicaid Management Information System (MMIS) known as ProviderOne.

Corrected Encounter – Encounter records corrected and resubmitted by the organization after an error rejected the original encounter or subsequent corrected encounters during the ProviderOne encounter edit process.

Delivery Case Rate – Payments approved by HCA for MCOs who perform a delivery of a newborn.

Encounter – A single healthcare service or a period of examination or treatment. HCA requires MCOs/BHOs/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 MCOs/BHOs/QHH lead entities in the standard 837 format and the National Council for Prescription Drug Program (NCPDP) 1.1 batch format.

Encounter Transaction Results Report (ETRR) – 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 detail of encounters processed.

ETRR number – The ProviderOne ETRR reference number that will be assigned to each unique encounter file produced.

Fully Integrated Managed Care (FIMC) – Managed care program under which an MCO provides medical, mental health, and substance use disorder services.

"GAP" Filling – Default coding formatted to pass level 1, 2 and 7 Electronic Data Interchange (EDI) edits. If the correct required information can't 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) – 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 (www.wpc-edi.com/hipaa/HIPAA_40.asp)

Managed Care Organization (MCO) – An organization having a certificate of authority or certification of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA enrollees under HCA managed care programs.

National Provider Identifier (NPI) – The standard unique identifier for all healthcare 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 – The 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.

Qualified Health Home (QHH) – Lead entities contracted with HCA to administer, oversee, and report encounters performed by their network of Care Coordination Organization (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 Provider – See attending provider.

RxCLAIM Pharmacy Point of Sale – A pharmacy claim/encounter processing system capable of receiving and adjudicating claims/encounters.

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

Wraparound Intensive Services (WISe) – Payments approved by HCA and DSHS to contracted WISe providers who provide services to Medicaid eligible individuals, up to 21 years of age with complex behavioral health needs, and their families.

General Information Section

Introduction

The Health Care Authority (HCA) publishes this Encounter Data Reporting Guide to assist contracted Managed Care Organizations (MCOs), Behavioral Health Organizations (BHO), 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, BHOs, 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.
- BHO Specific Section: This section includes specific information and guidance for the BHOs.

Standard Formats

Use this guide in conjunction with:

- 837 Healthcare Claim Professional and Institutional Guide (IG) version 5010. To purchase the IGs visit the http://www.wpc-edi.com/ (www.wpc-edi.com) or call (425) 562-2245.
- NCPDP telecommunication standard d.0 with NCPDP batch transaction standard 1.1. Obtain the standard from the National Council for Prescription Drug Programs website (www.ncpdp.org), call (408) 477-1000, or fax your request to (480) 767-1042.
- Washington State/CNSI 837 Professional, Institutional, and NCPDP Pharmacy encounter data companion guides (www.hca.wa.gov/medicaid/hipaa/)

Code Sets

HCA follows national standards and code sets found in:

Current Procedural Terminology (CPT)	https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp
Healthcare Common Procedure Coding System (HCPCS)	www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html
International Classification of Diseases Version 9 Clinical Modification (ICD-9-CM)	*Effective for dates of service before October 1, 2015* • http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/ • http://icd9cm.chrisendres.com/icd9cm/
International Classification of Diseases Version 10 Clinical Modification (ICD-10-CM)	*Effective for dates of service on and after October 1, 2015* • https://www.cms.gov/Medicare/Coding/ICD10/index.html • http://www.icd10data.com/

Other Helpful URLs

DSHS Division of Behavioral Health and Recovery (DBHR) Publications	https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/publications
HCA Medicaid Provider Guides, Provider Notes, and Apple Health information	www.hca.wa.gov/medicaid/billing/pages/bi.aspx
HIPAA 837I and 837P Implementation Guide	www.wpc-edi.com/hipaa/HIPAA_40.asp
Medi-Span® Master Drug Data Base	www.medispan.com
National Council for Prescription Drug Programs (NCPDP)	www.ncpdp.org
National Uniform Billing Committee Codes	www.nubc.org
Place of Service Code	www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
ProviderOne Secure File Transfer Protocol (SFTP) Directory	sftp://ftp.waproviderone.org *(Use for both Medical and Pharmacy Encounters. Requires a file transfer software to access)*
Quarterly NDC-HCPCD Crosswalk	https://www.cms.gov/McrPartBDrugAvgSalesPrice/01a18_2011ASPFiles.asp#TopOfPage

Revenue Code/Procedure Code Grid	www.hca.wa.gov/medicaid/hospitalpymt/Pages/outpatient.aspx *(Use the grid to help determine which revenue codes require the inclusion of a procedure code.)*
Taxonomy Codes	www.wpc-edi.com/codes/Codes.asp
HCA Secure File Transfer (SFT) Tumbleweed Server	https://sft.wa.gov/ *(SFT is separate from ProviderOne. HCA uses it to transfer confidential files and information.)*

Purpose

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

Reporting Frequency

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

The ProviderOne system has an automatic 365 day reporting limitation. Original encounters with dates of service over 365 days will be rejected. Adjustments to original encounters with dates of service over 730 days (two years from start date of service) 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 date of birth and 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, Rendering, Prescriber and other required providers in all provider segments.

ProviderOne has two NPI validation processes. 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.

The "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.

If the NPI is not known to the ProviderOne system the encounter record will reject and have an error message post identifying that the provider is not known to the system.

MCO/BHO/QHH Identifiers

To identify the MCO/BHO/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 specific to the Medicaid program the client is enrolled in such as: 105010101, 105010102, 105010103, 105010104, etc. as applicable.

ProviderOne Encounter Data Processing

Encounter Data Processing

Unless otherwise specified, the follow 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 displayed in the implementation guide.

Note: 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 5,000 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 5,000 claims.

- You may choose to combine several ST/SE segments of 5,000 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 5,000 claims each, rather than sending 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, BHO, 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>** – The trading partner ID. (Same as the 9digit ProviderOne ID)
- **<datetimestamp>** – the date and time stamp.
- **<originalfilename>** – The original file name derived by the trading partner.

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

Refer to the BHO specific section for the BHO file naming convention.

Transmitting Files

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

Upload Medical and Pharmacy Batch Encounter files to the ProviderOne SFTP Directory (sftp://ftp.waproviderone.org) – 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 Acknowledgement,
- HIPAA Error Folder,
- NCPDP Inbound,
- NCPDP Outbound,
- NCPDP Acknowledgement, 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 Acknowledgements

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 details level errors	File is resubmitted
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.

Note: 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 Acknowledgement

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

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 (TCN) – for reference, Encounter TCNs begin with "33", "34", "43", "44".
    - ✓ An ETRR Number.
    - ✓ The Error flags in sequential order.

- All Encounter Records will be listed with either:

000N	No edits posted. Encounter is accepted in ProviderOne.
000Y	Error edit posted. Check the edit list found in the MCO, Pharmacy, QHH, or BHO sections to determine if encounter rejected or accepted in ProviderOne.

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

    ✓ If you find that you didn't receive a response back on an ETRR for an encounter and it isn't in the following week's ETRR either, send an email to the HCA HIPAA Helpdesk (HIPAA-help@hca.wa.gov) with the claim number, file name, and the date the file was submitted.

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

    ✓ HCA expects errors to be corrected and retransmitted within 30 days of the original submission.

- **Remember**, only accepted encounter records are used during the rate setting review process, reconciliation, 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.

- 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).

- Encounter Errors are recorded by error number positions as illustrated above. Encounter Edit Error Occurrence values will be placed as follows:

  - Positions 1-59 837I and 837P encounter errors
  - Positions 60 through 150 reserved for future use in 837I and 837P encounters
  - Positions 151-179 NCPDP encounter errors
  - Positions 180 through 250 reserved for NCPDP encounter errors

The list of error edits is located in their respective section:

- Managed Care Section
- Pharmacy Section
- Health Homes Section
- BHO Section

Large ETRR

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

Original 837 Encounters

Original 837 Encounters are records that have not previously processed through HCA defined encounter edits. 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.

All ProviderOne original encounters will be assigned an 18-digit Transaction Control Number (TCN), and the eighth digit within the 18-digit TCN will be a '0' (e.g. 3309149**0**0034234000).

Corrected 837 Encounters

Corrected 837 Encounter records are resubmitted encounters that have been previously rejected by the ProviderOne encounter adjudication edit process or resubmitted by the MCO, BHO or QHH adjusting a previously accepted encounter.

All corrected, resubmitted encounters **must** include the original 18-digit Transaction Control Number (TCN).

Rejected Encounters

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.

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 each of the Edit lists located in the subsection related to the encounter.

Review the edit list to ensure that the TCN or line item truly rejected in ProviderOne.

Duplicate Encounter Records

A duplicate encounter record is defined as "multiple encounters where all fields are alike except for the ProviderOne TCNs and the Claim Submitter's Identifier or Transaction Reference Number." For MCOs and QHHs, duplicate encounters will reject with edits 98325 and 98328. For BHOs, the encounters will not reject but will 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 the ProviderOne processing system; this includes records within 837 files that have partial acknowledgement statuses.

HCA recommends that MCOs/BHOs/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, BHOs 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/BHO/QHH authorized designated staff must certify the data.

Each time you upload a file, send an email notification to the Encounter Data email box (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/BHO/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/BHO/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/BHO/QHH lead entity Contract in effect.*"

For an example of the email certification, see the appendices.

Monthly Certification Letter

At the end of the month, a signed original Letter of Certification needs to be sent to HCA that includes a list of all files submitted for the completed month. This includes files that have a rejected and partial acknowledgment status. Please indicate with an [R] if a file was rejected or a [P] for partial file status. Each file submitted must have its own unique file name.

Send the signed original Letter of Certification to:

MCO/QHH Lead Entities	BHO
Health Care Authority HCS/QCM PO BOX 45530 Olympia, WA 98584-5530	DSHS/DBHR Attn: BHO Oversight Unit PO BOX 45330 Olympia, WA 98504-5330

For an example of the Letter of Certification, see the appendices.

MCO Specific Section

MCO Claim Types and Format

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

Note: Ensure billing providers submit all information required for payment of the claim and that your claim system maintains all information required to report your encounter data.

837P

Any healthcare service that could be billed on the standard "1500 Health Insurance Claim" forms. These services usually include:

- Ambulatory Surgery Centers
- Anesthesia Services
- Durable Medical Equipment (DME) and Medical Supplies
- Laboratory and Radiology Interpretation
- Mental Health Services
- Physician Visits
- Physician-Based Surgical Services
- Substance Use Disorder (SUD) Services
- Therapy (i.e. Speech, Physical, Occupational)
- Transportation Services

837I

Any healthcare services and facility charges that could 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 and Treatment Centers
- Home Health and Hospice Services
- Kidney Centers
- Skilled Nursing Facility Stays
- Substance Use Disorder Residential Treatment Centers

NCPDP Batch 1.1 Format

All retail pharmacy services for prescription medicines and covered over-the-counter medicines.

Encounter Claim Usage

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

- Develop and establish capitation rates
- Evaluate health care quality
- Evaluate contractor performance
- Evaluate health care service utilization
- Obtain Medicaid Drug Rebates

Fully Integrated Managed Care (FIMC) & Behavioral Health Services Only (BHSO)

Mental health and substance use disorder (SUD) services are now included benefits being covered by the MCO.

Encounters for mental health and SUD services need to be submitted in the correct format.

MCOs currently contracted in areas where FIMC and BHSO programs are operational will need to be sure to include all of mental health and SUD encounters when submitting.

MCO 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.

MCO Client Identifiers

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.

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

Once you have the ID, please submit the newborn's encounter claims with the corresponding 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 mother's ID with the special indicator of B (SCI=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.

MCO Provider Identifiers

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 for the provider that billed the MCO for the services. For pharmacy files, report the servicing provider NPI (Field 201-B1).

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 (Field 880-K1) segments. This is how the system identifies which MCO submitted the encounter data.

Note: If the Billing Provider or 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".

Provider NPIs 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 providers contracted with an MCO 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. Encounters will reject if the NPI is not active in ProviderOne for the dates of service for the encounter.

To validate a provider's NPI, use the National Plan & Provider Enumeration System (NPPES) website: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Reporting Non-NPI (Atypical) Providers

Non-NPI (Atypical) providers usually provide services to 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 don't quality for an NPI.
- Correct use of the API will be measured by HCA on a regular basis.

Denied Service Line

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 specific denial codes listed in the 837 Encounter Companion Guide and as directed in the sub-section below.

Use segment HCP in Loop 2400 for reporting service line payments. Line level payments can be mixed (i.e., denied line, paid line, and capitated line).

Use segment HCP in Loop 2300 of the 837 encounter to report the "total paid amount" for the entire claim. *Refer to the "MCO Paid Amount" subsection.*

Service lines denied by the MCO will bypass edits pertaining to:

- Age related edits,
- Gender specific edits,
- Procedure code edits, and
- Diagnosis code edits.

Denied Service Lines with 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 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.

MCO 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: MCO paid a claim on 10/01/2013.
Loop 2300 DTP segment would look like: **DTP*050*D8*20131001**~

Note: See edits 00870 and 00865 for errors that post related to the “Paid Date”.

MCO Paid Amount

HCA requires Managed Care Organizations to report the paid amount for each medical, pharmacy and health home service encounter. *See Pharmacy Encounter section for NCPDP specific information.*

“Paid Amount” 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 “paid amount” as well as to report denied service lines of a paid claim.

Inpatient Encounters

For inpatient encounters submitted on an 837 Institutional file, the HCP segments (MCO paid amount) must be reported at both header and line level. HCA expects all services (revenue codes) related to the respective inpatient stay to be listed on the encounter claim.

HCA requires the following format to appear on inpatient encounters:

- The HCP 02 segment of the first line of the inpatient encounter should mirror what is listed at the header HCP 02 segment.

- Any lines after line one included in the payment for the inpatient encounter should be listed with a code of '02' in the HCP 01 segment (meaning MCO paid FFS) and a value of $0.00 in the HCP 02 segment.

If any lines after line one is not included in the header level payment, then the line should be submitted with a code of '00' in the HCP 01 segment with a value of $0.00 in HCP 02 segment.

How to use HCP segments

Scenarios below will guide you if any part of a claim was either paid by the MCO via fee-for-service or capitated payment arrangement, or denied.

SCENARIO	LOOP 2300 HCP SEGMENT	LOOP 2400 HCP SEGMENT
Claim partially denied by the MCO	HCP 01 = '02' And HCP 02 = 1530 (Total $ 'paid amount' 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 fee-for-service (FFS)	HCP 01 = '02' And HCP 02 = 2805 (Total $ 'paid amount' 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' And HCP 02 = 0	Each line item will have own value: 1. HCP 01 = '07' HCP 02 = 0 2. HCP 01 = '07' HCP 02 = 0

Claim partially paid by capitation and partially paid by MCO FFS directly to provider.	HCP 01 =‘02’ And HCP 02 = 1530 (Total $ ‘paid amount’ to provider)	Each line item will have own value: 1. HCP 01 = ‘07’ HCP 02 = 0 2. HCP 01 = ‘02’ HCP 02 = 1530
For formatting specifics, refer to the 837 Encounter Data Companion Guide and HIPAA Implementation Guide.		

Correcting and Resubmitting Encounter Records

When correcting an error, making 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.

Adjusting Encounters

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.’

Voiding Encounters

To void a previously reported encounter, use Claim Frequency Type Code ‘8.’ Previously reported encounters that are rejected cannot be voided.

Rejected Encounters

Rejected encounters should be replaced. When resubmitting a previously rejected encounter, make sure to use Claim Frequency Type Code ‘1’ or ‘7’.

National Drug Codes (NDC)

HCA requires all MCOs to report the NDC of drugs provided during outpatient and professional services. The ProviderOne system will reject the encounter with error/edit code 03640 “missing or invalid NDC”.

Delivery Case Rate Service Based Enhancement (DCR SBE)

The MCO must incur the expense related to the delivery of a newborn for HCA to pay the MCO a DCR SBE.

ProviderOne will "flag" encounters with any codes listed in the section under "Maternity Codes That Will Trigger a DCR SBE".

HCA will review encounter records for females under the age of 12 and over the age of 60.

ProviderOne will verify the following for DCR SBE payment:

- The client's eligibility and enrollment with the MCO.
- The last time HCA paid an SBE for the client - only one SBE per pregnancy within a nine-month period is paid.
- 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.
- For outpatient hospital delivery services, the encounter must include the statement 'From-To' date to generate the SBE.
- For professional encounters, the admission date field (not required) should not be used for any other date than the admission date, when reported.

Non-Payment of the DCR SBE.

MCOs will not receive a DCR SBE in the following situations:

- An abortion or miscarriage.
- Multiple births (only one SBE payment is paid).
- Patient is male.
- Patient is enrolled under the Apple Health Blind/Disabled (AHBD) program or Community Options Program Entry System (COPES).
- Claim was paid by a "Primary Insurance Carrier" other than the MCO.
- The encounter is rejected by an edit. The encounter must be fully accepted to generate the SBE payment.

- MCO on the encounter doesn't match the MCO the client is enrolled with on the date of admission. The admission date, when present, also applies to professional encounter claims.

- The MCO paid amount is not listed on the encounter claim.

Recoupment of DCR SBE Payments

HCA will recoup SBE payment when:

- An MCO voids the encounter which generated the SBE.

- The MCO voids the encounter which generated the SBE and there were 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 an SBE. The first SBE will be recouped and a new SBE will be generated from the replacement encounter.

Maternity Codes That Will Trigger a DCR SBE

HOSPITAL – 837 INSTITUTIONAL		
DRG Codes	• 540 – Cesarean Delivery • 541 – Vaginal Delivery with Sterilization or D & C • 542 – Vaginal Delivery with Complicating Procedure Excluding Sterilization or D & 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 (ICD-9)	***For Dates of Service before October 1, 2015.*** Labor & Delivery and other indications for care in pregnancy. The **Primary ICD-9** diagnosis code **must** be between 644.00 – 669.94.	

Diagnosis Codes (ICD-10)	***For Dates of Service on and after October 1, 2015.*** Labor & Delivery and other indications for care in pregnancy. The **Primary ICD-10** diagnosis code **must** be the following code, or within the code ranges: O09.40-O09.529, O10.011-O16.9, O20.0-O21.9, O23.00-O26.93, O29.011-O30.019, O30.031-O35.6xx9, O35.8xx0-O36.73x9, O36.8120-O36.8199, O36.8910-O48.1, O60.00-O77.9, O80-O82, O86.11, O86.13, O86.19, O86.20-O86.29, O88.12, O89.01-O89.9, O90.2, O90.4-O90.9, O98.011-O9A.53, Z13.89
Claim Type	Claim Type = Inpatient Hospital with type of bill 11x. Outpatient OPPS payment claim with procedure codes listed above.

PHYSICIAN – 837 Professional		
Procedure Codes	• 59400 • 59409 • 59410 • 59510 • 59514 • 59515	• 59610 • 59612 • 59614 • 59618 • 59620 • 59622
Claim Type	Claim Type = 1500 Health Insurance Claim Form	

Wraparound Intensive Services (WISe)

Under the FIMC and BHSO program, an MCO receives a WISe Service Based Enhancement (SBE) when a contracted WISe provider submits an encounter indicating a WISe SBE eligible service has been provided.

ProviderOne will verify the following for WISe SBE payment:

- The client's eligibility and enrollment with the MCO under the FIMC or BHSO.
- The Modifier 'U8' is submitted in combination with the allowed CPT/HCPCS codes on the encounter.
- The last time HCA paid an SBE for the client - only one SBE per month is paid.
- The services are provided by a WISe certified provider.

Procedure Code that will trigger a WISe SBE

Procedure Codes	• **90791** • **90792** • **90832** • **90834** • **90837** • **90846** • **90847** • **90849** • **90853** • **90889** • **96101** • **96102** • **96193** • **96110** • **96111** • **96116** • **96118** • **96119**	• **96120** • **96372** • **99075** • **99201** • **99203** • **99204** • **99205** • **99211** • **99212** • **99213** • **99214** • **99215** • **99324** • **99325** • **99326** • **99327** • **99328** • **99334**	• **99335** • **99336** • **99337** • **99341** • **99342** • **99343** • **99344** • **99345** • **99347** • **99348** • **99349** • **99350** • **H0004** • **H0023** • **H0025** • **H0030** • **H0031** • **H0032**	• **H0033** • **H0034** • **H0036** • **H0038** • **H0046** • **H2011** • **H2014** • **H2015** • **H2017** • **H2021** • **H2027** • **H2033** • **S9446** • **T1001** • **T1023**

Non-Payment of the WISe SBE.

MCOs will not receive a WISe SBE payment for the following reason:

- Individual is over the age of 21
- The encounter is rejected by an edit.
- Invalid ProviderOne Client ID

Recoupment of WISe SBE Payments

HCA will recoup SBE payment when:

- An MCO voids the encounter which generated the SBE.
- The MCO voids the encounter which generated the SBE and there were 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 an SBE. The first SBE will be recouped and a new SBE will be generated from the replacement encounter.

Managed Care Encounter Error Code List

Sequence Number	Error Code	Error Code Description	MCO Disposition
1	00005	Missing From Date of Service	Reject
2	00010	Billing Date is before Service Date	Reject
3	00045	Missing or Invalid Admit Date	Reject
4	00070	Invalid Patient Status	Reject
5	00135	Missing Units of Service or Days	Reject
6	00190	Claim Past Timely Filing Limitation	Accept
7	00265	Original TCN Not on File	Reject
8	00455	Invalid Place of Service	Reject
9	00550	Birth Weight Requires Review	Accept
10	00755	TCN Referenced has Previously Been Adjusted	Reject
11	00760	TCN Referenced is in Process of Being Adjusted	Reject
12	00825	Invalid Discharge Date	Reject
13	00835	Unable to Determine Claim Type	Reject
14	01005	Claim does not contain a Billing Provider NPI	Reject
15	01010	Claim Contains an Unrecognized Performing Provider NPI	Reject
16	01015	Claim contains an Unrecognized Billing Provider NPI	Reject
17	01280	Attending Provider Missing or Invalid	Reject
18	02110	Client ID not on file	Reject
19	02125	Recipient Date of Birth Mismatch	Reject
20	02145	Client Not Enrolled With MCO	Reject
21	02225	Client Not Eligible For All Dates of Service	Accept
22	02230	Claim spans Eligible and Ineligible Periods of Coverage	Reject
23	02255	Client is not Eligible for this Date of Service	Accept
24	03000	Missing/Invalid Procedure Code	Reject
25	03010	Invalid Primary Procedure	Reject
26	03015	Invalid 2ND Procedure	Reject
27	03055	Primary Diagnosis not found on the Reference File	Reject
28	03065	Diagnosis Not Valid For Client Age	Accept
29	03100	Diagnosis not Valid for Client Gender	Accept
30	03130	Procedure Code Missing or not on Reference File	Reject
31	03145	Service not allowed for client's age	Accept
32	03150	Procedure Not Valid For Client Gender	Accept
33	03175	Invalid Place of Service For Procedure	Accept
34	03230	Invalid Procedure Code Modifier	Accept
35	03340	Secondary Diagnosis not found on the Reference File	Reject
36	03555	Revenue Code Billed Not on The Reference Table	Reject
37	03935	Revenue Code Requires Procedure Code	Reject
40	98328	Duplicate HIPAA Billing	Reject
41	01020	Invalid Pay-To Provider	Accept
43	99405	Claim Missing Required HCP Amounts	Reject
47	03640	Missing or Invalid NDC Number	Reject
48	03645	Procedure Code Invalid With NDC	Reject

Sequence Number	Error Code	Error Code Description	MCO Disposition
49	01006	Missing/Invalid Managed Care Program ID	Reject
50	00535	First Date of Service more than 2 Years Old	Reject
54	00762	Claim was already credited	Reject
55	98325	Claim is an Exact Duplicate	Reject
56	00865	Invalid or Missing Managed Care Paid Date	Reject
57	00870	Encounter was not filed on timely basis	Reject
58	00006	Invalid claim Date of Service	Reject
59	02100	Missing or Invalid Client ID	Reject
60	00125	"TO" Date is Before "FROM" Date	Reject
61	02121	Recipient Gender Missing or Invalid	Reject
62	03885	Claim Dates of Service do not fall within the Begin or End of the Diagnosis Code on the Reference File	Reject
63	03886	Dates of claim versus dates of Diagnosis Reference File - Header	Reject

Premium Payment and Other Inquiry

MCO Premium Payment and Other Inquiry Form

The Managed Care Premium Payment and Other Inquiry Form (PPOIF), also known as Premium and Adjustment Request Form (PARF), is designed as a general purpose form for use by MCOs to request assistance regarding regular premium, newborn premium, SBE payment and other inquiries.

Use this form to submit inquires for:

- **Newborns** – Premiums not paid for months in which the first 21 days of life occurred. Submit inquires if after 180 days from the date of birth (DOB) the newborn premium has not been paid and the newborn doesn't have a ProviderOne client ID.

- **Delivery Case Rate Service Based Enhancement (DCR SBE)** – 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 DCR SBE inquiries.

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

- **Other Inquiries** – Includes verification of:
  - ✓ Address,
  - ✓ Name,
  - ✓ Head of Household (HOH),
  - ✓ Date of birth (DOB),
  - ✓ Date of death (DOD),
  - ✓ Social security number, or
  - ✓ Newborns.

The MCO must complete all actions available, including, but not limited to, correcting rejected encounters and reviewing all audit files in order to resolve the issue before submitting a form for HCA to research. If the MCO is still unable to resolve the issue, then a PPOIF should be completed.

Newborns, DCR, WISe, Other Inquiries

- Upload the form to the "Encounter Data" folder in the HCA Secure File Transfer (SFT) server. (https://sft.wa.gov/)

- Email the HCA ProviderOne (MMIS) help desk (MMISHelp@hca.wa.gov) when a document is uploaded.

- Wait 30 days before sending questions regarding the status of the PPOIF. Reply back to the auto-reply that has the help ticket information in the subject line.

Regular Premium Inquiries

- Upload the form to the "Managed Care" folder in the HCA Secure File Transfer (SFT) server. (https://sft.wa.gov/)

- Email Managed Care Programs (HCAMCprograms@hca.wa.gov) when a document is uploaded.

- Wait 30 days before sending questions regarding the status of the inquiry. Submit your question by email to Managed Care Programs (HCAMCprograms@hca.wa.gov).

PPOIF File Naming Convention

Newborns, DCR, WISe, Other Inquiries Naming Convention

The file naming convention includes all of the following elements:

<SequenceNumber>_<PlanName>_<SubmitDate>_POIFF.doc

- **<SequenceNumber>** – The sequence number (YY-001, YY-002, YY-003)
- **<PlanName>** – The MCO name abbreviated
- **<SubmitDate>** – Date submitted (MMDDYYYY)

Example of file name: **12-001_HCA_06152010_PPOIF.doc**

Regular Premium Inquiries Naming Convention

The file naming convention includes all of the following elements:

<SequenceNumber>_<PlanName>_<SubmitDate>_REG_PREM_RECON_RPT.doc

- **<SequenceNumber>** – The sequence number (YY-001, YY-002, YY-003)
- **<PlanName>** – The MCO name abbreviated
- **<SubmitDate>** – Date submitted (MMDDYYYY)

Example of file name: **12-001_HCA_06152010_ REG_PREM_RECON_RPT.doc**

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. Any forms with multiple inquiry types on one form will be returned to be corrected and resubmitted.

See the appendices section at the end of this document for an example of the Premium Payment and Other Inquiry Form (PPOIF).

Retail Pharmacy Section

Retail Pharmacy Data Processing

HCA requires the following:

- The standard NCPDP Batch 1.1 – The 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®. Drug manufacturers report their products to Medi-Span®. If an NDC isn't listed in Medi-Span®, ProviderOne will reject the encounter.

Note: HCA has found that most pharmacies in the State of Washington are able to use the Medi-Span® file. Other NDC contractor files are okay to use but are updated at different times, which may cause your encounter to reject.

Retail Pharmacy Required Field

- 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.

- 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 or more 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's formatted incorrectly.

- Unzipped Batch Files – The ProviderOne SFTP service 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 RxCLAIM Pharmacy Point of Sale (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.

Pharmacy Naming Standard

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

NCPDP.<SubmitterID>.<datetimestamp>.<originalfilename>.dat

- **<SubmitterID>** – The submitter ID. (Same as the 9-digit ProviderOne ID)
- **<datetimestamp> –** The date and time stamp.
- **<originalfilename> –** The original file name derived by the trading partner.

Example of file name: **NCPDP.101721502.122620072100.NCPDPFile.dat**
(This name example is 42 characters.)

Pharmacy Encounter Processing

To submit your NCPDP 1.1 batch encounter data file:

- Create encounter pharmacy files in the NCPDP 1.1 batch file format. Each encounter record will be in NCPDP D.0 format.

Note: Don't zip/compress your pharmacy encounter files.

- Upload your NCPDP 1.1 batch encounter files to the ProviderOne SFTP Directory NCPDP Inbound Folder.

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

File Acknowledgements

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

- 999s are not generated for the 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.

Note: The NCPDP Acknowledgment is similar in format to the 837 Custom Report generated with the 999 acknowledgement. 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 RxCLAIM Pharmacy Point of Sale 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 retrieved 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 system will find, void, and replace the original record based on the **Transaction Code field value.**

Follow the NCPDP standard for reversals.

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

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)

Pharmacy/NCPDP Encounter Error Code List

Sequence Number	Error Code	Error Code Description	Pharmacy Disposition
151	99075 RC: 50	Non-Matched Pharmacy Number	Reject
152	99077 RC: 52	Non-Matched Cardholder ID	Reject
153	99147 RC: CB	Missing/Invalid Patient Last Name	Reject
154	99009 RC: 09	Missing/Invalid Date Of Birth	Reject
155	99010 RC: 10	Missing/Invalid Patient Gender Code	Reject
156	99114 RC: 83	Duplicate Paid/Captured Claim	Reject

Sequence Number	Error Code	Error Code Description	Pharmacy Disposition
157	99023 RC: 21	Missing/Invalid Product/Service ID	Reject
158	99094 RC: 67	Filled Before Coverage Effective	Reject
159	99095 RC: 68	Filled After Coverage Expired	Reject
160	99099 RC: 70	Product/Service Not Covered	Reject
162	99113 RC: 82	Claim Is Post-Dated	Reject
163	99096 RC: 69	Filled After Coverage Terminated	Reject
164	99115 RC: 84	Claim Has Not Been Paid/Captured	Reject
165	99106 RC: 77	Discontinued Product/Service ID Number	Reject
166	99030 RC: 28	Missing/Invalid Date Prescription Written	Reject
167	99188 RC: E7	Missing/Invalid Quantity Dispensed	Reject
168	99195 RC: EE	Missing/Invalid Compound Ingredient Drug Cost	Reject
169	99286 RC: UE	Missing/Invalid Compound Ingredient Basis Of Cost Determination	Reject
170	99170 RC: DN	Missing/Invalid Basis Of Cost Determination	Reject
171	99027 RC: 25	Missing/Invalid Prescriber ID	Reject
172	99005 RC: 05	Missing/Invalid Service/Provider Number	Reject
173	99007 RC: 07	Missing/Invalid Cardholder ID	Reject
174	99013 RC: 13	Missing/Invalid Other Coverage Code	Reject
175	99116 RC: 85	Claim Not Processed	Reject
176	99193 RC: EC	Missing/Invalid Compound Ingredient Component Count	Reject
177	99092 RC: 65	Patient Is Not Covered	Reject
178	99105 RC: 76	Plan Limitations Exceeded	Reject
179	99234 RC: M2	Recipient Locked In	Reject

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 that provide the care coordination services to health home beneficiaries enrolled with the MCO 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 251B00000X. The standard ICD-9 diagnosis code for Health Home encounter claims is V6540. Effective with dates of service on and after October 1, 2015, the ICD-10 code to use is Z719.

The appropriate Health Home encounter procedure code must be used. All other standard beneficiary specific data field information one would routinely submit with any claim or encounter must also be submitted. 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 per month per beneficiary
G9150	Tier Three – Low-level Health Home care coordination	Once per 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 (CCO) 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 beneficiary's lifetime and should be completed before any other codes are submitted.

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 CCO 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 CCO prior to submitting a claim for the tier three encounter code of G9150 to the QHH lead entity of 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 may be unable to engage the beneficiary. Document the attempted contacts in the beneficiary's record. QHH lead entities and MCOs may not submit encounter data until the beneficiary chooses to participate in the Health Home program and a Health Action Plan is completed.

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.

If the QHH lead entity and/or MCO has questions regarding SBE payments and Health Home services, send an email to the Health Homes Email inbox. (healthhomes@hca.wa.gov).

Health Home Encounter Error Code List

Sequence Number	Error Code	Error Code Description	Health Home Disposition
1	00005	Missing From Date of Service	Reject
2	00010	Billing Date is before Service Date	Reject
4	00070	Invalid Patient Status	Reject
5	00135	Missing Units of Service or Days	Reject
6	00190	Claim Past Timely Filing Limitation	Reject
7	00265	Original TCN Not on File	Reject
10	00755	TCN Referenced has Previously Been Adjusted	Reject
11	00760	TCN Referenced is in Process of Being Adjusted	Reject
13	00835	Unable To Determine Claim Type	Reject
15	01010	Claim Contains An Unrecognized Performing Provider NPI	Accept
16	01015	Claim contains an Unrecognized Billing Provider NPI	Accept
17	01280	Attending Provider Missing Or Invalid	Accept
18	02110	Client ID not on file	Reject
19	02125	Recipient Date of Birth Mismatch	Reject
20	02145	Client Not Enrolled With MCO	Reject
21	02225	Client Not Eligible For All Dates of Service	Accept
22	02230	Claim spans Eligible and Ineligible Periods of Coverage	Reject
23	02255	Client is not Eligible for this Date of Service	Accept
24	03000	Missing/Invalid Procedure Code	Reject

Sequence Number	Error Code	Error Code Description	Health Home Disposition
27	03055	Primary Diagnosis not found on the Reference File	Reject
28	03065	Diagnosis Not Valid For Client Age	Accept
29	03100	Diagnosis not Valid for Client Gender	Accept
30	03130	Procedure Code Missing or not on Reference File	Reject
31	03145	Service not allowed for client's age	Accept
32	03150	Procedure Not Valid For Client Gender	Accept
33	03175	Invalid Place of Service For Procedure	Accept
34	03230	Invalid Procedure Code Modifier	Accept
35	03340	Secondary Diagnosis not found on the Reference File	Reject
40	98328	Duplicate HIPAA Billing	Reject
41	01020	Invalid Pay to Provider	Accept
43	99405	Claim Missing Required HCP Amounts	Reject
49	01006	Missing/Invalid Managed Care Program ID	Reject
50	00535	First Date of Service more than 2 Years Old	Reject
54	00762	Claim was already credited	Reject
55	98325	Claim is an Exact Duplicate	Reject
58	00006	Invalid claim Date of Service	Reject
60	00125	“TO” Date is Before “FROM” Date	Reject
61	02121	Recipient Gender Missing or Invalid	Reject
62	03885	Claim Dates of Service do not fall within the begin or end of the Diagnosis Code on the Reference File	Reject
63	03886	Dates on claim versus dates on Diagnosis Reference file - Header	Reject

BHO Specific Section

Reporting Claim Types

839P – Includes any professional healthcare service described in the "Encounter Data Reporting Instructions."

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

BHO Client Identifiers

If a client is a Medicaid client use the ProviderOne Client ID.

If the client is Non-Medicaid but eligible for services, use the BHO 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

BHOs 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.*

BHO Reporting Frequency

BHOs report encounters according to their contract requirements.

BHO Guides

BHO Service Encounter Reporting Instructions (SERI) – SERI provides BHOs with guidance on coding of encounters based on State Plan modalities and provider types. (https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information)

BHO File Naming Convention

File names must not exceed 50 characters in length and must be named using the following format:

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

- **<TPID>** – The trading partner ID. (Same as the 9-digit ProviderOne ID)
- **<datetimestamp>** – the date and time stamp.
- **<originalfilename>** – The sequential number that begins with "200000000" and must be the same as the number derived for Loop "ISA", segment "13".

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

Wraparound Intensive Services (WISe)

The BHOs receives a WISe Service Based Enhancement (SBE) for services that the Department of Social and Health Services (DSHS) Division of Behavioral Health Recovery (DBHR) determines are appropriate.

BHO Encounter Error Code List

Sequence Number	Error Code	Error Description	BHO (Mental Health) Disposition
1	00005	Missing from date of service	Reject
2	00010	Billing date is before service date	Reject
3	00045	Missing or invalid admit date	Reject
4	00070	Invalid patient status	Reject
5	00135	Missing units of service or days	Reject
6	00190	Claim past timely filing limitation	Reject
7	00265	Original TCN not on file	Reject
8	00455	Invalid place of service	Reject
10	00755	TCN reference has previously been adjusted	Reject
11	00760	TCN referenced is in process of being adjusted	Reject
12	00825	Invalid discharge date	Reject
16	01015	Claim contains an unrecognized billing provider NPI	Reject
17	01280	Attending provider missing or invalid	Reject
24	03000	Missing/Invalid procedure code	Reject
27	03055	Primary diagnosis not found on the reference file	Reject
30	03130	Procedure code missing or not on reference file	Reject
35	03340	Secondary diagnosis not found on the reference file	Reject
36	03555	Revenue code billed not on the reference table	Reject
38	02185	Invalid BHO Association	Reject

Sequence Number	Error Code	Error Description	BHO (Mental Health) Disposition
39	02265	Invalid procedure code for Community Mental Health Center	Reject
41	01020	Invalid Pay-to-Provider	Reject
42	02121	Gender on client file doesn't match submitted gender	Reject
44	99410	Facility Type must be 11 for BHO encounters	Reject
45	99415	Admission Source must be 2 or 8 for BHO Encounters	Reject
46	99420	Revenue Code must be 0124 for BHO Encounter	Reject
49	01006	Missing/Invalid managed care program ID	Reject
50	00535	First date of service more than 2 or 3 years old	Reject
54	00762	Claim was already credited	Reject
55	98325	Claim is exact duplicate	Accept
58	00006	Invalid claim Date of Service	Reject
61	02121	Recipient Gender Missing or Invalid	Reject
62	03885	Claim Dates of Service do not fall within the Begin or End of the Diagnosis Code on Reference File	Reject
63	03886	Dates on claim versus dates on Diagnosis Reference file – Header	Reject

Appendices

Appendix A: Email Certification

To: ENCOUNTERDATA@hca.wa.gov
CC:
Subject: [MCO/BHO/QHH] 837/Rx Batch File Upload [Organization name or initials]

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/BHO/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/BHO/QHH lead entity Contract in effect.

Batch Number	Date Submitted (MM/DD/YYYY)	Number of Encounters	Number of Encounter Records	File Reject [R] Partial File [P]

Appendix B: 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/BHO/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/BHO/QHH lead entity 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/BHO/QHH Name]** were uploaded to ProviderOne on the following dates during the transmittal period:

Batch Number	Date Submitted (MM/DD/YYYY)	Number of Encounters	Number of Encounter Records	File Reject [R] Partial File [P]

Sincerely,

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

Appendix C: Premium Payment & Other Inquiry Form (PPOIF)

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

Purpose: The Managed Care Inquiry Form is to be used by Managed Care Organizations (MCOs) to ask general Managed Care questions (e.g., newborn, eligibility, premium payment/recoupments, etc) as well as Managed Care regular premium questions. The form will be used by HCA staff to research and respond to information provided.

Submission Requirements: See the PPOIF File Naming Convention section, in the Encounter Data Reporting Guide, for the proper naming of the file.

Email: See the Premium Payment and Other Inquiries Section, in the Encounter Data Reporting Guide, to locate the proper emails to send the document to.