Washington State Health Care Authority

Encounter Data Reporting Guide:

- **Managed Care Organizations (MCO)**
- **Managed Care Third-Party Administrators (TPA)**
- **Retail Pharmacy (NCPDP)**
- **Health Home Lead Entities (HH)**
- **Behavioral Health – Administrative Services Organizations (BH-ASO/ASO)**

Published July 9, 2024

About this guide

This supersedes all previously published 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 from the version of July 1, 2022?

Section – Subsection	Change	Reason for Change
MCO section – Community Behavioral Health Support Services SBE	New SBE to begin July 1, 2024 see pg. 42	See HCA Issue #38847
MCO section – New Journeys Encounter SBE	New SBE to begin July 1, 2024 see pg. 41	See HCA Issue #38848
General Updates	• Updated hyperlink for Health Home Services provided by Tribal Care Coordination Organizations pg. 59 • Updated hyperlink for Denied Service Lines pg. 31 • Updated Axway SFT to MFT pg. 16 • Updated Contact Info pg. 12 • Updated Pharmacy SBE pg. 39	General updates
Pharmacy/NCPDP Encounter CARC/RARC crosswalk	• Updated Reject codes and CARC/RARCs	See HCA Issue #37556
Retail Pharmacy Section	• Updated HCA drug file contractor from Medi-Span to First Data Bank • Updated "Amount Paid" field name from 430-DU to 509-F9	HCA new POS system
General Updates	• Updated Pharmacy/NCPDP Encounter CARC/RARC crosswalk for claim error 99172. RARC is updated to M79.	See HCA Issue #37556

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 835, 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. For a comprehensive list of medical assistance definitions, refer to WAC 182-500.

Atypical Providers – Providers who do not provide medical services (e.g., non-emergency transportation, case management, environmental modifications, etc.) and are not eligible to receive a National Provider Identifier (NPI).

Behavioral Health Administrative Services Organization (BH-ASO) – Contracted entity that administers behavioral health services and programs, including crisis services, for residents in a defined service area. Also referred to as Administrative Services Organization (ASO).

Behavioral Health Data Guide (BHDG) – The guide containing the reporting requirements for contracted entities to report behavioral health supplemental data per state and federal requirements to the Health Care Authority.

Behavioral Health Data System (BHDS) – The Health Care Authority database that houses the behavioral health supplemental transaction submissions from contracted entities that support state and federal reporting requirements.

Behavioral Health Organization (BHO) – Contracted entity that historically assumed responsibility and financial risk for providing substance use disorder services (SUDS) and mental health services in non-integrated regions through 12/31/2019. All regions have been integrated as of 1/1/2020. Refer to definitions for BH-ASO and MCO for services on and after 1/1/2020.

Behavioral Health Services Only (BHSO) – Managed care program under which an MCO provides mental health and substance use disorder services. Physical medical services are not provided through this program.

Behavioral Health Supplemental Transactions – Specific data submissions from contracted entities to the BHDS. These submissions are in addition to encounter submissions to ProviderOne.

Claim adjustment reason codes and remittance advice reason codes CARC/RARC – The adjustment and reason code sets used to report payment adjustments in the 835.

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

Corrected Encounters – Encounter records that have been corrected and resubmitted by an organization after rejection during the ProviderOne encounter edit process.

Delivery Case Rate (DCR) – A type of service-based enhancement (SBE) payment that is payable one time to an MCO for labor and delivery expenses incurred by the MCO for enrollees in certain programs who are enrolled with the MCO during the month of delivery. Certain claims criteria must be met in order for this payment to be made.

Duplicate Encounters – Multiple encounters in which all fields are alike except for the ProviderOne TCN and the Claim Submitter's Identifier or Transaction Reference Number.

Encounter – A single healthcare service or a period of examination or treatment. HCA requires all contracted entities to report encounter data for services delivered to clients who may or may not be enrolled in managed care. Enrollment and encounter submission requirements are outlined in the respective contracts.

Encounter Data Transactions – Electronic data files created by contracted entities in the standard 837 format and the National Council for Prescription Drug Program (NCPDP) 1.1 batch format for reporting of encounter data.

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

Foundational Community Services – A managed care program through which housing and employment services are provided by a contracted entity as a third-party administrator. The contracted entity must submit corresponding encounter data for these services.

"GAP" Filling – Default code formatting used to pass level 1, 2, and 7 Electronic Data Interchange (EDI) edits. If the correct formatting requirements cannot be met, HCA allows "filling" of the required fields with values allowing for validation and passage through the ProviderOne portal syntax. This "filling" is specific to format and syntax only and is not related to content. For example, if the field requires a particular length or if a particular segment is required that is not relevant to the claim or encounter process, use the most appropriate value from a list in the Implementation Guide (IG) for the situation. See the 837 Professional and Institutional Encounter Companion Guide for HCA-required fields.

Health Home Lead Entity (HH) – Entities contracted with HCA to administer, oversee, and report encounters performed by their network of Care Coordination Organizations (CCO) that provide health home services to Medicaid clients not enrolled in managed care.

Implementation Guide (IG) – Proprietary 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.

Indian Health Services (IHS) – Is responsible for providing direct medical and public health services to members of federally recognized Native American Tribes and Alaska Native people.

Managed Care Organization (MCO) – An organization having a certificate of authority or certification of registration from the Washington State Office of the 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 that was implemented as a requirement of the Health Information Portability & Accountability Act (HIPAA) of 1996 (45 CFR Part 162).

Network Billing Provider – The identifying information, including the NPI, of the provider who billed the Managed Care Organization (MCO) or other contracted entity for services rendered.

Original Encounter – The first submission of an encounter record that has not been processed previously 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.

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

Service Based Enhancement (SBE) – A payment enhancement generated for specific encounter services provided to Medicaid managed care enrollees, fee-for-service (FFS) health home beneficiaries, and FCS enrollees. This payment enhancement is made to the contracted entity submitting the encounters.

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 for Intensive Services (WISe) – Payment enhancements approved by HCA and DSHS to contracted WISe providers who serve Medicaid-eligible individuals, up to 21 years of age with complex behavioral health needs, and their families.

835 Health Care Claim Payment/Advice (also referred to as 835)- The standard HIPAA compliant Health Care remittance advice (RA) format that allows for secure sending and receiving of claims payment and adjustment information.

General Information Section

Introduction

The Health Care Authority (HCA) publishes this Encounter Data Reporting Guide to assist contracted entities to include Managed Care Organizations (MCOs), MCOs acting as third-party administrators, Health Home (HH) Lead Entities, and Behavioral Health/Administrative Services Organizations (BH-ASOs/ASOs) in the standard electronic encounter data reporting process.

Use this guide as a reference. It outlines how to transmit managed care, managed care third-party administrative, health home, behavioral health, and administrative services encounter data to HCA's ProviderOne payment system. It also outlines how to interpret the ProviderOne response files that are generated from encounter data transmissions. It is the responsibility of each contracted entity to follow the guidelines as outlined in this document when transmitting encounter data to ProviderOne.

Contact Information

Send technical questions about encounters and EDI submission, including questions pertaining to this guide, to HIPAA-HELP@hca.wa.gov.

Send managed care policy and contractual questions to hcamcprograms@hca.wa.gov.

Send behavioral health supplemental data questions to HCABHASO@hca.wa.gov.

There are five separate sections in this guide:

- General Information Section: This section includes guidance and instructions for all types of encounter data reporting and applies to all reporting entities including MCOs, MCO third-party administrators, HH Lead Entities, and BH-ASOs/ASOs.

- MCO Section: This section includes specific information and guidance for MCOs regarding medical and pharmacy encounter submissions.
    - MCOs should use this section for encounter submission guidelines for all managed care enrollees, regardless of program.
    - The MCO third-party administrator(s) should use this section for FCS encounter submission guidelines.
    - Any subcontractors submitting encounters on behalf of MCOs for MCO enrollees should use this for encounter submission guidelines.

- Retail Pharmacy Section: This section includes guidance for MCOs on submitting pharmacy encounters.

- Health Home Lead Entity Section: This section includes specific information and guidance for Health Home Lead Entities to report health home services provided to Medicaid fee-for-service (FFS) eligible clients including dual Medicare- and Medicaid-eligible clients and clients receiving services through tribal organizations.
    - Encounters for health home services provided to managed care enrollees should be submitted according to the guidelines in the MCO Section.

- BH-ASO/ASO Section This section includes specific information and guidance for encounter submission by contracted entities delivering crisis services to Medicaid and non-Medicaid clients as well as non-Medicaid services to Medicaid clients.

Standard Formats

Use this guide in conjunction with the following national standards:

- 835 Health Care Claim Payment/Advice, version 5010. To purchase the Implementation Guide (IG), visit http://www.wpc-edi.com/ or call (425) 562-2245.
- 837 Health Care Claim: Professional IG, version 5010. To purchase the IG, visit http://www.wpc-edi.com/ or call (425) 562-2245.
- 837 Health Care Claim: Institutional IG, version 5010. To purchase the IG, visit http://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 (480) 477-1000, or fax your request to (480) 767-1042.

Additional Formatting Requirements Specific to HCA

In addition to the standard formats noted above, the following Companion Guides must be followed for requirements specific to HCA:

- Washington State/CNSI 837 Professional and Institutional Encounter Data Companion Guide – The document is entitled "837 Encounters".
- NCPDP D.O. payer specification sheet
- NCPDP Pharmacy Encounter Companion Guide – The document is entitled "NCPDP Pharmacy Encounters".

Code Sets

HCA follows national standards and code sets found in the following publications. Each contracted entity is responsible for obtaining these publications and remaining up-to-date on each one:

Current Procedure Terminology (CPT)	CPT® (Current Procedural Terminology) | AMA (ama-assn.org)
Healthcare Common Procedure Coding System (HCPCS)	HCPCS - General Information | CMS

International Classification of Diseases Version 10 Clinical Modification (ICD-10-CM)	ICD-10 | CMS
Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)	External Code Lists | X12

Other Helpful URLs

HCA general information for billers and providers	Billers, providers, and partners | Washington State Health Care Authority
HCA managed care information	Managed care | Washington State Health Care Authority
HIPAA 837I and 837P Implementation Guide	www.wpc-edi.com/
HIPAA 835 Implementation Guide	www.wpc-edi.com/
First Data Bank® Master Drug Data Base	www.interactive.fdbhealth.com
National Council for Prescription Drug Programs (NCPDP)	www.ncpdp.org
National Uniform Billing Committee	www.nubc.org
Place of Service Code Set	Place of Service Code Set | CMS
ProviderOne Secure File Transfer Protocol (SFTP) Directory	sftp://ftp.waproviderone.org *(Use for all encounter submissions. Requires file transfer software to access.)*
Medicare Part B Drug Average Sales Price	Medicare Part B Drug Average Sales Price | CMS
Revenue Code/Procedure Code Grid	Forms and Publications | Washington State Health Care Authority *(Use the grid to help determine which revenue codes require the inclusion of a procedure code.)*
Taxonomy Codes	Find Your Taxonomy Code | CMS

MFT Site	https://mft.wa.gov/ *(The MFT site is different than the ProviderOne file submission site and is used to transfer confidential files and information.)*
835 Health Care Payment/Advice Companion Guide	HIPAA Electronic Data Interchange (EDI) | Washington State Health Care Authority
Washington State Department of Health (facility search)	Facility Search (wa.gov)
IMC Service Encounter Reporting Instructions (SERI)	Service Encounter Reporting Instructions (SERI) | Washington State Health Care Authority
Rural Health Clinic Billing Guide and Encounter Rates	Provider billing guides and fee schedules | Washington State Health Care Authority *(Scroll to link for "Rural health clinics (RHCs)")*
Tribal Health Program Billing Guide	Provider billing guides and fee schedules | Washington State Health Care Authority *(Scroll to link for "Tribal Health Program")*
Tribal NPI Classifications for MCOs	tribal-npi-classifications-tribal-affairs (wa.gov)
HCA Pharmacy Information	Pharmacy | Washington State Health Care Authority
Apple Health Preferred Drug List	Apple Health Preferred Drug List (PDL) | Washington State Health Care Authority
ProviderOne Billing and Resource Guide	ProviderOne Billing and Resource Guide | Washington State Health Care Authority
Behavioral Health Data Guide and other behavioral health resources	Contractor and provider resources | Washington State Health Care Authority
New Journeys Manual	New Journeys Program, Policy and Procedure Manual

Purpose

HCA requires encounter data reporting from contracted MCOs and MCO Third-Party Administrators, HH Lead Entities, and BH-ASOs/ASOs. Data reporting must include all healthcare, health home, behavioral health, substance use disorder, and certain administrative services delivered to eligible clients, and as additionally defined in the MCO, HH Lead Entity, or

BH-ASO/ASO sections of this guide.

Complete, accurate, and timely encounter reporting is the responsibility of each MCO, MCO Third-Party Administrator, HH Lead Entity, and BH-ASO/ASO.
Contracted entities must not omit or alter information on claims submitted to HCA as encounter data. It is the responsibility of each contractor to perform editing on claims submitted to them for payment. For purposes of meeting HCA's encounter submission requirements, the contractor must not automatically populate fields or override claims information sent to them by their contracted providers. Contractors should refer to their respective contracts for additional information.

Reporting Frequency

Encounters may be reported as often as daily. Otherwise, use the information in the MCO, HH Lead Entity, or BH-ASO/ASO sections as a guide for reporting frequency.

In addition to the section-specific reporting frequency noted above, note that the ProviderOne system has an automatic reporting limitation of 365 days. All encounters submitted outside of the requirement outlined in each section of this guide will be rejected. 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 the start date of service) will be rejected.

All contracted entities must submit encounter data according to their respective contracts regardless of whether the submissions are expected to be rejected by ProviderOne. The term "reject" is meant to reflect the status of an encounter within ProviderOne. Rejected encounter data is not discarded and is still collected by ProviderOne and used for various analyses.

ProviderOne Identifiers

Client Identifiers

Use the ProviderOne Client ID to report encounter data for medical, pharmacy, health home, behavioral health, substance use disorder, and certain administrative services as outlined in this guide. The ProviderOne Client ID should be used on all encounter data submissions unless otherwise instructed in this guide. 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) for identification of all Network Billing (Pay-to), Servicing, Attending, Referring, Rendering, and Prescribing providers on all encounters.

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 HIPAA Electronic Data Interchange (EDI) file validation process.

If an NPI fails the "Check Digit" edit (a Level 2 HIPAA error), the complete file will be rejected. The submitting organization will need to find and correct the problem and then transmit a corrected file.

If the NPI is not known to the ProviderOne system, or if the provider is not active for the date of service, then the encounter record will be rejected by ProviderOne with a corresponding error message indicating that the provider is not known to the system or is inactive for the date of service.

If the NPI is known to the ProviderOne system but items within the provider record need to be maintained/updated by the provider, the encounter record will reject with a corresponding error message indicating that the provider NPI is missing, invalid, or inactive on the date of service.

MCO, HH Lead Entity, and BH-ASO/ASO Identifiers

To identify the MCO, MCO Third-Party Administrator, HH Lead Entity, or BH-ASO/ASO submitting the encounter, follow the instructions in the 837 Professional and Institutional Encounter Data Companion Guide for 5010 transactions and in the NCPDP Pharmacy Encounter Companion Guide for pharmacy transactions. The 9-digit ProviderOne provider ID, which includes the 7-digit ProviderOne ID followed by a 2-digit location code, **must** be included in the following fields:

- Billing Provider Secondary Identification LOOP 2010BB using REF01 = G2 and REF02 for 5010 transactions; or

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

The ProviderOne IDs must be specific to the program (e.g., IMC, BHSO, health home, FCS, etc.)

as applicable.

ProviderOne Encounter Data Processing

Encounter Data Processing

Unless otherwise specified, the following information applies to all encounter types (medical, pharmacy, health home, behavioral health, substance use disorder, crisis, and administrative services).

Only accepted encounters are used for evaluation of rate development, risk adjustment, quality assurance and the generation of Service-Based Enhancement (SBE) payments. ProviderOne processes encounter files by receiving and checking the EDI file 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 ProviderOne system, and is ready for encounter processing.

Acceptance of the EDI file by ProviderOne is the first step of encounter processing. If the EDI file is accepted, then the file's transactions are processed to completion and assigned a status of "accepted" or "rejected" on the response file. If the EDI file is rejected, the file's transactions are not processed further. An accepted EDI file is not the same as an accepted encounter. "Accepted" is one of the system statuses assigned to an encounter processed by ProviderOne and is not meant to imply that the encounter will not be evaluated in future program integrity audits.

The following information describes the HIPAA Level edits that are performed on the EDI file:

- **Level 1:** Integrity editing
  - ✓ Verifies the EDI file for valid segments, segment order, and element attributes;
  - ✓ Edits for numeric values in numeric data elements; and
  - ✓ Validates 837 and NCPDP syntax in addition to compliance with specified rules.

- **Level 2:** Requirement editing
  - ✓ Verifies for HIPAA Implementation Guide (IG) specific syntax requirements, such as repeat counts, used and unused codes, elements and segments, and required or intra-segment situational data elements; and
  - ✓ Edits for non-medical code sets and values via a code list or table as displayed in the IG.

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 submitted encounter records should not exceed 100,000 per entity per day.

- Number of Segments/Records allowed by 837 HIPAA IG standards (HIPAA IG Standards limit the ST/SE envelope to a maximum of 5,000 CLM segments).

- File size limitation for all encounter files based on batch file size limitation of the ProviderOne SFTP Directory 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 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, MCO Third-Party Administrator, HH Lead Entity, BH-ASO/ASO, or clearinghouse in the Submitter segments. The ProviderOne 7-digit Provider ID plus the 2-digit location code is the Submitter ID.

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

File Naming for Medical 837 Encounters

Name files correctly by following the file naming standard below. Do not exceed 50 characters:

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

- **<TPID>** – The trading partner ID. (Same as the 7-digit ProviderOne ID plus the 2-digit location code)
- **<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 BH-ASO/ASO section for the BH-ASO/ASO file naming convention.

Transmitting Files

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

Upload encounter files to the ProviderOne SFTP Directory (sftp://ftp.waproviderone.org) to the 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 is used for production and one set is used for testing.

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

- 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 Acknowledgement** – 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 Second Action
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
Encounter file submitted	Submitter receives: ✓ Positive TA1 ✓ Positive 999 ✓ Positive Custom Report Identifies no HIPAA level 1 or 2 errors at 'ST/SE' envelope or detail levels	File moves forward for encounter record processing (edits)	837 is generated

Retrieve the TA1, 999, and Custom Report acknowledgements from the 'HIPAA Ack' or 'NCPDP Ack' folder in the SFTP Directory. These items should be ready for retrieval within 24 hours after file upload.

If the file was not HIPAA compliant, or was not recognized by ProviderOne, it will be moved to the HIPAA Error folder in the SFTP Directory. Correct the errors found 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 through the end of the file.

Any HIPAA 837 files that have partial acknowledgement statuses need only the rejected records resubmitted.

For NCPDP pharmacy files that have partial acknowledgement statuses, ALL records must be resubmitted.

Review each 999 or Custom Report Acknowledgement. Always verify the number of file uploads listed in the Monthly Certification Letter with the number of files returned on the 999 and Custom Report acknowledgements. See sample Monthly Certification Letter in Appendix B.

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 and compare the subsequent 999 and Custom Report acknowledgements with the resubmitted data file to determine whether 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

Correcting and Resubmitting Encounter Records

Frequency Type Usage
The frequency type used for encounter submission should mirror the provider's billing to the contracted entity. It is HCA's expectation that encounters are submitted without alteration of the claims data submitted by a provider. If claims information needs to be corrected in order for an encounter to be correctly submitted to HCA without alteration, the contracted entity should work with providers to accomplish correct claims submission and then submit the encounter data accordingly.

When correcting a submission 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. Use Claim Frequency Type Code '7'. Previously reported encounters that are rejected can be adjusted using 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 using Frequency Type Code '8'.

The submitting entity is responsible for voiding encounters when needed. Encounters are automatically voided by HCA in the following circumstances:

- When premiums are recouped for clients enrolled in Medicare.
- When HCA's periodic date-of-death audit shows encounters that have been submitted with dates of service after the enrolled client's date of death.

Resubmitting Rejected Encounters
Rejected encounters should be replaced by corrected encounters. Do not submit a new encounter when correcting previously rejected encounters. When resubmitting a correction to a previously rejected encounter, use Claim Frequency Type Code '7' and reference the encounter to be replaced.

Validation Process

835 Health Care Payment/Advice

An 835 transaction is the standard HIPAA compliant Health Care remittance advice (RA) format that allows for secure sending and receiving of claim payment and adjustment information.

The naming convention for the 835 outbound transaction is as follows:

HIPAA.<ProgramId>.<SubmitterID (9 digits)>.<datetime>.835.O.out

- **<ProgramID>** – The 7-digit ProviderOne ID and 2-digit location code.
- **<SubmitterID**> –The 7-digit ProviderOne ID and 2-digit location code.
- **<datetime> –** The date and time stamp.

Example of file name: **HIPPA.123456789.123456700.** 835.O.out

Original 837 Encounters

An original 837 encounter is the first submission of an encounter record that has not previously been processed through ProviderOne. Original 837 encounters include those that are being:

- 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), with the eighth digit being a '0' (e.g., 3309149**0**0034234000). Refer to the ProviderOne Billing and Resource Guide for additional details on reading the TCN.

Corrected 837 Encounters

Corrected 837 encounter records are those that have been corrected and resubmitted after having been rejected during the ProviderOne encounter edit process.

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

Rejected Encounters

To identify a rejected encounter at header or line, review the CARC (Claim Adjustment Reason Code) and, if present, the RARC (Remittance Advice Reason Code). The CARC will be in the CAS segment of the 835; the RARC, if present, will be in the LQ segment of the 835. CARCs and RARCs are present only for headers and lines that are rejected.

If the encounter is rejected at the header, or if all lines in the encounter are rejected, then the CLP02 segment will contain a value of "4" for rejected.

If any of the lines on the encounter are accepted, then the CLP02 segment will contain a value of "1" for accepted.

For further information and instruction on the 835 response, see the 835 Health Care Payment/Advice Implementation Guide and Companion Guide here: HIPAA Electronic Data Interchange (EDI) | Washington State Health Care Authority

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." Specific duplicate edits will reject encounters submitted by MCOs and their subcontractors, MCO Third-Party Administrators, and HH Lead Entities.

Encounters submitted under a BH-ASO/ASO ID will not be rejected as duplicates; however, the duplicate information is available in ProviderOne for internal analysis. Although the duplicate edits will not reject these particular encounters, every effort should be made to correct and resubmit records instead of submitting new records.

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 all submitting entities check their batch files for duplicate records prior to transmitting.

Note: Historically, duplicate submission was unintentional and was the result of attempts to void or replace encounter records without including the Original TCN.

Certification of Encounter Data

To comply with 42 CFR 438.606, all entities must certify the accuracy and completeness of submitted encounter data or other required data submissions concurrently with each 837 or NCPDP file upload. The Chief Executive Officer, Chief Financial Officer, or other authorized staff must certify the data. Each time a file is uploaded, a notification must be sent in one of two ways:

1. By uploading a completed "Daily Encounter Upload Notification" template to MC-Track® if the entity and contract information has been entered into MC-Track®. If you have not been previously notified about utilizing MC-Track®, then this option does not apply to you.
    a. The naming convention for completed templates uploaded to MC-Track® should adhere to the following: **<Date>.Daily Certification.<Submitter Name or Acronym>**

2. By sending an email notification to the Encounter Data email box (ENCOUNTERDATA@hca.wa.gov) using the format provided in Appendix A.
    a. The naming convention for emailed notifications should adhere to the following: [MCO Third-Party Administrator/HH Lead Entity/BH-ASO/ASO] 837 Batch File Upload [Organization name or initials]

The completed template submission or email notification will be the concurrent certification of the accuracy and completeness of the encounter data file at the time of submission.

Monthly Certification Letter

At the end of each month, a signed, original Monthly Certification Letter must 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.

Each time a file is uploaded, a notification must be sent in one of two ways:

1. By uploading a completed "Monthly Certification Letter" template to MC-Track® if the entity and contract information has been entered into MC-Track®. If you have not been previously notified about utilizing MC-Track®, then this option does not apply to you.
    a. The naming convention for completed templates uploaded to MC-Track® should adhere to the following: **<Date>.Monthly Certification.<Submitter Name or Acronym>**

2. By sending an email notification to the Encounter Data email box (ENCOUNTERDATA@hca.wa.gov) using the format provided in Appendix B.
    a. The naming convention for emailed notifications should adhere to the following: [MCO Third-Party Administrator/HH Lead Entity/BH-ASO/ASO] 837 Batch File Upload [Organization name or initials]

Note: Do NOT send any other correspondence or questions to the email address of ENCOUNTERDATA@hca.wa.gov.

MCO Claim Types and Format

The information on each reported encounter record must include all data billed/transmitted for payment from the service provider or subcontractor.

Do not alter paid claims data when reporting encounters to HCA. For example, data must not be stripped, split from the service provider's original claim, or revised from the original claim submission.

MCOs, MCO Third-Party Administrators, and subcontractors submitting on behalf of an MCO should follow the guidelines in this section. Reference to MCOs is intended to also include MCO Third-Party Administrators and subcontractors submitting on behalf of an MCO.

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

837P – Used for all healthcare services that can be billed on a standard "1500 Health Insurance Claim" form. These services usually include:

- Ambulatory Surgery Center Services
- Anesthesia Services
- Durable Medical Equipment (DME) and Medical Supplies
- Laboratory and Radiology Services
- Behavioral Health Services
- Physician Services
- Physician-Based Surgical Services
- Other Healthcare Professional Services
- Substance Use Disorder (SUD) Services
- Therapies (i.e., Speech, Physical, Occupational)
- Transportation Services
- Housing and Employment Services

837I – Used for all healthcare services and facility charges that can be billed on a standard "UB-04 Claim" form. These services usually include:

- Inpatient Hospital Stays
- Outpatient Hospital Services
- Evaluation and Treatment Center Services
- Home Health and Hospice Services
- Kidney Center Services
- Skilled Nursing Facility Stays
- Substance Use Disorder Residential Treatment Center Services

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

Encounter Claim Usage

Accepted encounters are used for a variety of financial and oversight analyses performed by HCA. Rejected encounters are not used. Accepted encounters are used for:

- Drug Rebate
- Rate Development
- Risk Adjustment
- Quality Assurance
- Contractual Quarterly Reconciliation of Encounter Data
- Utilization Review and Report Development

Fully Integrated Managed Care & Behavioral Health Services Only

Beginning April 1, 2016, behavioral health services and substance use disorder services were included within the Fully Integrated Managed Care (FIMC/IMC) program's scope of coverage. Clients enrolled in Behavioral Health Services Only (BHSO) are eligible for behavioral health services only, and all covered physical services are received through HCA's fee-for-service (FFS) system. Please refer to the applicable contract for more specifics.

As with other managed care programs, encounters submitted for all managed care enrollees must be submitted using the correct Submitter ID.

Note: Services not contained within the BHSO scope of coverage should not be submitted as non-covered or $0 paid in the encounter data.

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. For example, if an MCO processes a claim during the month of January, the encounter data is due to HCA no later than March 1. If an MCO processes a claim during the month of June, the encounter data is due to HCA no later than July 30. HCA verifies timely submissions through file upload dates and system review and analysis. Encounters received outside of this time limit will be rejected; there are no exceptions to this requirement.

MCO Client Identifiers

MCOs must use the ProviderOne Client ID on all encounter claim records. The client's date of birth and gender must be on every encounter record in the Subscriber/Patient Demographic Information segments.

Use the newborn's ProviderOne Client ID when submitting encounters for the newborn. If the newborn's ProviderOne ID is unknown, use the 270 benefit inquiry transaction to get the ID.

Submit a **Newborn** Payment Assistance Request Form (Newborn PARF) using the template found in MC-Track® in the following instances:

- The newborn has not been assigned a ProviderOne Client ID.

- The retro newborn premium(s) have not been received for premiums covering the first 21 days of life.

Only submit an encounter for newborn services using the mother's ProviderOne ID with the special indicator "B" (SCI=B) if you have taken the above steps to get the newborn's ID and are nearing the timely filing deadline.

MCO Provider Identifiers

Report the NPI and taxonomy codes for the Network Billing Provider as instructed in the Washington State/CNSI 837 Professional and Institutional Encounter Data Companion Guide (Loops 2000A PRV and 2010AA NM for 837 files). This entry must represent 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 (7-digit ProviderOne ID with the 2-digit location code as the suffix) 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 and validates whether the submitted information is correct.

Note: If the Network Billing Provider or the NCPDP Sender ID on the file does not match the ID of the program in which the client is enrolled at the time of service, the encounter will reject for "client not enrolled in MCO" on medical encounters and "Product/Service Not Covered" on pharmacy encounters.

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; however, the encounter will be rejected for having an unknown NPI.

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 or if the provider file is not kept up to date by the provider in ProviderOne for the dates of service on 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 DOH Certification Number for Behavioral Health Services

Effective May 15, 2019, MCOs must report the Department of Health (DOH) Certification number for the site providing the service in the encounter data. This number is needed in order to identify site-specific agencies and services being provided. Submit only the certification number and do not include any preceding characters, including "BHA.FS" (i.e., BHA.FS.12345678). Additional specifics on how to submit this information can be found in the Washington State/CNSI 837 Professional and Institutional Encounter Data

Companion Guide. The DOH certification number is site-specific and must be reported for all encounters submitted to the agency for behavioral health services.

Reporting Fully Denied Claims as Encounter Data to ProviderOne

The Centers for Medicare and Medicaid Services (CMS) issued national guidance requiring each state's contracted managed care plans to report encounter data for claims that the MCO fully denies. Historically, HCA has not required submission of this data; however, starting on 1/1/2021, HCA implemented this requirement for medical encounter submissions. Although specific error codes have not been implemented yet, all MCOs should be submitting this data as soon as possible.

In addition to the fully denied claim itself, MCOs also must submit the reasons for denial at both header and line. The complete list of codes for reporting denial reasons can be found in the X12 Claim Adjustment Reason Code set, referenced in the Health Care Claim Payment/Advice (835) Consolidated Guide, and available from the Washington Publishing Company.

For purposes of reporting to CMS, HCA considers an encounter to represent a fully denied claim when there is a value of '00' in the HCP01 field of the 2300 Loop (header) of the 837I or 837P HIPAA submission. HCA considers a paid or partially paid encounter to be one that is submitted with the value of '02' or '07' in the HCP01 field of the 2300 Loop (header) of the 837I or 837P HIPAA submission.

If HCP Data Element 01 Value at the Header is:	And HCP Data Element 01 Value at Line is:	Then HCA Interpretation is:
00	00 on all lines	MCO denied the entire claim and no payment was made
00	02 or 07 on any line	MCO denied the entire claim and no payment was made
02	00 on any line	MCO partially denied/partially paid the claim
07	00 on any line	MCO partially denied/partially paid the claim
02	02 or 07 on all lines	MCO paid the entire claim
07	02 or 07 on all lines	MCO paid the entire claim

HCA's expectation is that the same claim denial information – at header or line or at both header and line – sent to a billing provider by the MCO must be the same information that is submitted on encounter transactions to HCA. There are no exceptions to this expectation. The complete list of codes for reporting denial reasons can be found in the X12 Claim Adjustment Reason Code set, which is referenced in the Health Care Claim Payment/Advice (835) Consolidated Guide and available from the Washington Publishing Company.

Denied Service Lines

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

Use the specific denial codes listed in the Washington State/CNSI 837 Professional and Institutional Encounter Data 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 different from line to line on a claim (i.e., denied line, paid line, 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 HCA edits pertaining to:

- Age,
- Gender,
- Procedure codes, and
- Diagnosis codes.

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 be reported correctly, do not split or alter a partially paid claim that is missing procedure or diagnosis codes in denied lines.

MCO Paid Date

HCA requires that MCOs report the paid date for each encounter submitted.

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; for capitated encounters, submit the date of when the claim was processed.

Example: MCO paid a claim on 10/01/2017.
Loop 2300 DTP segment would look like: **DTP*050*D8*20171001**~

MCO Paid Amount

HCA requires that MCOs report the paid amount for each encounter submitted. *See Pharmacy Encounter section for NCPDP specific information.*

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

Designated HCP segments were added to the Washington State/CNSI 837 Professional and Institutional Encounter Data Companion Guide to provide an area to report the "MCO paid amount" as well as to report denied service lines on a paid claim.

Using HCP Segments for Reporting Paid Amounts on Inpatient Encounters

For inpatient encounters submitted on an 837 Institutional file, the HCP segments for "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 of the lines after line one is not included in the total header level payment, then the excluded line should be submitted with a code of '00' in the HCP 01 segment with a value of $0.00 in the HCP 02 segment.

Using HCP Segments for Reporting Paid Amounts on Other Encounters

The scenarios below are meant to be a guide for encounter submission when any part of a claim is paid by the MCO via fee-for-service or capitated payment arrangement or if any part of a claim is 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 its 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 its 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

SCENARIO	LOOP 2300 HCP SEGMENT	LOOP 2400 HCP SEGMENT
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 its own value: 1. HCP 01 = '07' HCP 02 = 0 2. HCP 01 = '02' HCP 02 = 1530
For formatting specifics, refer to the *Washington State/CNSI 837 Professional and Institutional Encounter Data Companion Guide* ***and HIPAA Implementation Guide.***		

MCO Paid Units

HCA requires that MCOs report the number of units being reimbursed for each submitted encounter.

Designated HCP segments were added to the Washington State/CNSI 837 Professional and Institutional Encounter Data Companion Guide to provide an area for the MCO to report "MCO paid units" for all services.

Please note that "paid units" may be different from a provider's billed units submitted on the claim. Do not alter the billed units on any claim; however, you must enter the actual paid units in the designated HCP segments. The units for measuring procedure codes and revenue codes may differ from line to line in the same encounter. Report each line with the appropriate valid value based on what type of units were utilized in order to reimburse the line(s). Paid units at the line level will not always equal the number of paid units at the header. Use the valid values based on the encounter type (837P or 837I) and how your system calculated the reimbursement.

Using HCP Segments for Reporting Paid Units on all Encounters

The scenarios below are meant to be a guide for encounter submission when reporting paid units for all services. Payment methodologies can differ from payer to payer; therefore, correct reporting should be based on the valid values and how reimbursement was calculated.

Paid units are required for every **service line** on professional and institutional encounters whether the line has been paid FFS or capitated. Paid units are required at the claim **header** for institutional encounters only and must be entered regardless of whether the claim has been paid FFS or capitated.

SCENARIO Encounter type (837P or 837I) Valid values for encounter type	LOOP 2300 HCP SEGMENT	LOOP 2400 HCP SEGMENT
837P – Claim partially denied by the MCO HCP 11 Valid Values **'MJ' = minutes** **'UN' = unit**	HCP 11 and HCP 12 are not applicable at the header on professional claims	Each line item will have its own value: 1. HCP 01 = '02'/HCP 02 = 1530 HCP 11 = 'UN'/HCP 12 = 4 2. HCP 01 = '00'/HCP 02 = 0 HCP 11 = 'UN'/HCP 12 = 0

SCENARIO **Encounter type (837P or 837I)** **Valid values for encounter type**	**LOOP 2300 HCP SEGMENT**	**LOOP 2400 HCP SEGMENT**
837P – Entire claim paid by MCO fee-for-service (FFS) HCP 11 Valid Values **'MJ' = minutes** **'UN' = unit**	HCP 11 and HCP 12 are not applicable at the header on professional claims	Each line item will have its own value: 1. HCP 01 = '02'/HCP 02 = 1530 HCP 11 = 'UN'/HCP 12 = 4 2. HCP 01 = '02'/HCP 02 = 1275 HCP 11 = 'UN'/HCP 12 = 15
837P – Entire claim paid by capitation arrangement HCP 11 Valid Values **'MJ' = minutes** **'UN' = unit**	HCP 11 and HCP 12 are not applicable at the header on professional claims	Each line item will have own value: 1. HCP 01 = '07'/HCP 02 = 0 HCP 11 = 'UN'/HCP 12 = 4 2. HCP 01 = '07'/HCP 02 = 0 HCP 11 = 'UN'/HCP 12 = 15
837P – Claim partially paid by capitation and partially paid by MCO FFS directly to provider HCP 11 Valid Values **'MJ' = minutes** **'UN' = unit**	HCP 11 and HCP 12 are not applicable at the header on professional claims	Each line item will have its own value: 1. HCP 01 = '07'/HCP 02 = 0 HCP 11 = 'UN'/HCP 12 = 4 2. HCP 01 = '02'/HCP 02 = 1530 HCP 11 = 'UN'/HCP 12 = 15
837I – Nursing home claim with multiple stays on one claim for total of 20 days HCP 11 Valid Values **'DA' = day** **'UN' = unit**	HCP 11 and HCP 12 are required at the header on institutional claims HCP 11 = 'DA' HCP 12 = 20	Each line item will have its own value: 1. HCP 11 = 'DA'/HCP 12 = 12 2. HCP 11 = 'DA'/HCP 12 = 8
837I – Kidney Center claim with multiple drugs provided during one comprehensive visit HCP 11 Valid Values **'DA' = day** **'UN' = unit**	HCP 11 and HCP 12 are required at the header on institutional claims and should reflect the total payment that may include several lines within the claim HCP 11 = 'DA' HCP 12 = 1	Each line item will have its own value: 1. HCP 11 = 'DA'/HCP 12 = 1 2. HCP 11 = 'UN'/HCP 12 = 50 3. HCP 11 = 'UN'/HCP 12 = 75

SCENARIO Encounter type (837P or 837I) Valid values for encounter type	LOOP 2300 HCP SEGMENT	LOOP 2400 HCP SEGMENT
837I – Inpatient claim for multiple days with multiple services provided and billed on one claim HCP 11 Valid Values **'DA' = day** **'UN' = unit**	HCP 11 and HCP 12 are required at the header on institutional claims and should reflect the total payment that may include several lines within the claim HCP 11 = 'DA' HCP 12 = 14	Each line item will have own value: 1. HCP 11 = 'DA'/HCP 12 = 1 2. HCP 11 = 'UN'/HCP 12 = 50 3. HCP 11 = 'UN'/HCP 12 = 75 4. HCP 11 = 'UN'/HCP 12 = 1

National Drug Codes (NDC)

HCA requires all MCOs to report the NDC of drugs provided during outpatient and professional services. The NDC must be effective for the date of service on the encounter. The ProviderOne system will reject the encounter with either edit code 03640 "missing or invalid NDC" or 03645 "Procedure Code Invalid With NDC" when an NDC is not present, incorrect, or not associated in the ProviderOne system with the appropriate procedure code.

Service Based Enhancements

Delivery Case Rate (DCR)

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

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

The diagnosis code and the procedure code must be on the list of codes that will trigger a DCR SBE in order to be eligible for the SBE. For example, if the diagnosis code and the procedure code are on the list of codes that will trigger payment, the SBE payment will generate only if the encounter is accepted.

If the diagnosis code is on the approved list and the procedure code is not, then the SBE will not generate regardless of an overall accepted status of the encounter. The same is true for inpatient DRG codes.

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

ProviderOne will verify the following for each DCR payment:

- The client's eligibility and enrollment with the MCO.
- The encounter is accepted.
- The last time HCA paid a DCR for the client – only one DCR per pregnancy within a nine-month period is paid without manual review being required.
- For inpatient hospital encounters, an admission date must be present to generate the DCR. The eligibility for payment of the DCR is based on the hospital "admission" date. The system uses APR-DRG (V38) to derive a valid DRG code for payment of the DCR.
- For outpatient hospital delivery services, the encounter must include the statement 'From-To' date to generate the DCR.
- 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

MCOs will not receive a DCR in the following situations:

- The encounter is rejected by an edit.
- An abortion or miscarriage.
- Multiple births (only one DCR payment is paid per pregnancy without additional manual review being required).
- Patient is male.
- Patient is enrolled under the Apple Health Blind/Disabled (AHBD) program or Community Options Program Entry System (COPES).
- HCA shall not pay the Delivery Case Rate payment for Enrollees who have comparable Third-Party Insurance coverage.
- The MCO on the encounter does not match the MCO with which the client is enrolled 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.

Maternity Codes That Will Trigger a DCR

HOSPITAL – 837 Institutional (837I)	
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 • 59510 • 59610 • 59618 • 59409 • 59514 • 59612 • 59620 • 59410 • 59515 • 59614 • 59622
Revenue Codes	Will not generate a DCR.
Claim Type	Inpatient Hospital with type of bill 11x. Outpatient/OPPS payment claim with procedure codes listed above.

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

DIAGNOSIS CODES – 837I and 837P
For Dates of Service on and after October 1, 2015, the primary ICD-10 diagnosis code must be related to labor and delivery and within the ranges below. Every diagnosis code in the below ranges is not valid for a DCR, and information is provided as reference only. Send questions to HIPAA-HELP@hca.wa.gov. From Chapter 15 – Pregnancy, childbirth and the puerperium (O00-O9A): • O09: Supervision of high-risk pregnancy • O10-O16: Edema, proteinuria & hypertensive disorders in pregnancy, childbirth & the puerperium • O20-O29: Other maternal disorders predominantly related to pregnancy (O22 invalid for DCR) • O30-O48: Maternal care related to the fetus and amniotic cavity and possible delivery problems • O60-O77: Complications of labor and delivery • O80-O82: Encounter for delivery • O85-O92: Complications predominantly related to puerperium (O85/O87/O91/O92 invalid for DCR) • O94-O9A: Other obstetric conditions, not elsewhere classified (O94 invalid for DCR) From Chapter 21 – Factors influencing health status and contact with health services (Z00-Z99): • Z1389

Wraparound with Intensive Services (WISe)

Under the FIMC/IMC, BHSO and Foster Care programs, an MCO receives a WISe payment when an encounter from a contracted WISe provider for a WISe-eligible service is submitted correctly and accepted by ProviderOne. Regardless of the number of months reflected by the dates of service on an encounter, only one WISe payment is made per encounter.

ProviderOne will verify the following prior to generating a WISe payment:

- The encounter must be accepted.
- The client's eligibility and enrollment with the MCO must be with the FIMC/IMC, BHSO or Foster Care program.
- The modifier 'U8' must be submitted in combination with the specified, allowed CPT/HCPCS codes on the encounter.
- The last time HCA made a WISe payment for the client – only one WISe payment per month is paid.
- The services must be provided by a WISe-certified provider.
- If multiple months of service are included on one encounter on several lines, a WISe payment is generated only once for any given month if the above criteria are met.

Non-Payment of the WISe SBE

MCOs will not receive a WISe payment if any of the following criteria are true:

- The encounter is rejected by an edit.
- The client is over the age of 21.
- The ProviderOne Client ID is invalid.
- The client is not enrolled in the FIMC/IMC, BHSO or Foster Care program.
- A WISe payment for the month of service already has been made.
- The service is not provided by a WISe-certified provider.
- The procedure code and modifier combination is incorrect.

Procedure Codes that will trigger a WISe Payment

Procedure Codes	• 90791 • 90792 • 90832 • 90834 • 90837 • 90846 • 90847 • 90849 • 90853 • 90889 • 96101 • 96102 • 96103 • 96110 • 96111 • 96116 • 96118 • 96119	• 96120 • 96372 • 99075 • 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 • H0031 • H0032 • H0033 • H0034	• H0036 • H0038 • H0046 • H2011 • H2014 • H2015 • H2017 • H2021 • H2027 • H2033 • S9446 • T1001 • T1023

Pharmacy SBE

Beginning July 1, 2019, an SBE will be generated for pharmacy encounters with drugs that are contained in the Apple Health Preferred Drug List (AHPDL). An SBE will not be generated for fill dates after December 31, 2020.

Beginning January 1, 2023, an SBE will be generated for pharmacy encounters for drugs identified in the contract as Administrative Services Only (ASO) Non-Contracted Drugs.

Non-payment of the Pharmacy SBE

A pharmacy SBE will not be generated if any of the following criteria are true:

- The encounter is rejected by an edit.
- The National Drug Code (NDC) on the encounter is not on the preferred drug list.
- The fill date is on or after January 1, 2021.

Rural Health Clinic SBE

Rural health clinics (RHCs) receive enhanced reimbursement in return for serving clients in medically underserved areas. Each RHC in Washington State receives a unique, clinic-specific rate (called the encounter rate) based on allowable costs. Per federal and state regulations, HCA must ensure each clinic receives its exact encounter rate for each qualifying visit.

Beginning January 1, 2020, an SBE will be paid for qualifying managed care encounters submitted by an MCO related to rural health clinic (RHC) visits. The SBE amount will be based on the paid amount entered by the MCO at line level for the T1015 procedure code for encounter-rate-eligible services, not to exceed the clinic's established encounter rate. Clinic encounter rates can be found here.

In order for an SBE to be generated, the submitted encounter must meet the criteria outlined in the agency's Rural Health Clinics Billing Guide.

Non-payment of the Rural Health Clinic SBE

An RHC SBE will not be generated if any of the following criteria are true:

- The encounter is rejected by an edit.
- The client is enrolled in the Behavioral Health Services Only (BHSO) program.
- No encounter-rate-eligible services are included on the submission.
- The encounter does not meet criteria outlined in the Rural Health Clinics Billing Guide, including the use of correct taxonomy code(s).
- The amount entered at line level for the T1015 procedure code is equal to or less than $0.

IHS Clinic SBE, Tribal 638 Clinic SBE, and Tribal FQHC SBE

Direct Indian Health Service (IHS) Clinics, Tribal 638 Clinics, and Tribal FQHCs receive an all-inclusive rate that is published by the federal Office of Management and Budget in the Federal Register on an annual basis. Under the Centennial Accord and Section 1902(a)(73) of the Social Security Act, the agency supports a government-to-government relationship between Tribes and the State of Washington and partners with federally recognized Tribes to use all possible Medicaid and state health funding to assist Tribes in addressing the health needs of American Indian/Alaska Natives (AI/ANs) and to raise their health status to the highest possible level.

Beginning April 1, 2020, an SBE will be paid for qualifying managed care encounters submitted by an MCO for outpatient tribal health services paid to IHS clinics, Tribal 638 clinics, and Tribal FQHCs for American Indian and Alaska Native (AI/AN) enrollees. The SBE amount will be based on the paid amount entered by the MCO at line level for the T1015 procedure code for IHS encounter-rate-eligible services, not to exceed the amount published annually by the Office of Management and Budget in the Federal Register.

In order for an SBE to be generated, the submitted encounter must meet the criteria outlined in the agency's Tribal Health Program Billing Guide.

Non-payment of IHS Clinic SBE, Tribal 638 Clinic SBE, or Tribal FQHC SBE

An IHS Clinic SBE, Tribal 638 Clinic SBE, or Tribal FQHC SBE will not be generated if any of the following criteria are true:

- The encounter is rejected by an edit.
- No encounter-rate-eligible services are included on the submission.
- The encounter does not meet criteria outlined in the Tribal Health Program Billing Guide, including the use of correct taxonomy code(s).
- The amount entered at line level for the T1015 procedure code is equal to or less than $0.

New Journeys SBE

For programmatic and policy guidelines for the New Journeys Coordinated Specialty Care, please refer to the New Journeys Policy Manual and the Service Encounter Reporting Instructions (SERI). The MCO will receive a New Journeys SBE payment when the following encounter criteria are met; however, the MCO should refer to the program manual and the SERI Guide for complete rules and guidelines. An SBE will be generated in the following circumstances:

- The encounter must be accepted;
- The service must be one of the three codes outlined below
- The service must be accompanied by an HT modifier;
- The billing provider must be HCA-approved;
- The billing provider's taxonomy must be 261QM0801X or 251S00000X; and
- The client receiving services must meet the New Journeys age criteria.

The below SBE's and corresponding procedure codes should be used choosing between two separate reimbursement structures based upon threshold of intensity and 24 months of intervention.

Option A SBE: **H2041 HT**-New Journeys Encounter rate

Option B SBE: **T2022 HT**-Tier 1-Engagement and Outreach Team Based Rate (TBR)

SBE: **T2023 HT**-Tier 2-Recovery and Resiliency Team Based Rate (TBR)

A. Encounter Rate: If the service intensity threshold described below is met, then the provider encounters using the H2041 HT code for every service encountered within SERI that has the HT modifier attached and is provided by a member of an attested New Journeys team.

- **Tier 1** Intake through the first 6 months: Up to 7 or less service encounters per month
- **Tier 2** Months 7-24: Up to 5 or less service encounters per month
- **After Tier 2** (greater than 24-months up to 5 years), encounter for every service encounter per month, max of 7 encounter rates in any given month.

B. Team Based Rate (TBR) is a two-tiered SBE based on length and intensity of treatment. The TBR is used once per month when a minimum number of encounters to meet the threshold required for the full model is met.

- **Tier 1**: (T2022 HT) – intake through the first 6 months
  8 or more encounters per month
  The individual lifetime maximum is six months at Tier 1

- **Tier 2**: (T2023 HT) – months 7-24
  6 or more encounters per month
  The individual lifetime maximum is 18 months at Tier 2
- **After Tier 2**: use Encounter rate

Non-payment of the New Journeys SBE

A New Journeys SBE will not be generated if any of the following criteria are true:

- The encounter is rejected by an edit.
- The encounter does not meet the criteria outlined in the New Journeys Policy Manual and the Service Encounter Reporting Instructions (SERI)Service Encounter Reporting Instructions (SERI) for the New Journeys Coordinated Specialty Care Program.
- The encounter does not contain the eligible procedure code and an HT modifier.
- The billing provider's NPI is not HCA-approved.
- The billing provider's taxonomy submitted on the encounter is not 261QM0801X or 251S00000X.
- The client does not meet the New Journeys age criteria.

Community Behavioral Health Support Services (CBHSS) SBE

For programmatic and policy guidelines for the Community Behavioral Health Support Services (CBHSS) program, please refer to . The MCO will receive CBHSS SBE payment when the following encounter criteria are met. An SBE will be generated in the following circumstances:

- The encounter must be accepted;

- The service must be one of the five procedure code/Modifier combinations outlined below:

    - Tier 1 – S5126 no modifier
    - Tier 2 – S5126 TF modifier
    - Tier 3 – S5126 HE modifier
    - Tier 4 – S5126 TG modifier
    - Tier 5 – S5126 HK modifier
    - Tier 6 – S5126 HI modifier

- The billing provider's taxonomy must:

    - Tier 1 services: Adult Family HomE-311ZA0620X; 310400000X; 3104A0625X
    - Tier 2 services: Adult Residential Care (ARC) Facility-311ZA0620X; 310400000X; 3104A0625X
    - Tier 3 services: Enhanced Adult Residential Care Facility-311ZA0620X; 310400000X; 3104A0625X
    - Tier 4 services: Assisted Living Facility-311ZA0620X; 310400000X; 3104A0625X
    - Tier 5 services: Enhanced Services Facilities-311ZA0620X; 310400000X; 3104A0625X
    - Tier 6 services: Adult Family Home-311ZA0620X; 310400000X; 3104A0625X

- The client receiving services must have the Community Behavioral Health Support Services client indicator in ProviderOne.

- The client receiving services must meet the CBHSS age criteria of 18 years of age or older.

Non-Payment of the CBHSS SBE

A CBHSS SBE will not be generated if any of the following criteria are true:

- The encounter is rejected by an edit.

- The encounter does not contain the eligible procedure code and modifier combination for the Tier of CBHSS service identified above.

- The billing provider's taxonomy submitted on the encounter is not one of the acceptable taxonomies for the Tier of CBHSS service identified above.

- The client does not meet the CBHSS age criteria of 18 years of age or older.

Recoupment of Service-Based Enhancements

HCA will recoup any type of SBE payment when any of the following are true:

- The MCO voids the encounter that generated the SBE payment.

- If the MCO voids the encounter that generated the SBE payment and there were other

qualifying encounters, then the first SBE payment will be recouped. A new SBE payment then will be generated from one of the other qualifying encounters.

- If the MCO voids and replaces an encounter that previously generated an SBE payment, then the first SBE payment will be recouped. A new SBE payment then will be generated from the replacement encounter if it meets applicable criteria.

- The client is disenrolled from the plan.

Managed Care Encounter CARC/RARC Crosswalk

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
00005	Missing from DATE OF SERVICE	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid "from" date(s) of service.
00010	Billing Date is before Service Date	Reject	110	Billing date predates service date.	N/A	N/A
00045	Missing or Invalid ADMIT DATE	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA40	Missing/incomplete/invalid admission date.
00070	Invalid PATIENT STATUS	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA43	Missing/incomplete/invalid patient status
00135	Missing UNITS or Service or Days	Reject	16	Claim/service lacks information or has submission/billing error(s).	M53	Missing/incomplete/invalid days or units of service.
00265	Original TCN not on file	Reject	16	Claim/service lacks information or has submission/billing error(s).	M47	Missing/incomplete/invalid Payer Claim Control Number.
00455	Invalid Place of Service	Reject	16	Claim/service lacks information or has submission/billing error(s).	M77	Missing/incomplete/invalid/inappropriate place of service
00755	TCN Referenced has Previously Been Adjusted	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00760	TCN Referenced is in Process of Being Adjusted	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00825	Invalid Discharge Date	Reject	16	Claim/service lacks information or has submission/billing error(s).	N318	Missing/incomplete/invalid discharge or end of care date.
00835	Unable to Determine CLAIM TYPE	Reject	16	Claim/service lacks information or has submission/billing error(s).	N34	Incorrect claim form/format for this service.
01005	Claim does not contain Billing Provider NPI	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier
01010	Claim Contains an Unrecognized Performing Provider NPI	Reject	208	Claim/service lacks information or has submission/billing error(s).	N290	Missing/incomplete/invalid rendering provider primary identifier.
01015	Claim Contains an Unrecognized Billing Provider NPI	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier.
01280	Attending Provider Missing or Invalid	Reject	16	Claim/service lacks information or has submission/billing error(s).	N253	Missing/incomplete/invalid attending provider primary identifier.
01425	Billing Provider is not in Active Status	Reject	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service	N/A	N/A
01445	Attending or Servicing Provider is not Active for Date of Service	Reject	16	Claim/service lacks information or has submission/billing error(s).	N290	Missing/incomplete/invalid rendering provider primary identifier

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
02110	Client ID not on file	Reject	31	Patient cannot be identified as our insured.	N/A	N/A
02125	Recipient DOB Mismatch	Reject	16	Claim/service lacks information or has submission/billing error(s).	N329	Missing/incomplete/invalid patient birth date.
02145	Client not Enrolled with MCO	Reject	96	Non-covered charge(s).	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
02230	Claim spans Eligible and Ineligible periods of Coverage	Reject	200	Expenses incurred during lapse in coverage.	N/A	N/A
03000	Missing/Invalid Procedure Code	Reject	181	Procedure code was invalid on the date of service	N/A	N/A
03010	Invalid Primary Procedure	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA66	Missing/incomplete/invalid principal procedure code.
03015	Invalid 2nd Procedure	Reject	16	Claim/service lacks information or has submission/billing error(s).	M67	Missing/incomplete/invalid other procedure code(s).
03055	Primary Diagnosis not found on the reference file	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA63	Missing/incomplete/invalid principal diagnosis
03130	Procedure Code Missing or not on Reference File	Reject	16	Claim/service lacks information or has submission/billing error(s).	M51	Missing/incomplete/invalid procedure code(s).
03340	Secondary diagnosis not found on the reference file	Reject	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
03555	Revenue code billed not on the reference table	Reject	16	Claim/service lacks information or has submission/billing error(s).	M50	Missing/incomplete/invalid revenue code(s).
03935	Revenue code requires procedure code	Reject	16	Claim/service lacks information or has submission/billing error(s).	M67	Missing/incomplete/invalid other procedure code(s).
98328	Duplicate HIPAA billing	Reject	18	Exact duplicate claim/service	N/A	N/A
99405	Claim missing required HCP amounts	Reject	16	Claim/service lacks information or has submission/billing error(s).	M79	Missing/incomplete/invalid charge.
03640	Missing or Invalid NDC Number	Reject	16	Claim/service lacks information or has submission/billing error(s).	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
03645	Procedure Code invalid with NDC	Reject	16	Claim/service lacks information or has submission/billing error(s).	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
01006	Missing or invalid managed care program ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier.
00535	First date of service more than 2 years old	Reject	29	The time limit for filing has expired.	N/A	N/A

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
00762	Claim was already credited	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
98325	Claim is an exact duplicate	Reject	18	Exact duplicate claim/service	N/A	N/A
00865	Invalid or missing managed care paid date	Reject	16	Claim/service lacks information or has submission/billing error(s).	N307	Missing/incomplete/invalid adjudication or payment date.
00870	Encounter was not filed on timely basis	Reject	29	CARC-The time limit for filing has expired.	N/A	N/A
00006	Invalid claim date of service	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid “from” date(s) of service.
02100	Missing or invalid Client ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N382	Missing/incomplete/invalid patient identifier.
00125	"To" date is before "from" date	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid “from” date(s) of service.
02121	Recipient Gender missing or invalid	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA39	Missing/incomplete/invalid gender.
03885	Claim dates of service do not fall within the Begin or End of the Diagnosis Code on the reference file	Reject	146	Diagnosis was invalid for the date(s) of service reported	N/A	N/A
03886	Date on claim versus dates on Diagnosis reference file-Header	Reject	146	Diagnosis was invalid for the date(s) of service reported	N/A	N/A
00320	HCP 11 value missing - Header	Reject	16	Claim/service lacks information or has submission/billing error(s).	M53	Missing/incomplete/invalid days or units of service.
00322	HCP 12 value missing - Header	Reject	16	Claim/service lacks information or has submission/billing error(s).	M53	Missing/incomplete/invalid days or units of service.
00324	HCP 11 value missing - Line	Reject	16	Claim/service lacks information or has submission/billing error(s).	M53	Missing/incomplete/invalid days or units of service.
00326	HCP 12 value missing - Line	Reject	16	Claim/service lacks information or has submission/billing error(s).	M53	Missing/incomplete/invalid days or units of service.
02101	Missing client ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N382	Missing/incomplete/invalid patient identifier.
98430	Parent Invoice Type does not match Child Invoice	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00340	EBP code without corresponding procedure code on claim	Reject	284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	N/A	N/A
99450	RHC Encounter on claim without a payable qualifying service	Reject	107	The related or qualifying claim/service was not identified on this claim.	N/A	N/A

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
03990	Invalid Primary Diagnosis Code for RHC	Reject	12	The diagnosis is inconsistent with the provider type.	N/A	N/A
00305	T1015 encounter from a tribal clinic must be one of the four agency-recognized categories	Reject	16	Claim/service lacks information or has submission/billing error(s).	N255	Missing/incomplete/invalid billing provider taxonomy
00310	Tribal Encounter not billed correctly	Reject	4	The procedure code is inconsistent with the modifier used.	N/A	N/A
01220	Tribal billing guide requires mods for med/MH/SUD claims & EPA for dental claims	Reject	4	The procedure code is inconsistent with the modifier used.	N/A	N/A
14366	T1015 encounter from tribal clinic without a payable, qualifying service	Reject	107	The related or qualifying claim/service was not identified on this claim.	N/A	N/A
14367	Tribal CD Encounter not payable to CHIP	Reject	204	This service/equipment/drug is not covered under the patient's current benefit plan.	N/A	N/A
03841	T1015 encounter from tribal clinic not payable for state-only or non-Title 19 clients	Reject	96	Non-covered charge(s).	N30	Patient ineligible for this service.
14368	Non-Native Tribal Chemical Dependency Encounter T1015 w/Modifier SE Requires ABP Client RAC	Reject	4	The procedure code is inconsistent with the modifier used.	N/A	N/A
14369	Non-Native Tribal Chemical Dependency Encounter T1015 w/Modifier HX Requires Non ABP Client RAC	Reject	4	The procedure code is inconsistent with the modifier used.	N/A	N/A
14371	Non-Native Tribal Chemical Dependency Encounter T1015 w/Modifier HB Requires ABPSSI RAC 1217	Reject	4	The procedure code is inconsistent with the modifier used.	N/A	N/A

Payment Assistance Request

When to use the Newborn or Payment Assistance Request Form

The Newborn Payment Assistance Request Form (PARF) is designed to be used specifically for inquiries about newborn premiums and should be submitted using the correct template and associated template instructions located in MC-Track®.

A Newborn PARF should be submitted when a premium has not been paid for the month 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.

Newborn PARFs submitted incorrectly or with inquiries not related to newborn premium inquiries will be rejected in MC-Track®.

The Payment Assistance Request Form (PARF) is designed to be used as a general purpose form for use by MCOs to request assistance regarding SBE payments and to provide updates to client demographic information. Use the designated template and associated template instructions located in MC-Track® and include only one category of inquiry in each submitted form. PARFs submitted incorrectly will be rejected in MC-Track®.

For all PARF submissions, 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 the form to HCA for further research. If the MCO is still unable to resolve the issue, then a PARF should be completed and submitted.

Wait 30 days after submission before sending questions regarding the status of a submitted PARF.

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.

- First Data Bank® NDC File – HCA's drug file is maintained by the drug file contractor First Data Bank®. Drug manufacturers report their products to First Data Bank®. If an NDC is not listed in First Data Bank®, ProviderOne will reject the encounter.

Note: HCA has found that most pharmacies in the State of Washington are able to use the First Data Bank® 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 (509-F9 field name) is a requirement for pharmacy encounters. The amount paid is the total amount remitted to the 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 Washington State/CNSI NCPDP 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 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 then passed to the RxCLAIM Pharmacy Point of Sale (POS) system as encounter records. A file is passed only if it is compliant with NCPDP transaction standards.

Do not 'GAP' fill situational fields in NCPDP files unless indicated in the Washington State/CNSI NCPDP Pharmacy Encounter Companion Guide.

Do not include situational fields when there is no data to report. That data will cause the file to reject at the SFTP server.

Pharmacy File Naming Convention

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

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

- **<SubmitterID>** – The 7-digit ProviderOne ID and 2-digit location code.
- **<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 an 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: Do not zip/compress pharmacy encounter files.

- Upload the 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

ProviderOne searches frequently for new files to be sent for encounter data processing. An NCPDP acknowledgement file similar to the 999 Acknowledgement is generated along with a loading report within 24 hours of file upload. 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 provided previously in this guide.

Original Pharmacy Encounters

The NCPDP 1.1 batch file may include encounters reported for the first time or retransmitted after being rejected on the 835 transaction 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 CARC and RARC code for each TCN is listed in the 835 transaction that was retrieved by the MCO via the Trading Partner folder on the SFTP Server. These records should be corrected and resubmitted with the next file transfer, using the void/replace process listed in the table below.

The NCPDP format does not allow reporting of 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 the 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)

Adjustments to Pharmacy Encounters

Adjustments to NCPDP pharmacy encounters must be submitted within 15 months from the date of service.

Pharmacy/NCPDP Encounter CARC/RARC Crosswalk

HCA Error Code	Reject Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
99005	5	Missing/Invalid Service/Provider Number	Reject	16	Claim/service lacks information or has submission/billing error(s).	N290	Missing/incomplete/invalid rendering provider primary identifier.
99007	7	Missing/Invalid Cardholder ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N382	Missing/incomplete/invalid patient identifier.
99009	9	Missing/Invalid Date of Birth	Reject	16	Claim/service lacks information or has submission/billing error(s).	N329	Missing/incomplete/invalid patient birth date.
99013	13	Missing/Invalid Other Coverage Code	Reject	22	This care may be covered by another payer per coordination of benefits.	N/A	N/A
99015	15	M/I Date of Service	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	M/I “From” date of service
99023	21	Missing/Invalid Product/Service ID	Reject	181	Procedure code was invalid on the date of service.	N/A	N/A
99027	25	Missing/Invalid Prescriber ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N31	Missing/incomplete/invalid prescribing provider identifier.
99030	28	Missing/Invalid Date Prescription Written	Reject	16	Claim/service lacks information or has submission/billing error(s).	N57	Missing/incomplete/invalid prescribing date.
99064	41	Submit Bill to Other Processor Or Primary Payer	Reject	22	This care may be covered by another payer per coordination of benefits.	N/A	N/A
99075	50	Non-Matched Pharmacy Number	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier.
99077	52	Non-Matched Cardholder ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N382	Missing/incomplete/invalid patient identifier.
99079	54	Non-Matched Product/Service ID Number	Reject	16	Claim/service lacks information or has submission/billing error(s).	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
99092	65	Patient is Not Covered	Reject	200	Expenses incurred during lapse in coverage.	N/A	N/A
99099	70	Product/Service Not Covered	Reject	204	This service/equipment/drug is not covered under the patient's current benefit plan.	N130	Consult plan benefit documentation/guidelines for information about restrictions for this service.
99105	76	Plan Limitations Exceeded	Reject	119	Benefit maximum for this time period or occurrence has been reached.	N/A	N/A
99106	77	Discontinued Product/ServiceID Number	Reject	16	Claim/service lacks information or has submission/billing error(s).	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
99112	81	Claim Too Old	Reject	29	The time limit for filing has expired.	N/A	N/A

HCA Error Code	Reject Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
99113	82	Claim is Post-Dated	Reject	110	Billing date predates service date.	N/A	N/A
99114	83	Duplicate Paid/Captured Claim	Reject	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	N/A	N/A
99116	85	Claim not Processed	Reject	16	Claim/service lacks information or has submission/billing error(s).	N182	This claim/service must be billed according to the schedule for this plan.
99118	87	Reversal not processed	Reject	16	Claim/service lacks information or has submission/billing error(s).	N779	Replacement/Void claims cannot be submitted until the original claim has finalized. Please resubmit once payment or denial is received.
99136	AC	Product Not Covered Non-Participating Manufacturer	Reject	A1	Claim/Service Denied	N790	Provider/Supplier not accredited for product/service.
99147	CB	Missing/Invalid Patient Last Name	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA36	Missing/incomplete/invalid patient name.
99172	DQ	M/I Usual and Customary Charge	Reject	16	Claim/service lacks information or has submission/billing error(s).	M79	Missing/Incomplete/Invalid charge.

Health Home Lead Entity Section

Health Home Lead Entity Encounter Reporting

MCOs and Managed Fee-For-Service (MFFS) Health Home 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. HCA pays for Health Home services after successful processing of the monthly encounter data submission that generates a Service-Based Enhancement (SBE) payment to the MFFS Lead Entity. MCOs are not eligible for a separate SBE payment for their managed care enrollees since Health Home services are incorporated into each MCO's monthly premium payment rate. This is also true for MCOs who elected not to become a Health Home Lead Entity, but delegated the services for their MCO enrollees to another Health Home Lead Entity.

MCOs must report all Health Home services using the procedure codes listed below with their normal encounter data reporting described in this guide. Report only one service per month per beneficiary, and include the amount paid to the subcontracted Care Coordination Organization or delegated Health Home Lead Entity.

The MFFS Health Home 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. Effective with dates of service on and after October 1, 2015, the ICD-10 code to use is Z719.

Use the appropriate Health Home encounter procedure codes described below. Submit all other standard information routinely included with any claim or encounter.

Health Home Encounter Service/Procedure Codes

The three (3) Health Home 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 (HAP) development:

- Care Coordination Organization (CCO) submits the Tier One encounter code to the MCO or MFFS Lead Entity for payment when the beneficiary/enrollee agrees to

participate in the Health Home program and a HAP is completed.

- In turn, the MCO and/or MFFS Lead Entity submits the electronic encounter data transaction in the standard 837P format to HCA.

- Report and submit this code only once in a beneficiary's lifetime before any other codes.

G9149 – Tier Two: Intensive Health Home care coordination includes evidence that the care coordinator, the beneficiary, and the beneficiary's caregivers are actively engaged in achieving health action goals. This service is the highest level of care coordination. Typically intensive Health Home care coordination includes one face-to-face visit with the beneficiary every month in which a qualified Health Home service is provided to achieve one of the following:

- Clinical, functional, and resource use screenings, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;

- Continuity and coordination of care through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed;

- Beneficiary assessments to determine readiness for self-management and to promote self-management skills to improve functional or health status, or prevent or slow declines in functioning;

- Fostering communication between the providers of care including the treating primary care provider, medical specialists, personal care providers and others; and entities authorizing behavioral health and long-term services and supports;

- Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;

- Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and

- Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Exceptions to the monthly face-to-face visit may be approved as long as the Health Home service(s) provided during the month includes communication with the beneficiary or the beneficiary's caregivers in order to progress Health Action Plan goals; and meet the conditions noted for Tier Two services below.

All Tier Two encounters must achieve the following:

- 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 MFFS Lead Entity or MCO for payment.

- In turn, the MFFS 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:

- At tier three the review of the Health Action Plan (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 during the month through home visits or telephone calls prior to submitting a claim for the tier three encounter code of G9150 to the MFFS Lead Entity or MCO for payment.

- In turn, the MFFS Lead Entity and/or MCO submits the electronic encounter data transaction in the standard 837P format to HCA.

Health Home Services Provided by Tribal Care Coordination Organizations (CCO)

A Health Home Lead Organization must contract with the Tribe as a Care Coordination Organization (CCO) in order to receive payment for Health Home services. For specific information on Health Home services, refer to information found at https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home-resources.

The Health Home program will pay a Tribal CCO at the established Indian Health Service (IHS) encounter rate when:

1. A Health Home Care Coordinator from the contracted Tribal CCO provides Health Home services to American Indian or Native Alaskan (AI/AN) members enrolled in the Health Home program, AND

2. The service is provided in a face-to-face setting in a location of the AI/AN member's choice, AND

3. The Tribal CCO bills the HH Lead Entity appropriately using the Tribal National Provider Identifier (NPI) and taxonomy code 208D00000X.

The Health Home programs uses three procedure codes in billing for services. Only one of the codes below are payable during the month, i.e., a payment is not generated for more than one G code per month per client. They are:

Encounter/Procedure Code	Encounter Code Description	Encounter Reporting Frequency
G9148	Tier One – Outreach, engagement and Health Action Plan development.	Once per lifetime per AI/AN, usually, for the first month of the Health Home program participation.
G9149	Tier Two – Intensive Health Home care coordination	Once per month per beneficiary
G9150	Tier Three – Low-level Health Home care coordination (continual maintenance and engagement of the AI/AN member with minimal contact during the month by phone or in person)	Once per month per beneficiary.
Only one G code can be submitted for a client during any calendar month.		

Other details on the claim include using a second procedure code T1015. This identifies the client on the claim as an AI/AN member. This second procedure code, T1015 with the "UA" modifier, will trigger the SBE payment at the established IHS encounter rate to the Health Home Lead Entity submitting the encounter.

The modifiers below, added to the procedure code, will initiate the correct payment for the service provided:

1. Modifier "UA" with procedure code T1015 indicates the client is an AI/AN member.

2. Modifier "KX" with the G procedure code indicates the Health Home service was provided in a face to face setting with the client.

If the modifiers are not included on the claim from the Tribal CCO to the HH Lead Entity, then the Health Home service is reimbursed at the current established Health Home rates. The current rates for Health Home services can be found at https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf.

A Tribal CCO must submit claims to the Health Home Lead Entity to receive payment. The Health Home Lead Entity submits the encounter data to HCA to be reimbursed for the services provided to FFS, dual-eligible, AI/AN enrollees.

NOTE: A Managed Care Organization (MCO) Lead Entity does not receive the SBE payment from HCA. When the Tribal CCO provides Health Home services to the AI/AN client who is

enrolled with an MCO, the Tribal CCO will follow the billing instructions provided by the MCO Health Home Lead.

SAMPLE CLAIMS

AI/AN Client 1; Claim 1; Provider Billing the HH Lead Entity = Tribal Clinic CCO

Claim Line 1: G9148 + KX
Claim Line 2: T1015 + UA

This claim would qualify for the IHS encounter rate payment. T1015-UA indicates the client is an AI/AN member and G9148-KX indicates the health home service was face-to-face with the client.

AI/AN Client 2; Claim 2; Provider Billing the HH Lead Entity = Tribal Clinic CCO
Claim Line 1: G9149 + UA
Claim Line 2: T1015 +UA

This claim would pay at the current Health Home service rate because there is no indication the service was face-to-face with the client.

Client 3; Claim 3; Provider Billing the HH Lead Entity = Tribal Clinic CCO
Claim Line 1: G9150
Claim Line 2: T1015

This claim would pay at the current Health Home service rate because there is no indication the client served was an AI/AN member or that the service was face-to-face.

Health Home Encounter CARC/RARC Crosswalk

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
00005	Missing from DATE OF SERVICE	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid “from” date(s) of service.
00010	Billing Date is before Service Date	Reject	110	Billing date predates service date.	N/A	N/A
00070	Invalid PATIENT STATUS	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA43	Missing/incomplete/invalid patient status
00135	Missing UNITS or Service or Days	Reject	16	Claim/service lacks information or has submission/billing error(s).	M53	Missing/incomplete/invalid days or units of service.
00190	Claim past timely filing limitation	Reject	29	The time limit for filing has expired.	N/A	N/A
00265	Original TCN not on file	Reject	16	Claim/service lacks information or has submission/billing error(s).	M47	Missing/incomplete/invalid Payer Claim Control Number.
00755	TCN Referenced has Previously Been Adjusted	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00760	TCN Referenced is in Previously Been Adjusted	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00835	Unable to Determine CLAIM TYPE	Reject	16	Claim/service lacks information or has submission/billing error(s).	N34	Incorrect claim form/format for this service.
02110	Client ID not on file	Reject	31	Patient cannot be identified as our insured.	N/A	N/A
02125	Recipient DOB Mismatch	Reject	16	Claim/service lacks information or has submission/billing error(s).	N329	Missing/incomplete/invalid patient birth date.
02145	Client not Enrolled with MCO	Reject	96	Non-covered charge(s).	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
02230	Claim spans Eligible and Ineligible periods of Coverage	Reject	200	Expenses incurred during lapse in coverage.	N/A	N/A
03000	Missing/Invalid Procedure Code	Reject	181	Procedure code was invalid on the date of service	N/A	N/A
03055	Primary Diagnosis not found on the reference file	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA63	Missing/incomplete/invalid principal diagnosis
03130	Procedure Code Missing or not on Reference File	Reject	16	Claim/service lacks information or has submission/billing error(s).	M51	Missing/incomplete/invalid procedure code(s).

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
03340	Secondary diagnosis not found on the reference file	Reject	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
02265	Invalid Procedure code for Community Mental Health Center	Reject	170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.
98328	Duplicate HIPAA billing	Reject	18	Exact duplicate claim/service	N/A	N/A
99405	Claim missing required HCP amounts	Reject	16	Claim/service lacks information or has submission/billing error(s).	M79	Missing/incomplete/invalid charge.
01006	Missing or invalid managed care program ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier.
00535	First date of service more than 2 years old	Reject	29	The time limit for filing has expired.	N/A	N/A
12930	HH G9148 - once in a lifetime	Reject	256	Service not payable per managed care contract.	N117	This service is paid only once in a patient's lifetime.
12931	HH G9148 must be paid for date of service prior to payment for G9149 and G9150	Ignore	107	The related or qualifying claim/service was not identified on this claim.	N674	Not covered unless a pre-requisite procedure/service has been provided.
12932	Subsequent Health Home care billed before initial outreach	Ignore	107	The related or qualifying claim/service was not identified on this claim.	N674	Not covered unless a pre-requisite procedure/service has been provided.
00762	Claim was already credited	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
98325	Claim is an exact duplicate	Reject	18	Exact duplicate claim/service	N/A	N/A
00006	Invalid claim date of service	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid "from" date(s) of service.
02100	Missing or invalid Client ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N382	Missing/incomplete/invalid patient identifier.
00125	"To" date is before "from" date	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid "from" date(s) of service.
02121	Recipient Gender missing or invalid	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA39	Missing/incomplete/invalid gender.

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
03885	Claim dates of service do not fall within the Begin or End of the Diagnosis Code on the reference file	Reject	146	Diagnosis was invalid for the date(s) of service reported	N/A	N/A
03886	Date on claim versus dates on Diagnosis reference file-Header	Reject	146	Diagnosis was invalid for the date(s) of service reported	N/A	N/A
02101	Missing client ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N382	Missing/incomplete/invalid pay-to provider secondary identifier.
98430	Parent Invoice Type does not match Child Invoice	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.

BH-ASO/ASO Section

Reporting Claim Types

837P – Includes behavioral health crisis services for managed care enrolled clients, non-Medicaid services for Medicaid clients, and behavioral health services for non-Medicaid clients. Refer to the current contract for specifics on scope of coverage.
837I – Includes behavioral health crisis services delivered in an institutional setting.

BH-ASO/ASO Client Identifiers

Use the ProviderOne Client ID to report encounter data, unless the service is for a non-Medicaid client. Use the BH-ASO/ASO Unique Consumer ID for non-Medicaid clients. Report the client's date of birth and gender on every encounter record in the Subscriber/Patient Demographic Information segments. If unknown, refer to the instructions located in the Washington State/CNSI 837 Professional and Institutional Encounter Data Companion Guide.

Billing Guides

The Service Encounter Reporting Instructions (SERI) Guide provides BH-ASOs/ASOs with guidance on coding of encounters based on State Plan modalities and provider types.

Reporting DOH Certification Number for Behavioral Health Services

Effective April 1, 2017, BH-ASOs must report the Department of Health (DOH) Certification number for the site providing the service in the encounter data. This number is needed in order to identify site-specific agencies and services being provided. Submit only the certification number and do not include any preceding characters, including "BHA.FS" (i.e., ~~BHA.FS.~~12345678). Additional specifics on how to submit this information can be found in the Washington State/CNSI 837 Professional and Institutional Encounter Data Companion Guide. The DOH certification number is site-specific and must be reported for all encounters submitted to the agency for behavioral health services.

BH-ASO/ASO Reporting Frequency

BH-ASOs/ASOs report encounters according to their contract requirements.

BH-ASO/ASO File Naming Convention

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

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

- **<TPID>** – Trading partner ID. (Same as 7-digit ProviderOne ID and 2-digit location code)
- **<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.)

BH-ASO/ASO Encounter CARC/RARC Crosswalk

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
00005	Missing from DATE OF SERVICE	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid "from" date(s) of service.
00010	Billing Date is before Service Date	Reject	110	Billing date predates service date.	N/A	N/A
00045	Missing or Invalid ADMIT DATE	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA40	Missing/incomplete/invalid admission date.
00070	Invalid PATIENT STATUS	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA43	Missing/incomplete/invalid patient status
00135	Missing UNITS or Service or Days	Reject	16	Claim/service lacks information or has submission/billing error(s).	M53	Missing/incomplete/invalid days or units of service.
00190	Claim past timely filing limitation	Reject	29	The time limit for filing has expired.	N/A	N/A
00265	Original TCN not on file	Reject	16	Claim/service lacks information or has submission/billing error(s).	M47	Missing/incomplete/invalid Payer Claim Control Number.
00455	Invalid Place of Service	Reject	16	Claim/service lacks information or has submission/billing error(s).	M77	Missing/incomplete/invalid/inappropriate place of service
00755	TCN Referenced has Previously Been Adjusted	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00760	TCN Referenced is in Previously Been Adjusted	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00825	Invalid Discharge Date	Reject	16	Claim/service lacks information or has submission/billing error(s).	N318	Missing/incomplete/invalid discharge or end of care date.
01005	Claim does not contain Billing Provider NPI	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier
01015	Claim Contains an Unrecognized Billing Provider NPI	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier.
01280	Attending Provider Missing or Invalid	Reject	16	Claim/service lacks information or has submission/billing error(s).	N253	Missing/incomplete/invalid attending provider primary identifier.
03000	Missing/Invalid Procedure Code	Reject	181	Procedure code was invalid on the date of service	N/A	N/A
03055	Primary Diagnosis not found on the reference file	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA63	Missing/incomplete/invalid principal diagnosis
03130	Procedure Code Missing or not on Reference File	Reject	16	Claim/service lacks information or has submission/billing error(s).	M51	Missing/incomplete/invalid procedure code(s).

HCA Error Code	HCA Error Code Description	Encounter Disposition	CARC	CARC Description	RARC	RARC Description
03340	Secondary diagnosis not found on the reference file	Reject	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
03555	Revenue code billed not on the reference table	Reject	16	Claim/service lacks information or has submission/billing error(s).	M50	Missing/incomplete/invalid revenue code(s).
02185	Invalid RSN Association	Reject	N/A	N/A	N/A	N/A
02265	Invalid Procedure code for Community Mental Health Center	Reject	170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.
01020	Invalid pay to provider	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier.
01006	Missing or invalid managed care program ID	Reject	16	Claim/service lacks information or has submission/billing error(s).	N280	Missing/incomplete/invalid pay-to provider primary identifier.
00535	First date of service more than 2 years old	Reject	29	The time limit for filing has expired.	N/A	N/A
00762	Claim was already credited	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.
00006	Invalid claim date of service	Reject	16	Claim/service lacks information or has submission/billing error(s).	M52	Missing/incomplete/invalid “from” date(s) of service.
02121	Recipient Gender missing or invalid	Reject	16	Claim/service lacks information or has submission/billing error(s).	MA39	Missing/incomplete/invalid gender.
03885	Claim dates of service do not fall within the Begin or End of the Diagnosis Code on the reference file	Reject	146	Diagnosis was invalid for the date(s) of service reported	N/A	N/A
03886	Date on claim versus dates on Diagnosis reference file-Header	Reject	146	Diagnosis was invalid for the date(s) of service reported	N/A	N/A
98430	Parent Invoice Type does not match Child Invoice	Reject	16	Claim/service lacks information or has submission/billing error(s).	N152	Missing/incomplete/invalid replacement claim information.

Appendices

Appendix A: Email Certification

The following entities do not submit contract deliverables using MC-Track® and should submit the email certification directly to encounterdata@hca.wa.gov, using the format below:

- *HH Lead Entities*
- *Managed Care Third-Party Administrators*
- *Behavioral Health Organizations*
- *Behavioral Health – Administrative Services Organizations*

MCOs submit contract deliverables using MC-Track® and should submit the email certification using the appropriate template.

To: ENCOUNTERDATA@hca.wa.gov
Subject: [MCO, HH Lead Entity, or BH-ASO/ASO] 837/Rx Batch File Upload [Org Name/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, HH Lead Entity, or BH-ASO/ASO 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, HH Lead Entity, or BH-ASO/ASO 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: Monthly Certification Letter

The following entities do not submit contract deliverables using MC-Track® and should submit the monthly certification directly to encounterdata@hca.wa.gov, using the format below:

- *HH Lead Entities*
- *Managed Care Third-Party Administrators*
- *Behavioral Health Organizations*
- *Behavioral Health – Administrative Services Organizations*

MCOs submit contract deliverables using MC-Track® and should submit the monthly certification using the appropriate template.

TO: ENCOUNTERDATA@hca.wa.gov

[TODAY'S 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, HH Lead Entity, or BH-ASO/ASO]** 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, HH Lead Entity, or BH-ASO/ASO contract in effect.

MCOs and HH Lead Entities: 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, HH Lead Entity, or BH-ASO/ASO]** 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