ForwardHealth Portal

HMO Encounter User Guide

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ST*837*000000001*005010X223A2~ BHT*0019*00*PES51*20130205*1503*RP~ 73
7: Adjustment-Void 74
SE*45*000000001~ 75
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BHT*0019*00*PES69*20170531*1049*RP~ NM1*41*2*HP*****46*100000330~ PER*IC*DEB CRIST*TE*6082246762~ 77
N4*ARLINGTON*WI*539111234~ REF*EI*123654789~ 77
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PER*IC*ANDY*TE*9207379354~ 77
N3*4122 EAST TOWNE BLVD~ N4*MADISON*WI*537043732~ 77
N4*MILWAUKEE*WI*53201~ 77
HI*BK:Z23*BF:E119*BF:I10*BF:G4734~ 78
N4*MILWAUKEE*WI*53201~ 78
Example 11: Commercial Insurance Not Covered and HMO Payer 80
HL*1**20*1~ PRV*BI*PXC*282N00000X~ 80
HL*2*1*22*0~ SBR*T*18*******MC~ NM1*IL*1*LAST*FIRST****MI*4110790140~ N3*ADDRESS~ N4*GREENBAY*WI*543031234~ 80
NM1*IL*1*LAST*FIRST****MI*4110790140~ 80
SVD*69000000*5.00*HC:99212:25**1.0~ 80
Example 12: Commercial Insurance Not Covered and HMO Payer 81
PER*IC*PC MEDIA*EM*NAME@HMO.COM~ 81
N4*GREENBAY*WI*543031234~ 81
N4*GREENBAY*WI*543031234~ 81
N4*GREENBAY*WI*543031234~ NM1*PR*2*HMONAME*****PI*69000000~ LX*1~ SV1*HC:99212:25*30*UN*1.0***1~ 82

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NM1*41*2*TRADING PARTNER*****46*100000000~ PER*IC*PC MEDIA*EM*NAME@HMO.COM~
NM1*40*2*FORWARDHEALTH*****46*WISC_TXIX~ 83

NM1*IL*1*LAST*FIRST****MI*4110790140~ 83

NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~ 83

NM1*82*1*BERG*TROY*L***XX*1740216845~ 83

NM1*PR*2*HMONAME*****PI*69000000~ 83

**45*5.00~ 84

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Change Summary

Version 1.0 Revision Log

HMO Encounter User Guide
Approved: 11/2012
Modified by: DJC

Every change to this document (subsequent to initial sign-off) must be recorded in the revision history chart below. Modifications to this document are documented in the following chart. There are no exceptions.

Note: The Project Sponsor and the Project Manager must sign off any changes to the requirements document.

Changed Date	Changed By	Description of Change	Version
11/30/2012	Andy Whitens/ Deb Crist	Original Creation of Guide	1.0
3/28/2013	Andy Whitens/ Deb Crist	Updates to Response File and Medicare Information. Sections 4.6.3, 5.17 and 9. Added new	1.1
5/23/2013	Andy Whiten	examples in Appendix D. Updated examples in Appendix D.	2.0

		Added Appendix E for COB/Medicare	
8/9/2013	Andy Whitens/ Deb Crist	FAQ. Added 9.5 Adjustment Information on Response Files and 16.0 Other Coverage Discrepancy Reporting.	3.0
9/24/2013	Andy Whitens/ Deb Crist	Updated 5.12.4 Pricing Out of state Encounters. Removed out of state data sheet links from 1.3 Quick Links. Updated copayment implementation in 5.8 Encounter Edits, 5.12.3 Pricing Inclusions and Exclusions, and Appendix A.	4.0
10/7/2013	Andy Whitens/ Deb Crist	Updated 16.3 Batch Other Coverage Discrepancy Reporting via the SFTP with ForwardHealth TPL analyst	5.0
1/6/2014	Andy Whitens/ Deb Crist	process. Added PPACA to 1.2 Definitions. Added 17.0 HMO PPACA Primary Care Report. Added 2014 manual pricing percent to 5.12.3 Pricing Inclusions and Exclusions.	6.0
3/21/2014	Meg Cole	Updated wording for surgical procedures to ICD procedure codes in section 5.8. Changed segment name in section 5.10.	7.0
12/29/2014	Andy Whitens/ Deb Crist	Removed CLIA from section 5.12.3 Pricing Inclusions and Exclusions. Updated wording in section 5.13 regarding assignment of financial indicator. Updated section 9.6 as error codes are being added to the response file. Added 'error code' to section 1.2 Definitions. Added section 14.2 CLIA Enforcement and renumbered former sections 14.2 and 14.3 to 14.3 and 14.4. Added link to the report matrix to section 16.4 Other Coverage Discrepancy Report Layout. Added section 17.5 PPACA Timeline and Provider Attestation to reflect 12/31/2014 funding expiration. Updated	8.0

6/24/2015	Andy Whitens/ Deb Crist	Appendix B ANSI Codes used in assigning Updated password guidelines in 4.6.1. Added Encounter Testing section 4.7. Modified Atypical/Non-Healthcare provider section 5.3. Modified provider propagation section 5.7. Added reverse propagation, edit hierarchy and billing rule hierarchy sections 5.8. Added new ForwardHealth Update to drug carve out section 5.13.12. Added Shadow pricing section 5.17. Renumbered section 5. Modified Adjustment section 7. Corrected the claim form listed in section 16.3. Added references throughout the guide that effective 4/28/2015 encounters are not monitored for commercial insurance. Added Appendix D.	9.0
11/13/2015	Andy Whitens	Updated section 5.13.3 to include the new manually priced rate for 2016. Updated section 5.15 to remove references to up-front duplicate logic (up-front dupe check was removed from the system). Updated section	10.0
3/1/2016	Bouskill Xiong	Updated “Surgical” procedures to “ICD” procedures in Section 1.1 Introduction.	11.0
6/13/2017	Desiray DuPree	Updated Section 5.14. Updated Appendix B, removed ANSI group 1001. Added Section 18. Added SSI Care Management to Appendix D. Added filenames to Section 12.2. Updated Section 5.13.3 SYSMAN percentage. Updated	12.0
12/20/2017	Desiray DuPree	Updated Section 18.3 to include LARC, NTS, and HIV. Updated Section 5.9 to include Timely Filing and Credible Allegation of Fraud edits, Updated Section 5.13.3 SYSMAN percentage for 2018. Added sub capitated X12 to Appendix D. Updated font in Appendix D.	13.0
12/1/2018	Andy Whitens	Updated TPL edit description in section 5.9. Dropped section 17 on PPACA Primary Care Report. Re-numbered sections resulting from removal of 17. Added section 18 on OI submission processes. Added X12 examples in Appendix D related to Section 18. Added Appendix F. Updated Section 5.13.3 SYSMAN percentage for 2019.	14.0

1/10/2020	Andy Whitens	Updated links in section 1.3. Updated Section 5.13.2 Pricing Code listing. Updated Section 5.13.3 SYSMAN percentage for 2020. Updated Appendix F to include effective and	15.0
7/29/2020	Andy Whitens	end dates. Updated section 4.1 to included language spelling out that all encounter data should be submitted (paid or denied).	16.0
12/21/2020	Jacob Donahue	5.13.3 SYSMAN percentage for 2021. 4.6 Updated SFTP Host Name.	17.0
1/31/2022	Jacob Donahue	5.13.2 Added 'HIPPS' pricing indicator. 5.13.3 SYSMAN percentage for 2022. 5.14 Added TPL indicator logic. 17.3 Added COVID Encounter Based	18.0
12/13/2022	Desiray Brown	5.13.3 SYSMAN percentage for 2023. 17.3 Added CCM, CGM, NIPT, VNT Encounter Based Payments.	19.0
12/05/2023	Larry Tilley	5.3 National Provider Identifier Exempt Provider Types	20.0
12/18/2023	Desiray Brown	5.13.3 SYSMAN percentage for 2024.	21.0
6/7/2024	Desiray Brown	5.15.1 Update Duplicate Audit criteria.	22.0
12/26/2024	Desiray Brown	5.13.3 SYSMAN percentage for 2025.	23.0
01/02/2026	Rabia Akmal	5.13.3 Changes to SYSMAN pricing for 2026 DOS. Also removed Sub-acute Psychiatric Services and added Medically Tailored Meals in Section 5.2.	24.0

1 Overview

1.1 Introduction

Wisconsin ForwardHealth requires HMOs to report encounter data to analyze and monitor medical utilization and ensure quality of care. This user guide contains sections addressing overall HMO encounter transaction flow, file submission, encounter policy overview, chart review, encounter adjustments, encounter response, reports, member eligibility updates, CLIA processing information, and units per day and diagnosis restrictions.

The term **'encounter'** means a service or item provided through the HMO.

Examples include, but are not limited to, the following:

- Office visits
- ICD procedures
- Radiology, including professional and/or technical components
- Durable medical equipment
- Emergency transportation to a hospital
- Institutional stays (inpatient, rehabilitation)
- HealthCheck screens
- Dental
- Vision ○ Chiropractic

1.2 Definitions

Term	Description
837 SNIP Compliance	The Strategic National Implementation Process (SNIP) outlines transaction certification levels for EDI, HIPAA, and specialized testing.
837D	837 Health Care Claim Dental (837D) is the HIPAA transaction that outlines standard electronic data content and structure for dental health care claims/encounters.
837I	837 Health Care Claim Institutional (837I) is the HIPAA transaction that outlines standard electronic data content and structure for institutional claims/encounters.

837P	837 Health Care Claim Professional (837P) is the HIPAA transaction that outlines standard electronic data content and structure for professional claims/encounters.
999	Acknowledgement for Health Care Insurance (999) is the HIPAA transaction that reports the syntactical and relational analysis of an X12 guideline or acknowledges the receipt of an error-free transaction.

Term	Description
CLIA Certified	The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html
CMS	The Centers for Medicare and Medicaid Services (CMS) is the US Health and Human Services agency responsible for Medicare and parts of Medicaid. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the Healthcare Common Procedure Coding System (HCPCS) medical code set and the Medicare Remittance Advice Remark Codes administrative code set.
Compliant/Accepted Encounter	The encounter meets EDI requirements and is moved to the ForwardHealth claims/encounter engine.
Denied Encounter	The compliant encounter did not price in the ForwardHealth claims/encounter engine.
EDI	Electronic Data Interchange (EDI) is the standard developed by the Data Interchange Standards Association for exchanging electronic business data.
EOB	Explanation of Benefit (EOB) is the notice issued by a claims/encounter processor to the beneficiary of service that explains in detail the payment or nonpayment of a specific claim/encounter processed.
Error Code	Error Code is the denial issued by a claims/encounter processor to the beneficiary of service that explains in detail the nonpayment of a specific claim/encounter processed.
GS/GE	Interchange Functional Group Header and Trailer Envelopes (GS/GE) are contained within ISA/IEA envelopes. They include several control structures: type of transaction sets, sender's code, receiver's code, date, time, HIPAA version and count of ST/SE envelopes

HIPAA Transaction	Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care plans exchanging adopted transactions electronically must adhere to the Accredited Standards Committee (ASC) X12 standards.
ICN	The Internal Control Number (ICN) is a unique identification number assigned by ForwardHealth to each encounter in order to distinguish it from all other claims and encounters received.
ISA/IEA	Interchange Control Header and Trailer Envelope (ISA/IEA) is the outermost envelope of the 837 transaction. It includes several control components: control number, authorization information, security information, sender identification, receiver identification, date, time, and count of GS/GE envelopes.
MMIS	The Medicaid Management Information System (MMIS) is a computer application that makes up the entire Wisconsin Medical Assistance Program system. The MMIS processes medical claims/encounters and produces reports that track expenditures by aid category, claim/encounter type, category of service, or some other parameter.
Term	**Description**
NCPDP	The National Council for Prescription Drug Programs (NCPDP) is a council developed to review and define national standards for the billing of prescription drug services for reimbursement.
Priced encounter	The compliant encounter passed through ForwardHealth claims/encounter engine. In the fee-for- service system, the claim would be paid.
Rejected encounter	The encounter does not meet EDI requirements. It is not moved to the ForwardHealth claims/encounter engine.
SFTP	Secure File Transfer Protocol (SFTP) is a method of transferring files between computers over a secure data stream.
ST/SE	Transaction Set Header and Trailer Envelopes (ST/SE) are contained within GS/GE envelopes. They include all the information specific to an
Sub-Capitated Provider	Sub-capitated providers are typically paid a flat fee per member per month by the HMO rather than on a fee- for-service basis.
TA1	TA1 Interchange Acknowledgement (TA1) is the HIPAA transaction that reports the processing status of an encounter header and trailer.
Trading Partner	A trading partner is an entity that submits and/or receives HIPAA standard electronic transactions.

1.3 Quick Links

- 837D Companion Guide- *www.dhs.wisconsin.gov/publications/P0/p00263.pdf*
- 837P Companion Guide - *www.dhs.wisconsin.gov/publications/P0/p00265.pdf*
- 837I Companion Guide- *www.dhs.wisconsin.gov/publications/P0/p00266.pdf*
- TA1 Companion Guide - *www.dhs.wisconsin.gov/publications/P0/p00269.pdf*
- 999 Companion Guide - *www.dhs.wisconsin.gov/publications/P0/p00268.pdf*
- Portal User Guides – *www.forwardhealth.wi.gov/WIPortal/content/Provider/userguides/userguides.htm.spage*
- Managed Care Organization (MCO) Pricing Administration Guide - *https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage#pag*
- HMO Report Matrix link - *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*
- Explanation of Benefit Codes (EOB) - *www.forwardhealth.wi.gov/WIPortal/content/Provider/EOBs/EOB_Messages.htm.spage*
- EOB Cheat Sheet – www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encou nters_and_Reporting/pdf/EOBCheatSheet_120415.pdf.spage
- Wisconsin ForwardHealth Portal – *www.forwardhealth.wi.gov/WIPortal/*
- ForwardHealth Online Handbooks – *https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx*
- Provider Updates – *www.forwardhealth.wi.gov/WIPortal/content/Provider/Updates/index.htm.spage*
- Encounter Based Payment Guide – https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organizati on/Reimbursement_and_Capitation/Home.htm.spage#ebpg
- SSI Care Management Billing Guide - https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organizati on/Reimbursement_and_Capitation/Home.htm.spage#ebpg

2 Objectives

2.1 Objective Statement

This user guide explains ForwardHealth encounter processing and reporting. Separate implementation guides and companion guides contain specific field requirements and constraints for submitting the Health Insurance Portability and Accountability Act

(HIPAA) X12 837 transactions to ForwardHealth. The copyrighted 837 implementation guides are available from the Washington Publishing Company at *www.wpc-edi.com*.

2.2 For Assistance

For encounter process, pricing, Secure File Transfer Protocol (SFTP), and policy assistance, e-mail HMO Support Team at *VEDSHMOSupport@wisconsin.gov*.

For encounter Electronic Data Interchange (EDI) TA1, 999, and ForwardHealth Portal assistance, contact the Electronic Data Interchange Helpdesk at (866) 416-4979 or *VEDSWIEDI@wisconsin.gov*.

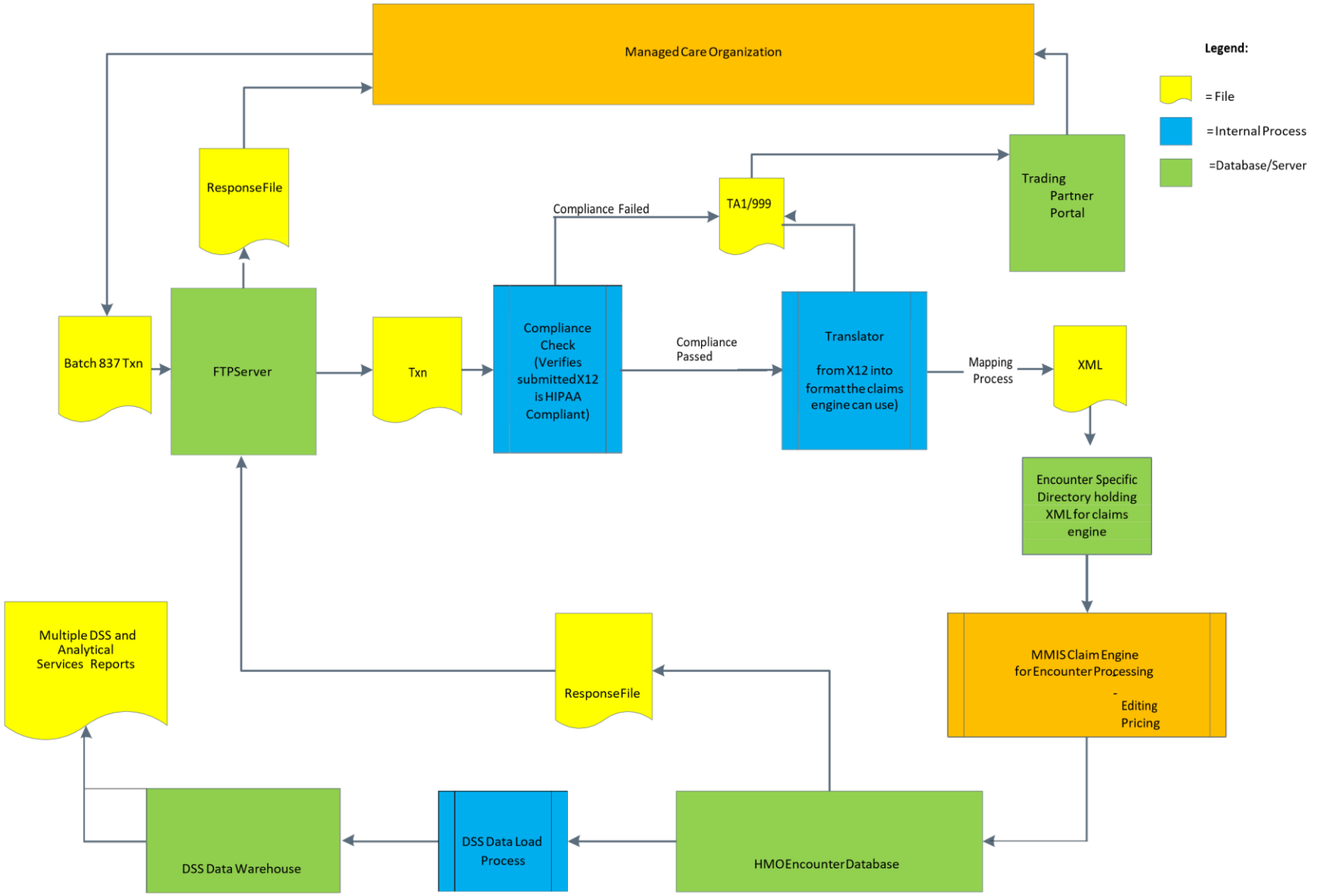
3 Overall Encounter Transaction Flow

3.1 Summary and Claims/Encounter Engine Process

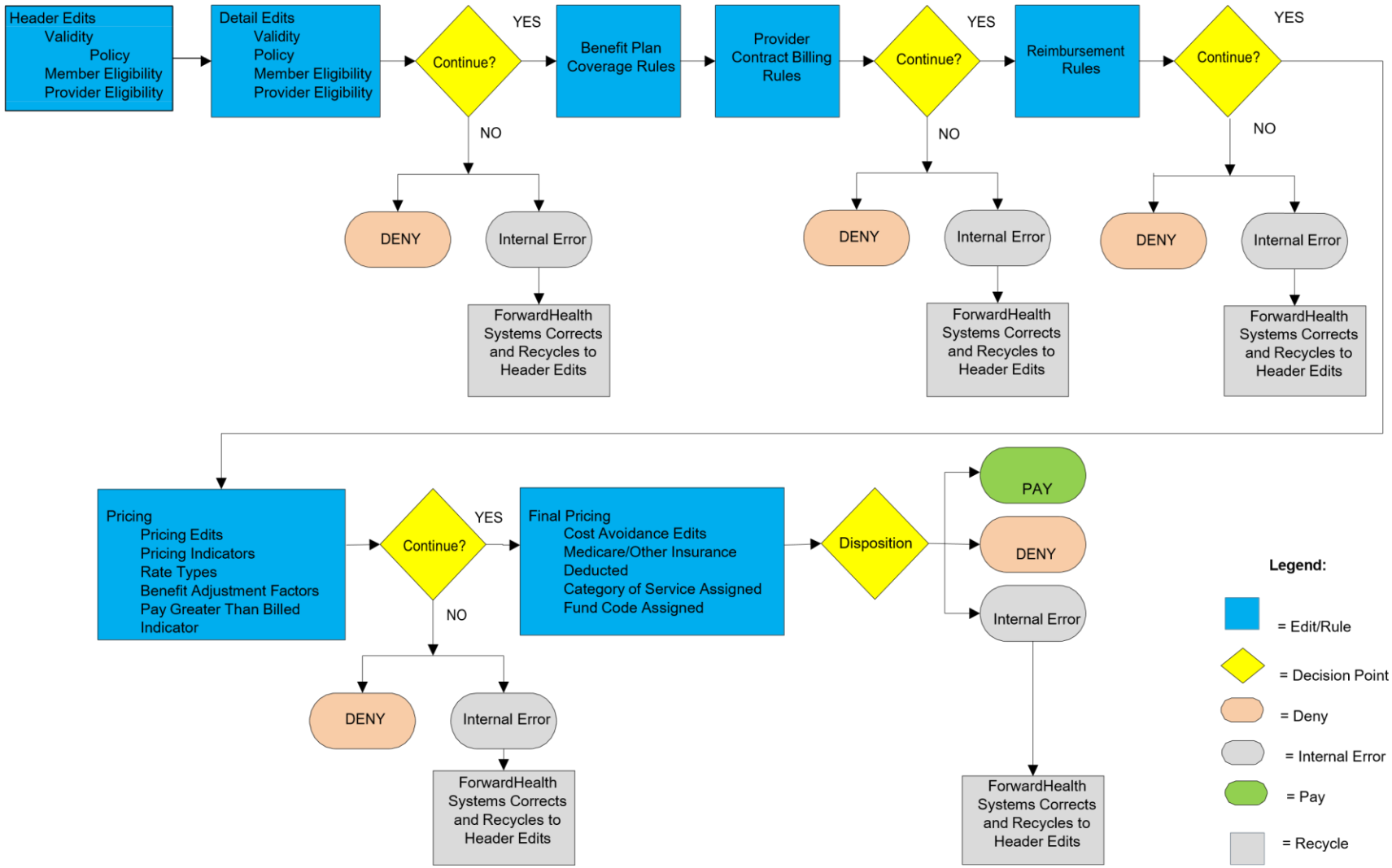
The following flowcharts display encounter processing. Flowchart 1 is a summary of the complete encounter process. Flowchart 2 is a detailed description of the Medicaid Management Information System (MMIS) Claims/Encounter Engine for encounter processing and pricing.

HMOs submit 837s and retrieve response files from the HMO SFTP server. The 837 transaction is processed through EDI for HIPAA 5010 compliancy. 999, TA1, and the Batch Submit Balance report are returned to the HMOs through the ForwardHealth Trading Partner Portal. A compliant 837 transaction is processed through the ForwardHealth claims/encounter engine, including edits, rules, and policies that have been developed for encounter processing. All encounter data is stored in a database.

3.2 Process Flowcharts


Managed Care Organization
Legend:
= File
= Internal Process
=Database/Server
ResponseFile
Compliance Failed
TA1/999
Trading Partner Portal
Batch 837 Txn
FTPServer
Txn
Compliance Check (Verifies submitted X12 is HIPAA Compliant)
Compliance Passed
Translator from X12 into format the claims engine can use)
Mapping Process
XML
Encounter Specific Directory holding XML for claims engine
Multiple DSS and Analytical Services Reports
ResponseFile
MMIS Claim Engine for Encounter Processing - Editing Pricing
DSS Data Warehouse
DSS Data Load Process
HMO Encounter Database

MMIS CLAIM ENGINE
FOR ENCOUNTER PROCESSING


Header Edits
Validity
Policy
Member Eligibility
Provider Eligibility
Detail Edits
Validity
Policy
Member Eligibility
Provider Eligibility
Continue?
YES
NO
Benefit Plan Coverage Rules
Provider Contract Billing Rules
Continue?
YES
NO
Reimbursement Rules
Continue?
YES
NO
DENY
Internal Error
ForwardHealth Systems Corrects and Recycles to Header Edits
DENY
Internal Error
ForwardHealth Systems Corrects and Recycles to Header Edits
DENY
Internal Error
ForwardHealth Systems Corrects and Recycles to Header Edits
Pricing
Pricing Edits
Pricing Indicators
Rate Types
Benefit Adjustment Factors
Pay Greater Than Billed Indicator
Continue?
YES
NO
Final Pricing
Cost Avoidance Edits
Medicare/Other Insurance Deducted
Category of Service Assigned
Fund Code Assigned
Disposition
PAY
DENY
Internal Error
DENY
Internal Error
ForwardHealth Systems Corrects and Recycles to Header Edits
ForwardHealth Systems Corrects and Recycles to Header Edits
Legend:
= Edit/Rule
= Decision Point
= Deny
= Internal Error
= Pay
= Recycle

4 File Submission Process

4.1 File Submission Introduction

This section describes encounter types, and guidelines for submitting encounters.

All HMO encounter data, including paper encounter submissions, with an effective process date on or after January 1st, 2013, are required to be submitted to ForwardHealth in the 837 format. HMOs are required to submit all of their data to ForwardHealth, whether the claim was paid or denied by the HMO.

837 Strategic National Implementation Process (SNIP) compliance criteria up to Level 6 Product Types/Types of Services Testing, are used to validate encounter submissions. In addition to EDI and HIPAA validation, Level 6 includes specialized testing required by certain healthcare specialties. For example, ambulance, chiropractic, podiatry, home health, parenteral and enteral nutrition, durable medical equipment, psychiatry, and other specialties have specific requirements that must be tested before putting the transaction in production.

4.2 Encounter Types

There are three different 837 transactions used to submit nine types of supported encounters:

- **837I - Institutional**
  - I - Inpatient
  - O - Outpatient
  - L - Long Term Care
  - H - Home Health
  - A – Inpatient Crossover
  - C - Outpatient Crossover
- **837P - Professional**
  - M - Professional
  - B - Professional Crossover
- **837D - Dental**
  - D - Dental

Note: National Council for Prescription Drug Programs (NCPDP) transactions are not supported for encounters.

4.3 Naming Convention

- The file naming convention contains the trading partner identification number, date, and daily sequence – TPID_CCYYMMDD_SEQ.dat
- See the example below for two 837 transactions submitted on the same day.
  - 100000123_20120322_001.dat
  - 100000123_20120322_002.dat

  For SFTP submission assistance, e-mail the HMO Support team at *VEDSHMOSupport@wisconsin.gov*.

4.4 File Size Guidelines

ForwardHealth limits the 837 file size to 50 MB. The 837 file includes three envelopes.

- The 837 ISA/IEA segments comprise the outer level.
- Within this ISA/IEA envelope, there can be many functional GS/GE group envelopes.
- Within each GS/GE envelope, there can be many ST/SE envelopes.

The implementation guide recommends limiting each ST/SE envelope to 5000 encounters. Each ST/SE envelope can have up to 100 encounters per member/provider combination. The 837D and 837P transactions can have up to 50 service lines per encounter. An 837I transaction can have up to 999 service lines per encounter.

4.5 File Processing Schedule

HMOs submit files as often as desired throughout the month and multiple files may be submitted on the same day. HMOs are encouraged to submit files periodically throughout the month. Note that encounters cannot be adjusted until they are assigned an Interchange Control Number (ICN). See *Section 7— Encounter Adjustment Process* for further information.

ForwardHealth picks up encounter 837 files from the SFTP server at regular intervals throughout the day. Files picked up from the SFTP server are processed through EDI and the claims/encounters engine daily. The Proprietary Response File and Control Report will be created on a weekly basis and be available on the first business day following the weekend.

4.6 SFTP Server

837 transactions are created and submitted to the SFTP server based on the trading partner, and one trading partner can have multiple lines of business. When there are multiple lines of business a separate file can be created for each, or one file combining all of the lines may be utilized. For example, BadgerCare Plus and Supplemental Security Income (SSI) create files based on the trading partner and not the specific HMO IDs. In these instances, the 837 transaction files may be submitted to either the BadgerCare Plus or SSI directory on the SFTP server.

Files following the encounter 837 naming convention as detailed in *Section 4.3* are picked up and removed from the SFTP server at scheduled intervals throughout the day.

SFTP Information	
Host Name	ftpb.forwardhealth.wi.gov
SFTP Port	22
Assistance	vedshmosupport@wisconsin.gov

4.6.1 SFTP Password Policy

- The password expires after 91 days.
- Seven day advance notice that the password will expire is given during sign on.
- The password cannot be any of the past 10 passwords.
- The old and new passwords must differ by at least seven positions.
- The password must contain at least one number.
- The password must contain at least one special character.
- The password must contain at least two uppercase and two lowercase alpha characters.
- The password cannot contain a space.
- The password cannot be a dictionary word, or a reverse dictionary word. The minimum size word checked is three characters. Dictionary check ignores case and skips special characters as part of its word comparison.
- The password must be at least eight characters; however, only the first eight are read. Be sure to have all password requirements in the first eight positions.
- Consecutive characters cannot be the same.

4.6.2 SFTP Retention Policy

Files are automatically deleted 15 days after they are posted to the SFTP server to conserve storage space and limit the amount of stored personal health information. For example, any files posted on June 1 delete on June 16.

4.6.3 SFTP Transmission Process

Files with the correct naming convention are picked up by ForwardHealth. To prevent files from being picked up before it is fully transmitted, HMOs rename the files with an invalid naming convention during the FTP transmission process. For example, many FTP clients will append a '.tmp' in place of the appropriate '.dat' extension onto the file during transmission.

4.7 Encounter Testing

HMO test files are submitted on the SFTP server to the corresponding test directory. Test files are processed using the same method and timeline as production file submissions. Associated 999 acknowledgments are available on the test Portal the same day. Test response files and status reports process over the weekend and are returned to the test directory on the SFTP.

5 Encounter Policy Overview

5.1 Policy Introduction

ForwardHealth Online Handbooks and Provider Updates contain Wisconsin Medicaid and BadgerCare Plus policy questions and clarifications. Refer to the following links:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx

www.forwardhealth.wi.gov/WIPortal/content/Provider/Updates/index.htm.spage

5.2 In Lieu of Services

In lieu of services are only applicable to encounter pricing and must meet the following criteria:

- Health related
- Cost effective
- Similar to the substituted Medicaid state plan service

ForwardHealth accepts encounters for two in lieu of services, Institution for Mental Disease (IMD) and Medically Tailored Meals.

National Provider Identifier Exempt Provider Types

Select provider types, referred to as Atypical/Non-Healthcare providers, are exempt from submitting or receiving National Provider Identifiers (NPIs).

Submitted encounters for Atypical/Non-Healthcare providers continue to indicate the

Medicaid provider number using Loop 2010BB, Billing Provider Secondary Identification REF segment, with a G2 qualifier. When the provider's G2 qualifier is used, Loop 2010AA NM109 will not contain biller NPI information.

Qualified NPI exempt provider types are as follows:

- Personal care only providers (Provider Type 05, Specialty 052)
- Blood banks (Provider Type 28, Specialty 283)
- Community Care Organizations (Provider Type 69, all Specialties)
- Specialized medical vehicle providers (Provider Type 51, all Specialties)
- Behavioral Treatment providers (Provider Type 34, Specialties 302, 401, and 404)

See Appendix D – Example 8

5.3 Member ID

The Member ID is the subscriber's identification number as assigned by ForwardHealth.

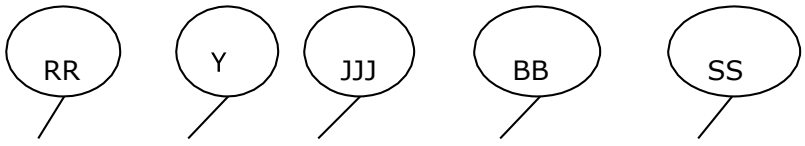
TheMember ID is populated in Loop 2010BA NM109 Subscriber Primary Identifier (NM108=MI).

5.4 Encounter ID Numbers

The Claim Submitter's Identifier is populated in Loop 2300 CLM01 in the 837 encounter header. The Line Item Control Number (previously Record Identification Number, RIN) is populated in Loop 2400, REF02 (REF01=6R). The Claim Submitter's Identifier and Line Item Control Number are stored for inclusion on the response file. The RIN is applicable for the HMOs to identify returned encounters and adjustments required on encounters submitted in the legacy system. Refer to *Section 7* for further information on encounter adjustments.

A unique 13-digit ICN is assigned to each encounter and subsequent adjustments. Due to the implementation of the HMO Encounter Process project, the ForwardHealth ICN is used for HMO encounter identification.

The following diagram and table provide detailed information about the ICN.



Region Year Julian Date Batch Range Sequence Number

Region - Two digits indicate the region assigned by ForwardHealth for encounter. Further region information can be found in *Section 5.6*.	41 – Converted Encounters. 70 – Original Encounters. 72 – Adjusted Encounters. 73 – Mass Adjustment Encounters. 74 – State Re-Submitted Encounters. 79 – Member Linking Encounters.
Year - Two digits indicate the year ForwardHealth received the encounter.	For example, the year 2012 would appear as 12.
Julian Date - Three digits indicate the day of the year, by Julian date, that ForwardHealth received the encounter.	For example, February 3 appears as 034.
Batch Range - Three digits indicate the batch range assigned to the encounter.	The batch range is used internally by ForwardHealth.
Sequence Number - Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

5.5 Encounter Region Descriptions:

The region code makes up the first two digits of the encounter ICN. See below for further information:

- *Region 41* – Converted Encounter: Assigned to encounters converted from the legacy encounter system.
- *Region 70* — Original Encounter: Assigned to new day encounter submissions.
- *Region 72* — Adjusted Encounter: Assigned to HMO initiated adjustments. See *Section 7 — Encounter Adjustment Process* for further information.
- *Region 73* — Mass Adjustment Encounter: Assigned to state initiated adjustments of paid encounters.
- *Region 74* — State Resubmitted Encounter: Assigned to state-initiated adjustments of denied encounters.
- *Region 79* — Member Linking Encounter: Assigned to state-initiated adjustments used to update the member ID when a member has multiple IDs merged within the Forward Health system.

5.6 Provider Propagation Logic

The billing provider is submitted at the 837-header level. The rendering provider is submitted at the header level ONLY IF the rendering provider is different from the billing provider. The rendering provider is submitted at the detail level ONLY IF the detail rendering provider is different from the header rendering provider.

Propagation logic is utilized on Medicaid professional encounters, dental encounters, and adjustments for encounter adjudication. Propagation logic is not used on crossover encounters. Forward Health policy dictates that each provider service location is assigned a billing status. The valid values for billing status are:

- B – Biller and Performer
- Y – Biller
- N – Performer

Some providers are assigned as both billing and rendering (performing) providers. When the rendering provider is not certified with Forward Health, the billing provider is utilized and its billing status is validated by modified processing logic.

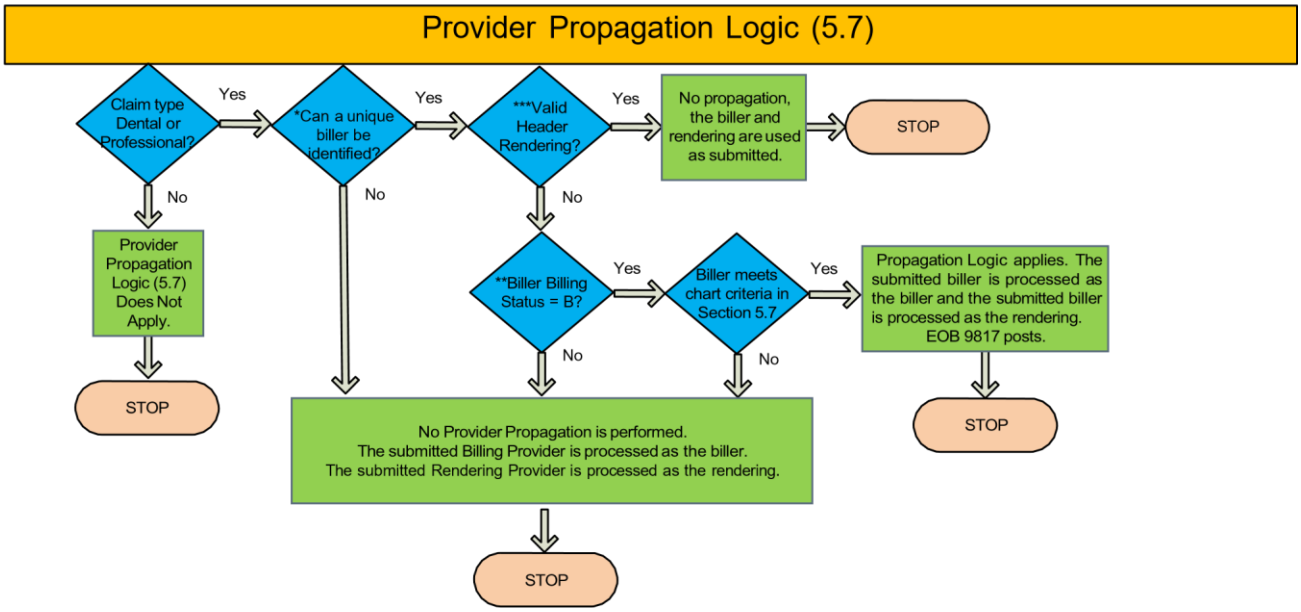
When the provider billing status is B (both billing and performing), the billing provider's type and primary specialty are in the group designated to use the billing provider as the rendering provider. If the rendering provider is not certified, the encounter is processed using the rules below.

Provider Types	Primary Specialty	Billing Indicator	Resolution
01, 02, 04, 05, 06, 12, 21, 24, 25, 26, 28, 29, 30, 53, 58, 61, 63, 67, 71, 72, 73	All	B (both billing and performing)	The billing provider is processed as both the billing and performing provider.

Provider Types	Primary Specialty	Billing Indicator	Resolution
All	900	B (both billing and performing)	The billing provider is processed as both the billing and performing provider.

11	801, 802, 803	B (both billing and performing)	The billing provider is processed as both the billing and performing provider.
19	191	B (both billing and performing)	The billing provider is processed as both the billing and performing provider.
33	333, 341	B (both billing and performing)	The billing provider is processed as both the billing and performing provider.
All others	All others	B (both billing and performing)	The billing provider and performing provider are processed as submitted.

The Certified Provider Listing extract is available on the ForwardHealth Portal. The layout is available on the report matrix at: *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*. The extract displays associated provider types, specialty codes, and billing indicators.



* Unique is defined as a single provider match. This is based on NPI, taxonomy, and zip submitted for the billing provider and NPI and taxonomy submitted for the rendering provider. ** Billing status is defined as either B Biller and Performer, Y Biller Only, or N Performer Only. *** Valid provider is defined as a submitted provider that has at least one match on the NPI in the ForwardHealth database for the DOS, regardless of contracts assigned.

5.7 Provider Matching and Usage Enhancements

To identify a unique biller and/or rendering provider on HMO encounters, ForwardHealth implemented provider reverse propagation and hierarchy logic enhancements. The reverse propagation and hierarchy logic enhancements are not performed on fee-for-service claims. The provider matching and usage enhancements are performed after provider propagation logic, Section 5.7 Provider Propagation Logic. This logic is applied when an encounter meets the conditions to flag one of the following errors:

- 1000 – Billing provider ID not on file.
- 1945 – Multiple provider locations for billing provider.
- 1952 – Multiple provider locations for performing provider.
- 1999 – Billing provider not effective for date of service.

The following steps are taken to identify a unique provider:

1. ForwardHealth determines if a unique billing provider can be identified using a combination of submitted NPI, taxonomy and zip code. If a unique billing provider cannot be identified, proceed to step #2 for professional or dental claim types (M, B or D). Process to step #4 for institutional claim types (I, O, H, A or C).
2. ForwardHealth determines if a header rendering provider is present for professional or dental claim types. If a header rendering provider is present, proceed to step #3. If a header rendering provider is not present or cannot be found, proceed to step #4.
3. ForwardHealth determines if a unique header rendering provider that is certified as either a performer or a biller and performer can be utilized for professional or dental claim types.

a. Reverse propagation (Section 5.8.1) is used if ForwardHealth determines that a unique header render provider, that is certified as either a performer or a biller and performer, can be identified using a combination of submitted NPI

and taxonomy. The header rendering provider will treated as the header billing and rendering provider.

b. Provider service location hierarchy logic (Section 5.8.2) is performed on the header rendering provider if a unique header rendering provider, certified as either a performer or a biller and performer, cannot be determined using the submitted NPI and taxonomy. If the hierarchy logic determines a match, reverse propagation logic (Section 5.8.1) is performed. The header rendering provider will be treated as the header billing and rendering provider.

c. Proceed to step #4 if the header rendering provider is certified as a biller or a prescribing/referring/ordering provider.

4. Provider service location hierarchy logic (Section 5.8.2) is performed on the header billing provider. If the hierarchy logic determines a match, the biller is used to process the encounter. If the hierarchy cannot determine a match, the encounter is denied with the submitted biller.

5.8.1 Provider Reverse Propagation Logic

Provider reverse propagation logic is performed on professional and dental claim types when a unique billing provider cannot be determined. The renderer is processed as the biller and performer if a unique rendering provider can be determined using a combination of submitted NPI and taxonomy or using provider service location hierarchy logic (Section 5.8.2), and the unique renderer is certified as a performer or a biller and performer. Informational EOB 1599 'Header Rendering Provider Used as the Billing Provider' is returned on the Encounter Response File.

5.8.2 Provider Service Location Hierarchy Logic

Provider service location hierarchy logic is performed when a unique provider cannot be determined with the submitted NPI, taxonomy, and/or zip code (where applicable). The encounter hierarchy logic will consider all service locations for the submitted NPI, regardless of submitted taxonomy and zip code. The hierarchy logic will use the first detail on the encounter and, in order of the logic, search until a match is found. When a match is found, all details of the encounter are processed using that provider, and informational EOB 1652 'HMO Hierarchy Logic Used to Determine Service Location' is returned on the Encounter Response File.

Refer to the Encounter Provider Hierarchy document found on the MCO Portal for examples and provider types used within the hierarchy logic:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage

5.8.3 Procedure Billing Rule Hierarchy Logic

Provider procedure billing rule service location hierarchy logic is performed when a procedure billing rule related error sets on professional and dental claim types. The hierarchy logic is triggered by the following errors:

- 4149 – Billing PT/PS restriction on procedure billing rule.
- 4150 – Performing/Facility PT/PS restriction on procedure billing rule.
- 4257 – Modifier restriction for procedure billing rule.
- 4714 – Age restriction on procedure billing rule.

- 4801 – No billing rule for procedure.
- 4821 – Place of service restriction on procedure billing rule.

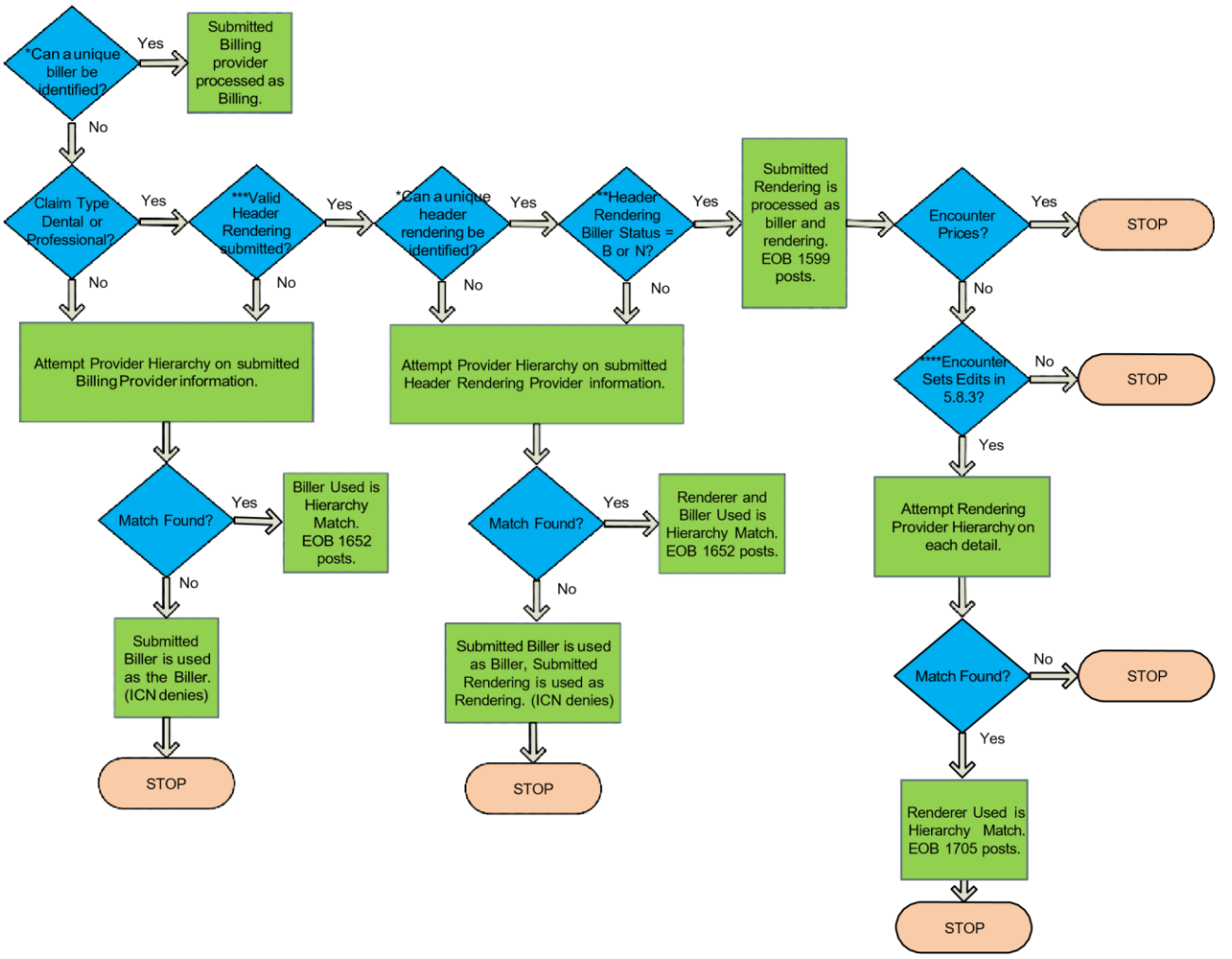
- 4865 – Claim region restriction on procedure billing rule.
- 4871 – Claim type restriction on procedure billing rule.
- 4990 – Benefit plan restriction for procedure billing rule.

The procedure billing rule hierarchy checks each detail within the encounter to assign an appropriate provider service location. If the detail rendering provider has multiple provider locations, the hierarchy attempts to apply the most suitable location for the procedure billed. Informational EOB 1705 'HMO Hierarchy Logic Used to Determine Service Location for Detail Rendering Provider' is returned on the Encounter Response File.

Refer to the Encounter Provider Service Hierarchy document found on the MCO Portal for examples and provider types used within the hierarchy logic:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage

5.8.4 Provider Reverse Propagation and Hierarchy Flow Diagrams

Provider Matching and Usage Enhancements (5.8)



*Unique is defined as a single provider match. This is based on NPI, taxonomy, and zip submitted for the billing provider and NPI and taxonomy submitted for the rendering provider.
**Billing status is defined as either B Biller and Performer, Y Biller Only, or N Performer Only.
***Valid provider is defined as a submitted provider that has at least one match on the NPI in the ForwardHealth database for the DOS, regardless of contracts assigned.
****Procedure Billing Rule Edits from 5.8.3 include 4149, 4150, 4257, 4714, 4801, 4821, 4865, 4871, 4990.

5.9 Encounter Edits

An edit is defined as a verification of encounter data on the submitted encounter. Edits consist of checks for required presence, format, consistency, reasonableness, and allowable values. Edit disposition for encounters are established according to state guidelines. Only internal errors are set to suspend. Encounters with internal errors are worked through an exception process. All other errors are set to inactive, price, or deny.

Some of the fee-for-service claim edits are set to active for encounter processing. See below for examples of these encounter edits:

- Validity Edits:
  - Diagnosis, Procedure, Condition Codes
  - Appropriate data formats
  - ICD-9 and ICD-10 Codes cannot be on same encounter
  - All standard code sets as defined in Appendix A of the 837 implementation guides
- Cost Avoidance Edits:
  - Commercial Insurance adjudication not submitted (Effective DOS 4/28/2015 through 7/6/2018, encounters were not denied for commercial insurance.)
  - Medicare Insurance adjudication not submitted
- Benefit Plan Rule Edits (the following are not applicable to HMOs):
  - ADAP AIDS Drug Assistance Program
  - AE Alien Emergency Services
  - BCBAS BadgerCare Plus Basic Plan
  - BCBEE BC+ Benchmark EE for Pregnant Women
  - BCSEE BC+ Standard EE for Pregnant Women
  - CRSW Community Recovery Services Waiver
  - CTS State Supplemental Payment - Caretaker Supplement
  - FC Family Care Non-MA
  - FPW Family Planning Services Only
  - MAPW Medicaid Purchase Plan Waiver < Waiver Medicaid>
  - PE Presumptive Eligibility - Pregnancy Only
  - QDWI Qualified Disabled Working Individuals
  - QMB Qualified Medicare Beneficiary
  - SC1 Senior Care Level 1- 0 to 200% FPL
  - SC2 Senior Care Level 2- Over 200% FPL
  - SLB Specified Low-income Medicare Beneficiary
  - SLB+ Specified Low-income Medicare Beneficiary Plus
  - SSI State Supplemental Payment - State Supplemental In
  - SSIE State Supplemental Payment - State Supplemental In
  - TB Tuberculosis Services Only
- Dental Edits:
  - Missing tooth number

- Invalid tooth number
- Invalid tooth surface

- Coverage Restriction Edits:
  - Gender
  - Age
  - Procedure modifiers
  - Procedure codes for diagnosis
  - Procedure codes not a benefit for Wisconsin (unless specifically addressed in this guide)
  - Procedure quantity restrictions
  - Diagnosis for revenue codes
  - Unit per day guidelines
  - Diagnosis and ICD procedure code specificity
- National Provider Identifier Edits:
  - Applied if unique location cannot be determined
- Taxonomy Edits:
  - Applied if multiple locations with matching zip (See *Section 5.8*)
  - If submitted, the taxonomy must be valid
- Encounter Balancing Edits:
  - Total header and total detail submitted amounts
  - Total header and total detail paid amounts
- Timely Filing Edits:
  - Applied if encounter submission date and TDOS is greater than 1232 days
  - Applied if encounter submission date and TDOS is greater than 375 days
    - 375 day edit applies to SSI Care Management records
- Credible Allegation of Fraud Edits:
  - Applied if provider contains credible allegation of fraud
  - Edit no longer sets when allegation of fraud is decided

Appendix A includes additional information pertaining to the encounter general policies and editing guidelines.

The following fee-for-service edits are examples of those that will be reconsidered after January 1, 2013 for encounter processing:

- ClaimCheck (GMIS)
- Medically Unnecessary Edit (MUE)
- Correct Coding Initiative (CCI)

5.10 Edit Disposition

Encounters may be denied at the header or detail level. Encounters with detail level errors may still be priced at the header level if other details are priced.

5.11 Diagnosis Pointers

All 837P (professional) encounter transactions require a diagnosis code pointer. Each detail allows up to four diagnosis pointers. Diagnosis pointers are designated in 837P Loop 2400 SV107. Diagnosis pointers are assigned in the order of importance to the service. The first pointer designates the primary diagnosis for the service line. Remaining diagnosis pointers indicate declining level of importance to the service line. Acceptable values are 1 through 12 and correspond to Loop 2300 Health Care Diagnosis Code HI01-2 through HI12-2. Policy edits monitor that appropriate diagnosis codes are billed with specific procedure codes.

Diagnosis pointers are situational on the 837D (dental) encounter transactions. If diagnosis codes are submitted in Loop 2300 Health Care Diagnosis Code HI01, the diagnosis pointer in Loop 2400 SV311 Composite Diagnosis Code Pointer is required.

5.12 Abortion, Hysterectomy and Sterilization Requirements

HMOs should continue to comply with the following state and federal compliance requirements for the services listed below:

- Abortions must comply with the requirements of *s. 20.927, Wis. Stats.,* and 42 CFR Subpart E-Abortions at *https://www.ecfr.gov/cgi-bin/text-idx?SID=70dcf815a9d37844184f809640313ea1&mc=true&node=pt42.4.441&rgn=div5#sp42.4.441.e*

- *Hysterectomies* and sterilizations must comply with 42 CFR Subpart F- Sterilizations at *https://www.ecfr.gov/cgi-bin/text-idx?SID=70dcf815a9d37844184f809640313ea1&mc=true&node=pt42.4.441&rg n=div5#sp42.4.441.f* Sanctions in the amount of $10,000 may be imposed for non-compliance with the above compliance requirements. The HMO must abide by *s. 609.30, Wis. Stats*.

For auditing purposes, HMOs should obtain and provide necessary supporting documentation for any abortion, hysterectomy and sterilization procedures.

5.13 Encounter Pricing Policy

Effective January 1, 2013, ForwardHealth prices most encounters using existing fee-for- service pricing methodologies. Exceptions are included in this section. HMO payment information is stored and is used to determine whether the HMO actually paid for the services.

5.13.1 Pricing Guide Documentation

The MCO Pricing Administration Guide is a resource for HMOs to interpret the Max Fee extract and MMIS reimbursement policy, and is updated quarterly. To view the MCO Pricing Guide, refer to the following link:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage

5.13.2 Pricing Indicator Values

The pricing indicator determines the reimbursement methodology for encounters.

Pricing Indicator	Description
ANESTH	Anesthesia pricing
APC	OPPS PRICING
AWP	Average Wholesale Price
BILLED	Pay the billed amount
CEPR	Calculated Ceiling Price
DRG	Diagnosis Related Groups
EAC	Estimated Acquisition Cost
EAPG	Enhanced Ambulatory Patient Grouping
EMAC	Expanded Maximum Allowed Cost
ESRD	End Stage Renal Disease
ESRDMC	ESRD - non rule indicator
ESRDMX	ESRD Max Fee
HIPPS	LTC HIPPS Code Pricing
IPDIEM	Inpatient per diem price
LTCANC	LTC Ancillary Pricing
LTCLOC	Level of Care Pricing
MAC	Maximum Allowable Cost
MANUAL	Suspended and Manual Priced
MAXFEE	Max rate on file
MAXOUT	OUTPA procedure pricing
MINSPC	Crossover Institutional
NADAC	National Average Drug Acquisition Cost
NDCLOW	Lowest Available Rate
OPPRVR	Percentage & per diem
PAY0	Allowed amount pay 0
RBRVS	Resource Based Relative Value Scale
SMAC	State Max Allowable Cost
SPEC	Specialty Pricing
SYSMAN	Reimbursement rules price
UCBILL	Billing providers UCC
UCCALL	Billing or providers UCC
UCPERF	Performing providers UCC
WAC	Wholesale Acquisition Cost
WPQC	Pay Billed Amt for MTM

5.13.3 Pricing Inclusions and Exclusions

The following are examples of policies that are included for encounter pricing:

- For DOS on or after January 1, 2026, SYSMAN encounters will no longer use a percent-of-billed pricing. Instead, pricing will be based on the actual HMO-paid amount submitted at the encounter detail. Current logic remains in place for earlier dates.
- Manual Pricing is replaced by a single default percent based on the date of service. This default percentage will be updated annually. In the ForwardHealth system, manually priced services are procedure codes with a Pricing Indicator Code of SYSMAN, as listed on the monthly Max Fee file:
    - 72.1 of the billed amount for dates of service prior to January 1, 2012.
    - 75.9 for dates of service between January 1, 2012 and December 31, 2013. ○ 56.74 for dates of service on and after January 1, 2014. ○ 52.38 for dates of service on and after January 1, 2016. ○ 42.2 for dates of service on and after January 1, 2017. ○ 33.8 for dates of service on and after January 1, 2018. ○ 28.7 for dates of service on and after January 1, 2019. ○ 31.0 for dates of service on and after January 1, 2020. ○ 30.8 for dates of service on and after January 1, 2021. ○ 25.3 for dates of service on and after January 1, 2022. ○ 26.1 for dates of service on and after January 1, 2023. ○ 22.9 for dates of service on and after January 1, 2024. ○ 24.8 for dates of service on between January 1, 2025, and December 31, 2025.

- Medicare payments (crossover encounters) are accounted for during the pricing process.
- Other insurance payments are accounted for during the pricing process.
- Assignment of Other Insurance (OI) indicator and Medicare Disclaimer codes applies.
- Services not covered by the current HMO contract are denied.
- Encounters submitted with quantities exceeding the quantity limits for the services provided are denied or cut-back to the policy limitation.
- The ForwardHealth encounter system allows for the interim billing of inpatient encounters.
- All End Stage Renal Disease (ESRD) encounters are processed according to the standard policy outlined in the ForwardHealth Online Handbook on the Portal.
- If the Provider Type/Provider Specialty (PT/PS) is not within the policy guidelines for the services provided, the encounter or encounter detail is denied.
- If the place of service (POS) is not within the policy guidelines for the services provided, the encounter or encounter detail is denied.

The following policies are examples of those that are excluded from encounter pricing January 1, 2013:

- Prior Authorization
- Medical Review Rules
- Spenddown
- Dental Coinsurance and Deductibles

- Access Payments for Ambulatory Surgery Center, Hospitals, and Critical Access Hospitals
- Hospital Pay for Performance, encounter withhold
- Drug rebates

5.13.4 Pricing Out of State Encounters

Out of state providers must be licensed in the United States (and its territories), Mexico, and Canada. Out of state providers are required to be licensed in their own state of practice. Reimbursement for services in an emergency situation is defined in DHS 101.03(52), Wis. Admin. Code. The out of state provider must be in the state provider file before an encounter is submitted.

A non-certified out of state provider must apply through the ForwardHealth Portal at www.forwardhealth.wi.gov to have an NPI or provider ID entered into the state's provider file as a certified Wisconsin Medicaid provider. To begin the application, select 'Become a Provider', 'Start or Continue Your Enrollment', and 'Medicaid In-State Emergency/Out of state Provider Enrollment.' The user will then be guided through a series of screens. Affordable Care Act out of state provider requirements and potential fees apply. For application process assistance, call Provider Services at 800- 947-9627. Upon submission, an application tracking number (ATN) will be given. From the Portal, select the 'Enrollment Tracking Search' quick link for enrollment status information. The effective date of enrollment is the date the provider rendered service. Out of state providers are required to revalidate enrollment every three years. A notice is mailed to the HMO when revalidation is required. When submitting encounters for out of state emergency services via X12 837 transactions, populate the following segments based on the encounter type:

- 837P: Set element SV109 (Emergency Indicator) in Loop 2400 to 'Y'.
- 837D and 837I: Set element REF02 (Service Authorization Exception Code) in Loop 2300 to "3" – Emergency Care.

5.13.5 Hospice Pricing

Manual pricing at a percentage of the billed amount is used to price hospice encounters.

5.13.6 Benchmark Dental

The Benchmark Plan dental enhancement pricing is applied outside the encounter processing system.

5.13.7 Ventilator, Neurobehavioral, and Coma Pricing

Encounter uses Diagnosis Related Group (DRG) pricing for inpatient hospital ventilator, neurobehavioral, and coma encounters.

5.13.8 Mental Health

Mental Health/Substance Abuse encounters submitted without modifiers are priced at the lowest applicable professional rate.

5.13.9 Hearing Aids

Manual pricing at a percentage of the billed amount is used for hearing aid encounters. Rentals use existing Max Fee pricing.

5.13.10 Vision Pricing

Manual pricing at a percentage of the billed amount is used for vision services.

5.13.11 Carved Out Services

Encounters for services that are carved out of encounter processing are denied. For further information on carved out services in the HMO contract, Article III.E.1 refer to the following link:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/Home.htm.spage

5.13.12 Drug Carve Out

In most cases, providers receive payment for provider administered drugs billed as an unbundled service on the 837 transaction through the fee-for-service system. Refer to May 2009 Forward Health Update (2009-25), titled "Clarification of Policy and Reimbursement for Provider-Administered Drugs," at *www.forwardhealth.wi.gov/kw/pdf/2009-25.pdf*. For further clarifications and changes see 2014 Forward Health Update (2014-79), titled "Changes to Provider-Administered Drugs Carve-Out Policy," at *www.forwardhealth.wi.gov/kw/pdf/2014-79.pdf.* These codes are not submitted as HMO encounters.

The following are submitted as encounters:

- *Dental* — Encounters for drugs included in the cost of the procedure are submitted on the 837P transaction.
- *Vaccines* — Encounters for vaccines and the associated administration fees are submitted on the 837P transaction.
- *I.V. Therapy* — Encounters for certain bundled services are submitted on the 837P transaction. Examples include hydration, catheter maintenance, and Total Parenteral Nutrition (TPN).
- *Radiopharmaceuticals (PET scans, Bone scans etc.)* — Encounters for radiopharmaceuticals are submitted on the 837P transaction. Radiopharmaceuticals are included in the Deficit Reduction Act (DRA) requirements. HMOs are required to indicate the National Data Corporation/National Drug Codes (NDCs) with Healthcare Common Procedure Coding System (HCPCS) procedure codes on encounters for radiopharmaceuticals that are submitted separately from a composite radiology service. For radiopharmaceuticals submitted as a part of a composite radiology service, an NDC is not required.
- *Synagis*® — Encounters for Synagis® are submitted on the 837P transaction.
- *ESRD* — Encounters for ESRD, except those for members enrolled in the Program for All Inclusive Care for the Elderly (PACE) and Family Care Partnership, are submitted on the 837I transaction.

5.14 Financial, TPL, and Utilization Logic

Financial, TPL (Third Party Liability), and utilization indicators determine whether an encounter is used in rate setting and/or reporting.

Each encounter header and detail is assigned a financial, TPL, and utilization indicator:

- A financial indicator of 'Y' (Yes) signifies the encounter header or detail has an HMO payment and will be used in rate setting for the HMO.
- A TPL indicator of 'Y' (Yes) signifies the encounter header or detail has an other insurance payment and will be used in rate setting for the HMO.
- A utilization indicator of 'Y' (Yes) signifies the encounter header or detail will be included in utilization reports for the HMO.

A header or detail financial indicator of 'Y' results in a utilization indicator of 'Y'. However, a header or detail may be assigned a utilization indicator of 'Y', even if the financial indicator is 'N'.

Chart reviews are given a financial indicator of 'N' and a utilization indicator of 'Y' regardless of what is submitted on the record.

The financial indicator is determined by the HMO paid amount and the HMO shadow paid amount submitted on the encounter. When a paid or shadow amount greater than zero is submitted at the header level, the header will receive a financial indicator of 'Y'. When a paid or shadow amount greater than zero is submitted at the detail level, the detail will receive a financial indicator of 'Y'.

A paid amount > 0 at the header level results in the header and all details receiving a financial indicator of 'Y' and a utilization indicator of 'Y' for Claim Types I, A, O, C, but not for Claim Types M, B, D, H, L.

A shadow amount > 0 at the header level results in the header and all details receiving a financial indicator of 'Y' and a utilization indicator of 'Y' for Claim Types I, A, O, C, H, or L but not CT M, B, D.

If an HMO does not submit a paid amount, the adjustment reason codes submitted are used to assign the utilization indicators.

Group 1002 contains all ANSI codes that indicate utilization only.

See *Appendix B — ANSI Code Groups*

The TPL indicator is determined by the other insurance paid amount submitted on the encounter. When any other insurance (Medicare, Commercial Insurance, etc.) amount greater than zero is submitted at the header level, the header and all details will receive a TPL indicator of 'Y'. When an other insurance amount is submitted at the detail level, only that detail receives a 'Y' TPL indicator.

Encounters with a TPL indicator of 'Y' and a financial indicator of 'N' reprice at $0 and apply EOB code 9965 [Pricing Adjustment – The payment amount cutback due to a zero dollar HMO payment].

5.15 Duplicate Monitoring

Encounters are monitored for duplicates in the current encounter submission and historic encounter submissions.

5.15.1 Duplicate Audits

Each compliant encounter is matched against the HMO encounter database to determine if it is a duplicate. Duplicate encounters are denied. The table below outlines the criteria monitored for 837 transactions.

Encounter Types	Duplicate Criteria
Physician Physician Crossover Home Health	Modifier Member ID Billing Provider Performing Provider Procedure Code FDOS TDOS
Dental	Member ID Performing Provider FDOS TDOS Procedure Code Area of the Oral Cavity Tooth Number
Outpatient Outpatient Crossover Inpatient Inpatient Crossover Long Term Care	Member ID Claim Type Billing Provider ID FDOS TDOS Billed Amount

5.16 HMO Adjudication Information

HMOs are required to submit paid service and coordination of benefits information on the 837 encounter transaction. This information provides Wisconsin ForwardHealth the ability to compare aggregate costs of interChange priced amounts based on the Medicaid fee schedule to the HMO paid amounts. The following sections detail required data elements in the 837 encounter transaction.

5.16.1 Population of the HMO ID

- The HMO is identified as a payer on the 837 transaction in Loop 2320 Other Subscriber Information.
- Element SBR01 Payer Responsibility Sequence Number Code indicates the order in which the HMO as a payer has adjudicated the encounter.
- Element SBR09 Filing Indicator Code is 'HM' to indicate HMO adjudication.

- The 8-digit ForwardHealth HMO ID is submitted in Loop 2330B Other Payer Name, Element NM109 Other Payer Primary Identifier where NM108 is populated with 'PI'.
- The HMO is identified as a payer at the line level, if applicable, in Loop 2430 Line Adjudication Information.
- The value in Loop 2430, Element SVD01 Other Payer Primary Identifier must match the value in 2330B NM109.

Note: Loop 2320 is repeated for each other payer that has adjudicated the encounter. This includes Commercial Insurance, Medicare, Medicare Advantage, or Medicare Supplemental Policies. One iteration of this loop is required on all encounters to indicate the HMO payment information. See *Section 5.17* for further information on submitting Medicare adjudication information.

Refer to *Section 7* for further information on the HMO ID submitted when adjusting a converted encounter.

5.16.2 Population of the HMO Payment Information

Refer to the 837 implementation guides and 837 companion guides for detailed information on loops and segments that contain specific HMO payment information. The 837 companion guides are available at:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Account/StaticHTML.aspx?srcUrl=CompanionDocuments.htm

5.16.3 Proprietary Information

An HMO may designate the HMO paid amounts within the submitted encounter data and its medical-loss ratio reports (if the information qualifies as a trade secret as defined in Wis.Stats. s. 134.90(1)(c)) as confidential and proprietary. The Department will accept the designation and deny disclosure to unauthorized persons, including to those who request such information under Wisconsin public records law. If the designation of confidentiality is challenged, the HMO will provide legal counsel or other necessary assistance to defend the designation of confidentiality and will not hold the Department accountable for any costs or damages arising out of the Department's agreement to withhold such information.

5.17 Sub-Capitated Encounter Information

Sub-capitated providers are typically paid a flat fee per member per month by the HMO rather than on a fee-for-service basis. HMOs submit sub-capitated payment information on the 837 transaction in Loop 2320 for encounters paid at the header and in Loop 2430 for encounters paid at the detail. The sub-capitated payment amount is zero. Adjustment reason codes, including Code 24 (charges are covered under a capitation agreement/managed care plan), balance the transaction. Code 24 is present at the detail level for professional and dental services. Code 24 is present at the header level for institutional services.

5.17.1 Shadow Pricing on Sub-Capitated Encounters

When an encounter is sub-capitated, the 837 Medicaid HMO payer loops include a zero paid amount and Adjustment Reason Code 24. The HMO assigns a shadow price that would have been paid if the service was not sub-capitated. The shadow priced amount is populated in the CN1 segment of the 837 transaction. The CN1 segment is present at the header and detail level for professional and dental services, and is only available at the header level for institutional services.

5.18 Medicare Adjudication Information

HMOs are required to submit Medicare adjudication information on the 837 encounter transaction. The information provides Wisconsin ForwardHealth the necessary elements to accurately adjudicate encounters for dual eligible members. The following sections detail specific required elements in the 837 encounter transaction.

5.18.1 Population of the Medicare Adjudication Information

- Element SBR01 Payer Responsibility Sequence Number Code indicates the order in which Medicare as a Payer has adjudicated the encounter.
- Element SBR09 Filing Indicator Code is 'MA' – Medicare Part A or 'MB' – Medicare Part B or '16' – Medicare Advantage to indicate Medicare adjudication.
- Medicare is identified as a payer at the line level, if applicable, in Loop 2430 Line Adjudication Information.
- The value in Loop 2430, Element SVD01 Other Payer Primary Identifier must match the value in 2330B NM109.
- Medicare encounters include all patient responsibility information as adjudicated by Medicare in the appropriate CAS segments (header vs. detail)
- Professional encounters with Medicare adjudication information should include the Medicare paid amounts at both the header and detail. The patient responsibility information should be provided at the detail only.
- Outpatient encounters with Medicare adjudication information should include the Medicare paid amount at the detail. The patient responsibility information should also be provided at the detail.
- Inpatient encounters with Medicare adjudication information should include the Medicare paid amount at the header. The patient responsibility information should also be provided at the header.

5.18.2 Medicare Pricing

It is important that the patient responsibility amount(s) from Medicare are provided on all 837 transmissions to ForwardHealth. Medicare pricing is based on the Medicare patient responsibility submitted on the Medicaid 837 encounter transaction. Medicaid never pays more than the Medicare patient responsibility amount(s) submitted. If no Medicare patient responsibility is submitted, the encounter will price at zero. Examples of Medicare patient responsibility are: 1 - Deductible, 2 – Coinsurance, 3 – Copayment (Medicare Advantage), 66 – Blood Deductible or 122 – Psychiatric Reduction.

6 Chart Review Overview

6.1 Chart Review Definition

An encounter may be created from data acquired through medical record/chart reviews or other non-encounter sources. Data may be pulled from member medical records, provider reports, and electronic supplemental data. Member reported biometric values from self- administered tests and member survey data may not be used for chart review data.

Examples of services or items the HMO might include as a chart review encounter are:

- HealthCheck services
- Medical records transferred from another state
- HbA1c (blood sugar test)
- Lead screen from a Women Infants and Children (WIC) agency

6.2 Chart Review Submission

Chart reviews are submitted on the 837I or 837P transactions and edited with the same policies as encounters, i.e., all 837 required fields are populated. Dental providers do not submit chart reviewed data. Chart reviews are designated in Loop 2300 on the 837I or 837P with the PWK*09*AA segment. Use of the PWK segment coincides with the CMS encounter companion guides.

The encounter chart review is "unlinked" if it is not submitted to supplement an existing encounter. The encounter chart review is "linked" if it is submitted to supplement an existing encounter. "Linked" chart reviews are designated with the ForwardHealth ICN in Loop 2300 with the REF-Payer Claim Control Number segment, REF*F8*<ICN number>. Use of the REF-Payer Claim Control Number segment coincides with the CMS encounter companion guides.

7 Encounter Adjustment Process

7.1 Encounter Adjustment Reasons

After reviewing the encounter and ForwardHealth priced amount, an HMO determines if an adjustment is needed on an allowed encounter. HMOs file adjustment requests for reasons including the following:

- To correct billing or processing errors.
- To correct inappropriate encounter submitted amounts.
- To add and delete services.
- To supply additional information that may affect the allowed amount.

Only encounters that were paid in the ForwardHealth system can be adjusted or voided. A paid encounter is identified as any encounter with a paid status at the header level as returned on the Encounter Response File. Attempting to adjust or void a previously denied encounter will result in an error. Whether the HMO paid or denied the original encounter has no bearing on whether an adjustment/void can be submitted.

7.2 Encounter Adjustment Submission

HMOs may initiate reconsideration of a priced encounter by submitting an 837 adjustment request to ForwardHealth with a frequency of 7 (Replacement) or 8 (Void). The entire encounter is resubmitted in order to replace or void; individual details are not submitted independently. Loop 2300 Element CLM05-3 and Loop 2300 REF Payer Claim Control Number are used to designate an encounter as an original, resubmission after deny, replacement, or void. The ForwardHealth ICN is assigned to the HMO encounter.

All adjustments or void submissions need to follow the 837 compliance standards and must contain all required fields. For further guidance consult the 837 implementation and companion guides.

7.3 Examples

Original submission or resubmission of a denied encounter:

CLM05-3=”1”

REF Payer Claim Control Number Segment is not used since a priced ICN has not yet been assigned.

Scenario: A compliant encounter was denied because of a mismatch of diagnosis and revenue codes. The codes are corrected and the encounter is submitted. A new ICN is assigned.

Correct a previously priced encounter:

CLM05-3= “7”
REF*F8*ICN_NUMBER~

Scenario: One detail of a mental health/substance abuse encounter was priced at the lowest applicable professional rate due to missing modifiers. A total of 10 details were originally submitted for the encounter. The modifiers are added and the entire encounter is submitted. A new ICN is assigned.

Void a previously priced encounter:

CLM05-3=”8”
REF*F8*ICN_NUMBER~

Scenario: The HMO discovers it submitted erroneous information on an encounter and wants to void the encounter. The **entire** encounter is resubmitted as a void. A new ICN is assigned.

7.4 Evaluating Adjustment/Void Responses

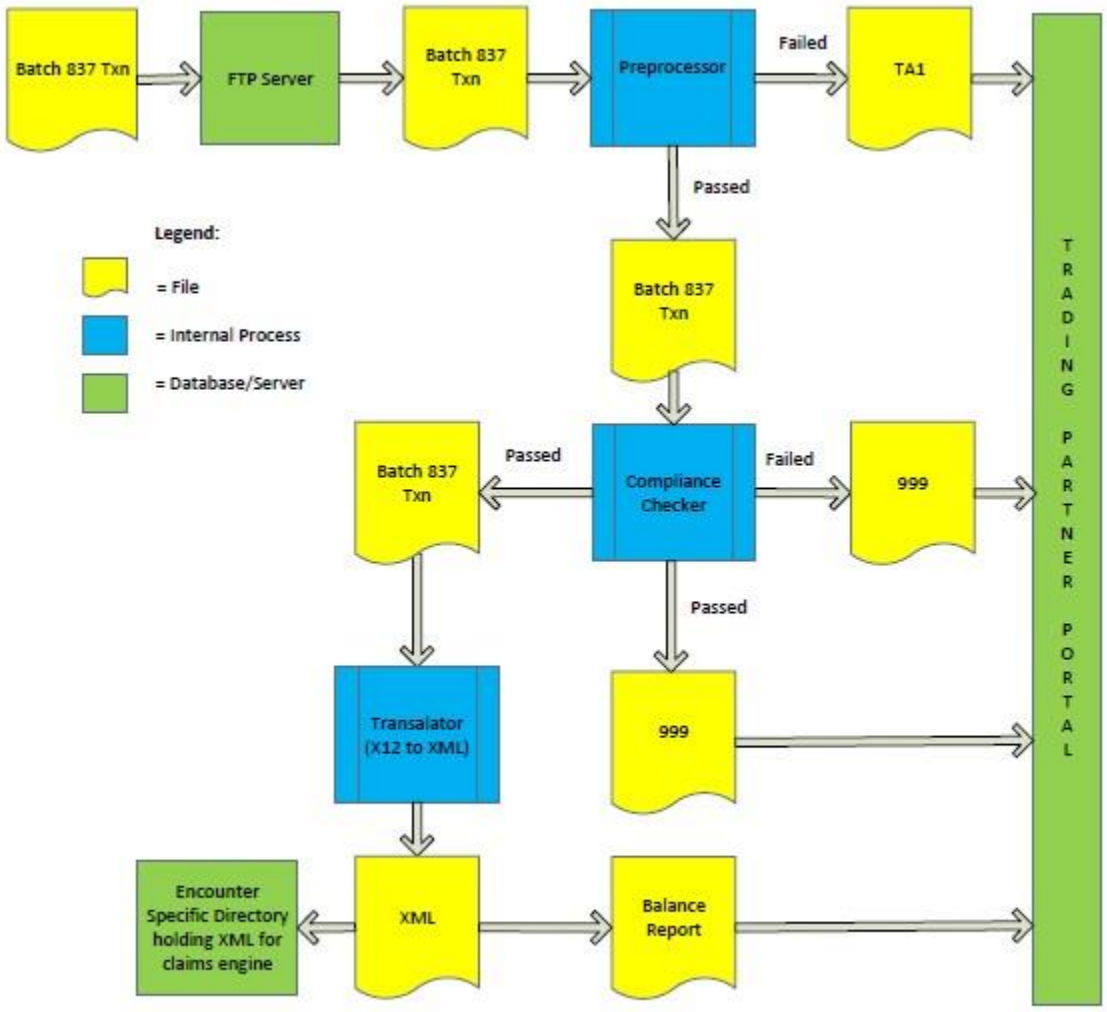
The weekly Encounter Response File allows HMOs to evaluate results of an attempted encounter adjustment/void. The region returned on the encounter dictates whether the

attempted adjustment or void was successful. Successful adjustments/voids receive a region 72 on the returned ICN. Region 72 means the original ICN has been adjusted/voided and is no longer active. Future adjustments/voids submitted will reference the new region 72 ICN, unless it is denied, then any new submissions are submitted as a new day encounter (frequency 1).

For example, if ICN 7012345678901 is adjusted and the resulting ICN is 7212345678901, the adjustment was successful and ICN 7012345678901 is no longer active. If ICN 7212345678901 is a paid encounter, any future voids or adjustments reference that ICN. If ICN 7012345678901 is adjusted and the resulting ICN is populated with region 70, the adjustment was not successful. The original ICN is still active, and any future adjustments/voids reference 7012345678901.

8 EDI File Response

8.1 EDI Response Flowchart



8.2 EDI Response Transactions

This section describes the EDI response files returned for an 837 submission and how to retrieve them.

- HMO encounters are accepted or rejected based on 837 compliance criteria.
- TA1 responses are for X12 header data errors.

- TA1 errors stop the files from processing further.
- 999 responses are for X12 functional group errors or acknowledgement.
- TA1/999 responses are available on the Trading Partner Profile. **EDI Response Table**

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837 Data	Accept or Reject	EDI Response
Header/Trailer A	**Accept**	**none**
ST/SE Envelope 1 (100 encounters)	Accept	999 – Accepted – File
ST/SE Envelope 2 (100 encounters)	Reject	999 – Rejected – File
Header/Trailer B	**Reject**	**TA1 File**
ST/SE Envelope 1 (100 encounters)	Never evaluated	none
ST/SE Envelope 2 (100 encounters)	Never evaluated	none

Electronic Data Interchange response files are located on the Trading Partner area of the Portal. Portal user guides are available on the Portal at: *www.forwardhealth.wi.gov/WIPortal/content/Provider/userguides/userguides.htm.spage* Companion Guides:

TA1 – *www.dhs.wisconsin.gov/publications/P0/p00269.pdf*

999 – *www.dhs.wisconsin.gov/publications/P0/p00268.pdf*

8.3 EDI Response Report

In addition to the HIPAA X12 transaction, HMOs receive an EDI report from the Trading Partner area of the Portal. The EDI department produces an EDI Batch Submit Balance Report in response to each 837 transaction. The report displays the count of compliant, accepted, and rejected encounters.

Report : EDI-0420-D FORWARDHEALTH INTERCHANGE Run Date: 02/27/2012
Process : EDI_MOVEINB Run Time: 10:20:12
Location: EDI0420D EDI BATCH SUBMIT BALANCE Page: 1
Payer : ALL REPORT PERIOD: 02/27/2012

SUBMITTER: 100000XXX

FILENAME: <filename here>

SAK File Track	Transaction Type	Compliant Count	Translate Accepted	Translate Rejected
222769	5010-Institutional (837I)	1	1	0

*** END OF REPORT ***

8.4 EDI File Retention

EDI retains Trading Partner Portal files on the file server for six months. After six months, the files are moved to offline storage and are archived for 12 years. To retrieve archived files, contact EDI Support at *VEDSWIEDI@wisconsin.gov* or (866) 416-4979.

8.5 Trading Partner Information

New trading partners are required to complete a Trading Partner Profile (TPP), containing transaction and contact information as the first step in the EDI enrollment process. The Trading Partner Profile is completed online at *www.forwardhealth.wi.gov*. Current trading partners add the 837 transaction to their Trading Partner Profile. Trading Partner Profile assistance is available from EDI Support at *VEDSWIEDI@wisconsin.gov* or (866) 416-4979.

9 Encounter File Response

9.1 Encounter File Format

The Encounter Response File is the main source for evaluating the processing and pricing of encounters by ForwardHealth interChange. The Encounter Response File is located on the SFTP server, and contains encounter status, pricing information, EOB codes, and other data submitted on the 837 encounter. To view the Encounter Response File layout refer to the Report Matrix: *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*.

For the Explanation of Benefit Codes see: *www.forwardhealth.wi.gov/WIPortal/content/Provider/EOBs/EOB_Messages.htm.spage*.

9.2 Encounter File Timing

The Encounter Response File is created and delivered to the HMO SFTP server weekly, and is available the first working day of each week. The response file contains all encounter records that finalized in the previous week. The finalized records include records submitted in the current week, records submitted in previous weeks, or records created as the result of state initiated adjustments.

9.3 ForwardHealth Initiated Adjustments

An adjustment may be initiated on the ForwardHealth side of processing. These adjustments can be identified by the region code of the ICN. Refer to *Section 5.6* for further information on region codes.

ForwardHealth initiated adjustments display on the response file with a blank 150 record. HMOs identify ForwardHealth adjustments on the weekly Encounter Response File. Future adjustments or voids to those ForwardHealth adjusted encounters use the new adjusted ICNs.

9.4 Void Information on Response Files

Successfully voided encounters appear on the Encounter Response File as denied with Region 72 and EOB 8188. Field values on the Encounter Response File for a void encounter are from the encounter being voided.

9.5 Adjustment Information on Response Files

Successfully adjusted encounters appear on the Encounter Response File with Region 72. The Claim Submitters Identifier populated on the response file is from the encounter being adjusted.

9.6 Interpreting Response File Error and EOB Information

The Encounter Response File records 520 (header) and 620 (detail) return error and EOB information for processed encounters. The errors and EOBs provide additional information about the encounter. To determine the reason for an encounter denial, all errors and EOBs should be evaluated as a group.

Tag along errors and EOBs post with the error(s) and EOB(s) directly related to the denial. Tag along error(s) and EOB(s) post because there are restrictions, not necessarily that the restrictions were not met.

10 Encounter Control Report

10.1 Encounter Control Report Format

The encounter Control Report contains balancing information from submitted encounter records. To view the report layout refer to the Report Matrix:

www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage.

10.2 Encounter Control Report Timing

The encounter Control Report is created and delivered to the HMO SFTP server weekly, and is available the first working day of each week.

10.3 Encounter Control Report Fields

The encounter Control Report contains the following fields:

- Trading Partner — Trading Partner ID followed by the name associated with the ID.
- File Name – Name of the submitted encounter file.
- Input Count – Number of encounter transactions in the specified file.
- Rejected Encounters: EDI/Compliance – Number of encounter transactions in the specified file that failed EDI compliance processing.
- Rejected Encounters: Duplicate – Number of duplicate encounter transactions in the specified file.
- Rejected Encounters: Invalid – Number of invalid encounter transactions in the specified file.
- Processed Encounters – Number of encounter transactions in the specified file that were successfully processed by the encounter processing engine.
- Paid Encounters – Number of paid encounter transactions in the specified file.
- Denied Encounters – Number of denied encounter transactions in the specified file.
- Suspended Encounters – Number of suspended encounter transactions in the specified file.
- Processing Status –The file processing status at the time this report is produced
  - In Progress – File has passed compliance but has not yet been processed through the claims engine
  - Complete – File has processed through the claims engine

TP Totals – The totals for all of the above columns.

11 Available Reports

11.1 Report Introduction

A number of reports are available to assist HMOs. To view report layouts refer to the Report Matrix:
www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data_ta/hmomatrix.htm.spage

11.2 Encounter Reports

This section outlines the reports used in the submission of encounter data.

Certified Provider Listing — a listing of all certified Medicaid providers organized by provider type and specialty. All providers with a valid certification within the previous two years are included, along with the associated certification beginning and end date, NPI, taxonomy, and zip code.

HMO Max Fee Extract — an extract showing all Medicaid procedure codes that are paid on a
Max Fee basis. The extract includes procedure base information with associated provider types, POS values, and covered contracts. To view the Max Fee extract layout refer to the HMO Pricing Administration Guide:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/En_counters_and_Reporting/Home.htm.spage

Encounter Response File – Detailed in *Section 9* of this user guide.

Encounter Control Report – Detailed in *Section 10* of this user guide.

EDI Batch Submit Balance Report – Detailed in *Section 8.3* of this user guide.

Encounter Suspend Report – A weekly report which lists all currently suspended encounters for the HMO. It lists the HMO claim number, the ICN and the reason for suspension.

12 HMO Contact Information

12.1 Encounter HMO Contacts

This section outlines how HMO contact information is stored and utilized by the encounter system. Contact information is communicated via the HMO Support Mailbox (*vedshmosupport@wisconsin.gov*). ForwardHealth maintains a primary and backup contact.

To update HMO contact information, email *vedshmosupport@wisconsin.gov* including the name, email address, and phone number for the primary and backup contact.

12.2 HMO Contact Usage

An automated SFTP scanning process notifies the HMOs and HMO Support when files are present that do not meet anticipated naming conventions.

The following naming conventions are recognized:

- 100000001_CCYYMMDD_001.dat (Encounter 837 Submission).
  - Trading partner ID – 9 digit numeric. ○ Date – numeric – CCYYMMDD format.
  - Sequence – numeric with leading zeroes – 3 digits.
- PEHIDATA6900XXXX.txt (Physical Examination Health Indicator file).
- PROVIDER_NETWORK_6900XXXX_MMDDYY.zip (HMO provider network files).
- XXXX_KICK_PAYMENT_NEWBORNS_MMYY.zip (or .txt) (HMO kick payment report where XXXX is the last 4 digits of the HMO ID).
- TPL6900000011132015.xlsx (TPL Discrepancy files).
- PPACA_100000001_20151113.zip (PPACA Returned Files, should use the same naming convention as the original PPACA report delivered to the HMO).
- WIHMO_PAH_6900XXXX_e_ccyymm.txt (HMO PA submission files) ○ 6900XXXX – HMO ID submitting the file ○ e - Environment indicator (P-Production or T-Test)
- HPN-6900XXXX-CCYYMMDD.zip (Provider Network Files)
- ENC_BASED_PAYMENT_6900XXXX_YYYYMMDD_RETURN.csv (Encounter Based Payment Return files showing the HMO distributed payments)

13 Eligibility Updates for HMO Members

13.1 Demographic or Eligibility Information

HMO concerns about member demographic or eligibility information are directed to the county agency.

13.2 Third Party Liability Discrepancies

HMOs receive 2 files detailing member Third Party Liability (TPL) information:

- The TPL MCO Coordination of Benefit (COB) extract runs monthly and contains HMO members and the associated TPL information in interChange. A file is created for each HMO and sent to the Portal and SFTP server for the MCOs to retrieve.
- The X12 834 Benefit Enrollment and Maintenance transaction is produced twice a month and provides HMOs with TPL information that includes Member, Insurer, Policy and Group number, Coordination of Benefits Eligibility Dates and Service Type Codes.

If the HMO identifies insurance coverage outside the member TPL extracts, or the insurance does not cover the service for the date, the 'Other Coverage Discrepancy Report' – Form F-1159 in *Appendix C* must be completed and submitted.

The Portal input form can be updated with all required information and a copy of the member's insurance identification card. The form will be submitted via the Portal.

14 CLIA Processing Information

14.1 CLIA Introduction

Congress implemented CLIA to improve the quality and safety of laboratory services. CLIA requires all laboratories and providers that perform tests (including waived tests) for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. This requirement applies even if only a single test is being performed. Refer to the CMS CLIA website for further information on CMS requirements:

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html

14.2 CLIA Enforcement

Encounters are not monitored during processing. It is the responsibility of the HMOs to verify that their providers have all necessary CLIA certifications.

14.3 CLIA Extract

HMOs receive a CLIA extract on a weekly basis. To view the CLIA report layout refer to the HMO Report Matrix:

www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data_ta/hmomatrix.htm.spage

The extract is posted to the SFTP and Managed Care Portal.

14.4 CLIA Extract Fields

The following fields will be included in the CLIA extract:

- Medicaid Provider Number – proprietary provider ID pointing to unique provider service location.
- Provider NPI – National Provider Identifier for the Provider.
- CLIA Number – Provider Clinical Laboratory Improvement Act identification number.
- Certification Type – CLIA type certification code [Regular, Waiver, Accreditation, Provider-Performed Microscopy Procedure (PPMP), Partial Accredited and Registration].
- CLIA Start Date – start date of Provider's CLIA number.
- CLIA End Date – end date of Provider's CLIA number.
- Certification Effective Date – date this CLIA number is effective for this provider.
- Certification End Date – date this CLIA number is no longer effective for this provider.
- Lab Code – the CLIA lab code.
- Lab Effective Date – effective date of CLIA lab code.
- Lab End Date – end date of CLIA lab code.

15 Units per Day and Diagnosis Restriction Report

15.1 Report Overview

The Unit per Day and Diagnosis Restriction Report contains procedure code restrictions that limit the units allowed per date of service. The report also lists diagnosis, procedure, and revenue codes that are required or excluded when a specific procedure code is billed.

The report is created quarterly following the quarterly HCPCS updates and is available on the SFTP.

15.2 Units per Day and Diagnosis Restriction Report Fields

- Contract Name – ForwardHealth provider contract.

- Procedure Code – the specific procedure being referenced.
- Claim Type – ForwardHealth claim type restriction.
- Effective Date – ForwardHealth effective date of service for the restriction.
- End Date – ForwardHealth end date of service for the restriction.
- Place of Service – ForwardHealth place of services covered under the restriction.
- Units Per Day – ForwardHealth unit per day limits on the procedure code.
- Diagnosis Header Any – ForwardHealth diagnosis codes required to be submitted in the header.
- Diagnosis Detail Any – ForwardHealth diagnosis codes required to be submitted on the details.
- Procedure on Same Detail – ForwardHealth procedure codes required to be billed with the procedure code on restriction.
- Revx – ForwardHealth revenue codes required to be billed with the procedure code on restriction.

16 Other Coverage Discrepancy Reporting

16.1 Overview

HMOs have two options for reporting discrepancies between what ForwardHealth has on file for member other insurance coverage and what the HMO has in their system. The discrepancies can be reported on an individual basis through the Portal, or with a batch submission via the SFTP. It is recommended that HMOs review the enrollment report for the upcoming month prior to reporting discrepancies.

16.2 Other Coverage Discrepancy Reporting via the Portal

To complete the Other Coverage Discrepancy Report, go to the Managed Care Portal. After logging into the Managed Care Portal, select the Other Coverage Discrepancy Report option under Quick Links.

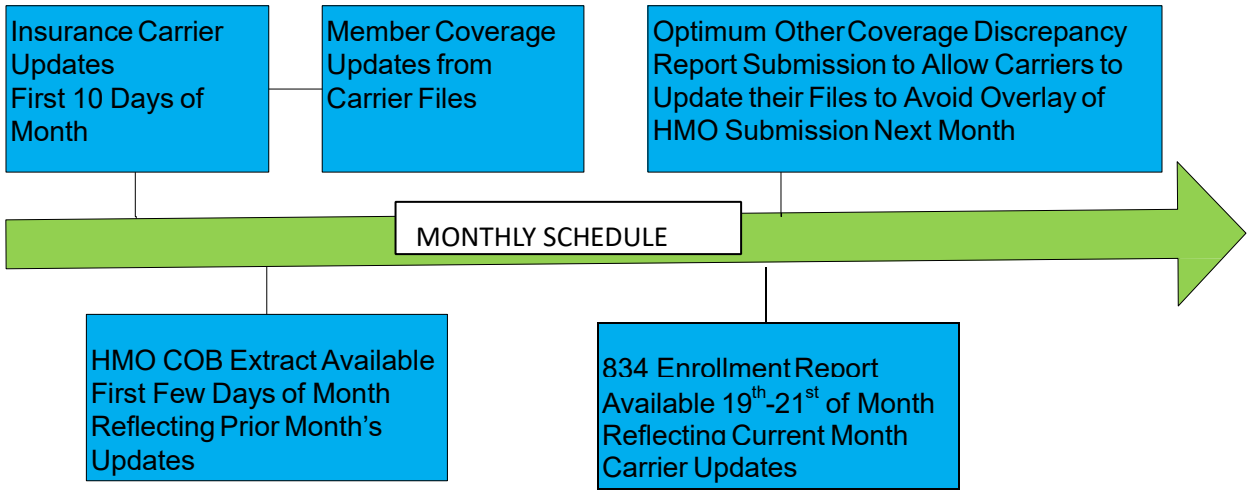
16.3 Batch Other Coverage Discrepancy Reporting via the SFTP

HMOs complete the Other Coverage Discrepancy spreadsheet to report additions and changes to their members' Medicare or commercial coverage. This method allows HMOs to submit multiple updates with a single process.

HMOs populate an Excel spreadsheet using the given format. The completed spreadsheet is placed on the FTP server using the following naming convention: TPL6900XXXXMMDDCCYY.xlxs (TPL-MCO ID-Date of Submission). HMOs have the option of submitting a single spreadsheet for multiple HMO IDs. The spreadsheet may be named using any of the HMO IDs. The spreadsheet may be placed in the SFTP directory for any of the HMO IDs.

ForwardHealth TPL analysts process HMO Other Coverage Discrepancy spreadsheets after the monthly Insurance Carriers updates are processed. The Insurance Carriers updates process between the first and tenth of the month. The HMO Other Coverage Discrepancy spreadsheets process within five to seven business days after the Insurance Carriers update processes. TPL analyst research that results in an update will prompt the submission of the F-13427 Verification Form and Questionnaire to Insurance Carrier to verify policy coverage and effective dates. HMOs verify updates on the Managed Care Portal.

BATCH OTHER COVERAGE
DISCREPANCY REPORTING



16.4 Other Coverage Discrepancy Report Layout

The view the Other Coverage Discrepancy Report refer to the HMO Report Matrix: *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*

17 HMO Encounter Based Payments

17.1 Overview

The weekly HMO Encounter Based Payment Report notifies HMOs of submitted encounters that are eligible for payments outside of the capitation rates. Refer to the Encounter Based Payment Guide located on the MCO Portal for further information regarding the report and services qualified for enhanced payments.

17.2 Encounter Based Payment Links

- Encounter Based Payment Report Guide: *https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage#ebpg*
- Refer to HMO Report Matrix for Report Format: *https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*

17.3 Encounter Based Payment Qualified Services

- Dental Pilot Project – Enhanced rates are applied to designated dental services provided in pilot counties. For further information, refer to Resources for Enhanced Dental Services at: *https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage#ebpg*
- SSI Care Management – Funds are paid outside of the capitation process for SSI Care Management services provided by the HMO.
- HIV/AIDS Health Home – Funds are paid outside of the capitation process for HIV/AIDS Health Home services provided by the HMO.
- Maternity Kick Payments – This will be incorporated into the Encounter Based Payment Report at a later date.
- LARC Incentive Payments – Funds are paid outside of the capitation process for Long-Acting-Reversible-Contraceptive services provided by the HMO.
- NTS Payments – Funds are paid outside of the capitation process for Narcotic Treatment Service.
- COVID Payments - Funds are paid outside of the capitation process for COVID procedures.
- CCM Payments - Funds are paid outside of the capitation process for Collaborative Care Services.
- CGM Payments – Funds are paid outside of the capitation process for Continuous Glucose Monitors.
- NIPT - Funds are paid outside of the capitation process for Non-Invasive Prenatal Testing
- VNT – Funds are paid outside of the capitation process for Ventilator services.

18 Other Insurance Editing

18.1 Overview

Edits monitoring other insurance coverage were turned on in the encounter processing system in July 2018. The following errors are the main Coordination of Benefits (COB) related errors seen in processing: TPL Related Errors –

- 2504 – Recipient Covered by Private Insurance
- 2516 – Other Insurance not on File
- 2517 – Member Covered by MCARE Advantage Managed Care

- 2518 – Recipient has Other Dental Coverage
- 2519 – Recipient Covered by MCARE Supplemental
- 2527 – Member Covered by MCARE Cost Managed Care Medicare Related

Errors -

- 2500 – Member Covered by Medicare Part A
- 2502 – Member Covered by Medicare Part B

Further TPL information is found in the 'Third Party Liability 101' document found on the portal at:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage#tpl101

18.2 Submitting Encounters for Members with Other Insurance

When submitting encounters for members with other insurance coverage, HMOs acknowledge other insurance adjudication to bypass the COB errors, whether or not the members' other insurance paid. HMOs submit encounters in one of three ways to bypass errors for members with Other Insurance:

Scenario 1 – An other insurance payment amount greater than zero is submitted on the encounter. See Example 1 in Appendix D for an illustration of this scenario.

Scenario 2 – An other insurance payment of zero is submitted on the encounter. The adjustment reason group code is found in Appendix F. See Example 12 in Appendix D for an illustration of this scenario.

Scenario 3 –The service is not covered under commercial insurance. A commercial noncovered amount is present on the submission. See Example 11 in Appendix D for an illustration of this scenario.

18.3 Understanding the Usage of Medicare Disclaimer Codes

When submitting encounters for members with Medicare coverage, the HMOs acknowledge Medicare coverage, whether or not Medicare paid. Similar to Other Insurance submissions, HMOs submit encounters in one of three ways to bypass errors for members with Medicare:

Scenario 1 – A Medicare payment amount greater than zero is submitted on the encounter. See Example 2 in Appendix D for an illustration of this scenario.

Scenario 2 –A Medicare payment of zero is submitted on the encounter. The adjustment reason group code is 'PR' (Patient Responsibility). The adjustment reason code is 1, 2, 3, 66 or 122. See Example 13 in Appendix D for an illustration of this scenario.

Scenario 3 – The service is not covered under Medicare. A Medicare non-covered amount is present on the submission. See Example 3 in Appendix D for an illustration of this scenario.

Appendix A: Encounter Editing Overview

I. Overview

I.I Introduction

Wisconsin ForwardHealth requires HMOs to report encounter data to analyze and monitor medical utilization and ensure quality of care. This section highlights significant policy areas to prepare HMOs for 837 submission. The following policies do not allude to the guidelines required for the 837 transactions to pass compliance. Refer to the implementation guides for further information on 837 compliance.

I.II Audience

The target audiences for this section are HMOs, to aid in any clarification as they begin using the X12 837 process to submit encounters.

II. Policy Overview

II.I Overall 837 Items

- All Validity Edits are used for encounter processing. The monitored code sets are defined in Appendix A of the 837 implementation guides.
- Attachments are not accepted on encounters.
- Encounters are only submitted to the Wisconsin Medicaid payer. More information is found in the 837 companion guides.
- When submitting the 837 transaction for the provider billing address, Loop 2010AA, enter the address that is currently on file with ForwardHealth. Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop. Reference the companion guides for further explanation of this policy.
- Prior authorization is never required on encounter submissions.
- Encounter Chart Reviews are submitted via the 837 transaction using the PWK segment to signify chart reviews. They are monitored and edited using the same policies as all other encounter submissions. See *Section 6* for further information on chart reviews.

II.II Overall Policy Clarifications

- If the member's age is not within the policy guidelines for the services provided, the encounter denies. The member's age is calculated using the detail FDOS.

- Documentation about policy guidelines is found in the Online Handbook and the monthly Max Fee extract. Birth to 3 example: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=87&s=6&c=141&nt=Eligibility Criteria&adv=Y

- If the member's gender is not within the policy guidelines for the services provided, the encounter denies. Documentation about policy guidelines is found in the Online Handbook.

  The Wisconsin encounter process monitors for missing tooth number,invalid tooth number, or invalid tooth surface on dental encounters. The tooth-specific fields are included on the 837D transaction and are necessary in certain dental procedures. Documentation about policy guidelines is found in the Online Handbook Dental example: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=15&s=2&c=10&nt=Tooth+Numbers+and+Letters

- If modifiers are not submitted within the policy guidelines for the services provided, the encounter may deny. Certain procedures default to the lowest rate when the modifiers are not present. Documentation about policy guidelines is found in the Online Handbook. Vision modifier example: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=64&s=2&c=10&nt=Modifiers

- Diagnosis codes are monitored to ensure that they are appropriate for the services provided based on policy guidelines. Documentation about policy guidelines is found in the Online Handbook. Nurse midwife example: *https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=37&s=2&c=10&nt=Cellular%2fTissue-Based+Products*

- The encounter 837P transactions include diagnosis code pointers. The Diagnosis Code Pointers are used to indicate the declining level of importance for each diagnosis indicated in the service line. Policy edits monitor that the appropriate diagnosis codes are billed with specific procedure codes. For additional information on Diagnosis Code Pointers, see Section 5.11 or the 837P Implementation Guide (reference SV107).

- All codes indicated on encounter submissions must be the most specific for the ICD Code Sets for the service dates on the encounter. If an ICD Code is used that is not the most specific, an edit posts. Documentation about policy guidelines is found in the Online Handbook. Mental Health specificity example: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=45&s=2&c=10&nt=Valid+Codes+Required+on+Claims

- If the Place of Service (POS) is not within the policy guidelines for the services provided, the encounter denies. Documentation about POS guidelines is found in the Online Handbook or the monthly Max Fee extract. Podiatry POS example: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=52&s=2&c=10&nt=Place+of+Service+Codes

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- If the Provider Type/Provider Specialty (PT/PS) is not within the policy guidelines for the services provided, the encounter denies. These encounters result in N8 pricing errors in the current encounter pricing system. Documentation about policy guidelines is found in the Online Handbook. The specific PT/PS guidelines are in the monthly Max Fee extract.
- Encounters are billed with quantities that do not exceed the allowed quantities for the services provided. Documentation for the allowed quantities is found in the Online Handbook. A onetime report will be produced illustrating the appropriate quantity limits for the HMOs to reference. DMS quantity limit example: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=16&s=3&c=11&nt=Supplies+that+Exceed+Quantity+Limits

Encounters for Outpatient Hospital TherapyServices are submitted as a professional encounter using the 837P. Refer to the November 2011 Update 2011-76, titled "Reminder: Claims for Outpatient Hospital Therapy Services Must Be Submitted Using a Professional Claim," for an explanation of the policy: *https://www.forwardhealth.wi.gov/kw/pdf/2011-76.pdf*

- Medical Review is not part of encounter pricing. Encounters are not suspended for manual internal review. These encounters are processed in the current encounter system using a percentage of billed amount. It is the responsibility of the HMO to determine if the services rendered are medically necessary and appropriate.
- Hearing aids are priced at a percent of the billed amount, similar to how they are handled in the current encounter system.

II.III Institutional Policy

- The Wisconsin encounter system allows for interim billing. Information regarding the usage of the frequency code in relation to the interim bills is referenced in the 837I companion guide. HMO's can also reference the February 2010 Update, titled "ForwardHealth Is Allowing Hospitals to Submit the Initial Claim for Interim Payments after 60* Days," for Wisconsin Policy information pertaining to interim bills: *https://www.forwardhealth.wi.gov/kw/pdf/2010-12.pdf*
- All ESRD encounters are processed according to the standard policy outlined in the Online Handbook. ESRD example: *https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=102&nt=End-Stage+Renal+Disease+Services*
- For all occurrence codes on a nursing home encounter, when a valid occurrence span date is present and the corresponding occurrence code is not, an edit posts and the encounter denies. The same applies to an occurrence code submitted without the span date. This policy is used for nursing home bed hold days. Further explanation is available in the Online Handbook. Nursing home example: *https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1*

- *&sa=40&s=4&c=13&nt=UB-04+(CMS+1450)+Claim+Form+Instructions+for+Nursing+Home+Services*
- Inpatient encounter pricing for Vent, Neuro, and Coma services is handled through DRG pricing.

II.IV Provider Editing Policy and Guidelines

- Taxonomy is required if the NPI has multiple certifications and the taxonomy is necessary to determine the appropriate one. This policy is similar to current encounter edits 224 and 226.
- HMOs submit the billing provider at the 837 billing provider header level. HMOs submit the rendering provider at the encounter header level ONLY IF the rendering provider is different than the billing provider. HMOs submit the rendering provider at the encounter detail level ONLY IF the detail rendering provider is different than the encounter header rendering provider.

  Wisconsin policy allows certain providers to be designated as both the billing and rendering provider. In some cases, the billing provider is treated as the rendering provider even when a rendering provider ID is submitted on the encounter. This does not change the way the HMOs submit provider information on the encounter. Additional details and rules are found in the user guide.
- All laboratories and providers performing tests for health assessment, diagnosis, prevention, or treatment of disease or health impairment on humans must be CLIA certified. Edits post for providers who are not appropriately certified. Additional information about CLIA is found in the Online Handbook. CLIA example: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=85&s=1&c=1&nt=CLIA+Certification+or+Waiver

II.V Cost Avoidance Policy

- Edits for cost avoidance are enforced. If a member has other commercial insurance or Medicare on file, the HMO shows evidence on its submitted 837 transaction of how the other payer adjudicated the encounter. (Copayment implemented 10/11/2013 effective for Dates of Service on or after 1/1/2013. PPACA encounters retroactively adjusted.)
- If the member has commercial insurance on file and the encounter indicates that commercial insurance was not billed correctly, the encounter may deny. (Effective 4/28/2015 encounters are not denied for commercial insurance. It is the responsibility of the HMOs to verify all commercial insurance is billed.)

II.VI Future Policy Considerations

- Copay deduction continues to be monitored outside the encounter processing system for the initial implementation. Future enhancements will incorporate this into the Wisconsin encounter system. (Copayment implemented 10/11/2013 effective for

- Dates of Service on or after 1/1/2013. PPACA encounters retroactively adjusted.)
- ClaimCheck (GMIS) edits continue to be monitored outside the encounter processing system. Future enhancements may incorporate this into the Wisconsin encounter system.

Appendix B: ANSI Code Groups

ANSI Group 1002: Utilization Indicator Assigned

ANSI Code	WPC Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	This care may be covered by another payer per coordination of benefits.
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
24	Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
36	Balance does not exceed co-payment amount.

37	Balance does not exceed deductible.
38	Services not provided or authorized by designated (network/primary care) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
41	Discount agreed to in Preferred Provider contract.

ANSI Code	WPC Description
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)
46	This (these) service(s) is (are) not covered.
48	This (these) procedure(s) is (are) not covered.
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.

ANSI Code	WPC Description
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	Correction to a prior claim.
64	Denial reversed per Medical Review.
65	Procedure code was incorrect. This payment reflects the correct code.
66	Blood Deductible.
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68	DRG weight. (Handled in CLP12)
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
71	Primary Payer amount.
72	Coinsurance day. (Handled in QTY, QTY01=CD)
73	Administrative days.

74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days. (Handled in QTY, QTY01=CA)
78	Non-Covered days/Room charge adjustment.
79	Cost report days. (Handled in MIA15)
80	Outlier days. (Handled in QTY, QTY01=OU)
81	Discharges.
82	PIP days.
83	Total visits.
84	Capital adjustment. (Handled in MIA)
85	Patient Interest Adjustment (Use Only Group code PR)
86	Statutory adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only.
91	Dispensing fee adjustment.
92	Claim paid in full.
93	No Claim level Adjustments.
94	Processed in Excess of charges.
95	Plan procedures not followed.

ANSI Code	WPC Description
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service

97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
99	Medicare secondary payer adjustment amount.
100	Payment made to patient/insured/responsible party/employer.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
111	Not covered unless the provider accepts assignment.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
116	The advance indemnification notice signed by the patient did not comply with requirements.
117	Transportation is only covered to the closest facility that can provide the necessary care.
118	ESRD network support adjustment.
119	Benefit maximum for this time period or occurrence has been reached.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
126	Deductible -- Major Medical

127	Coinsurance -- Major Medical

ANSI Code	WPC Description
128	Newborn's services are covered in the mother's Allowance.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
134	Technical fees removed from charges.
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
141	Claim spans eligible and ineligible periods of coverage.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
145	Premium payment withholding
147	Provider contracted/negotiated rate expired or not on file.
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
152	Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
153	Payer deems the information submitted does not support this dosage.

154	Payer deems the information submitted does not support this day's supply.
156	Flexible spending account payments. Note: Use code 187.
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.

ANSI Code	WPC Description
163	Attachment/other documentation referenced on the claim was not received.
164	Attachment referenced on the claim was not received in a timely fashion.
165	Referral absent or exceeded.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
169	Alternate benefit has been provided.
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
173	Service/equipment was not prescribed by a physician.

174	Service was not prescribed prior to delivery.
177	Patient has not met the required eligibility requirements.
178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
186	Level of care change adjustment.

ANSI Code	WPC Description
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
188	This product/procedure is only covered when used according to FDA recommendations.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)

192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	Refund issued to an erroneous priority payer for this claim/service.
196	Claim/service denied based on prior payer's coverage determination.
197	Precertification/authorization/notification absent.
198	Precertification/authorization exceeded.
200	Expenses incurred during lapse in coverage
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement.
202	Non-covered personal comfort or convenience services.
203	Discontinued or reduced service.
204	This service/equipment/drug is not covered under the patient's current benefit plan
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)

ANSI Code	WPC Description
210	Payment adjusted because pre-certification/authorization not received in a timely fashion
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered
213	Non-compliance with the physician self referral prohibition legislation or payer policy.

214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only
215	Based on subrogation of a third party settlement
216	Based on the findings of a review organization
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)
218	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only
219	Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)

ANSI Code	WPC Description

229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)
232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
235	Sales Tax
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
A0	Patient refund amount.
A2	Contractual adjustment.

A3	Medicare secondary payer liability met.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.

ANSI Code	WPC Description
A7	Presumptive Payment Adjustment
B1	Non-covered visits.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B16	'New Patient' qualifications were not met.
B18	This procedure code and modifier were invalid on the date of service.
B2	Covered visits.
B20	Procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.
B4	Late filing penalty.
B5	Coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B9	Patient is enrolled in a Hospice.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.

D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code
W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).
ANSI Code	**WPC Description**
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.

Appendix C: Other Coverage Discrepancy Report

Link to fillable PDF and Word versions: https://www.forwardhealth.wi.gov/kw/html/OtherCoverageDiscrepancyReport.html

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability F-1159 (10/08)

STATE OF WISCONSIN

FORWARDHEALTH
OTHER COVERAGE DISCREPANCY REPORT

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Personally identifiable information about applicants and members is confidential and is used for purposes directly related to program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

This form is mandatory; use an exact copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. Attach additional pages if more space is needed.

Instructions: Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.

SECTION I PROVIDER AND MEMBER INFORMATION

Name Provider	Provider ID	
Name Member (Last, First, Middle Initial)	Date of Birth Member	Member Identification Number

SECTION II MEDICARE PART A AND B COVERAGE

Name Policyholder (Last, First, Middle Initial)		Social Security Number Policyholder
Policy Number	Coverage Start Date	Covera ge End Date
Member Left HMO Service Area ✈ Yes ✈ No	Date Member Left HMO Service Area (If Applicable)	
Member Medicare / HIC Numbe r		

✈ Add		✈ Remove	
✈ Part A Coverage	Start Date	✈ Part A Coverage	End Date
✈ Part B Coverage	Start Date	✈ Part B Coverage	End Date

SECTION III □ COMMERCIAL HEALTH INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

✈ Add	✈ HMO	✈ Medicare Managed Care
✈ Remove	✈ Medicare Supplement	✈ Other
Name □ Insurance Company		
Address □ Insurance Company (Street, City, State, ZIP Code)		

SECTION IV □ REPORT INFORMATION

Name □ Individual Completing This Rep ort	Date Signed	Telephone Number / Extension
Name □ Source of Information Included on This Report		Telephone Number / Extension
Mail to ForwardHealth Coordination of Benefits PO Box 6220 Madison WI 53716-6220	Fax to Coordination of Benefits (608) 221-4567	Comments (Attach a dditional pages if necessary.)

Appendix D: 837 Examples

Example 1: Two Commercial Payers and HMO Payer

ISA*00* *00* *ZZ*100000000 *ZZ*WISC_DHFS
*130319*1150*^*00501*000000053*0*P*:~
GS*HC*100000000*WISC_TXIX*20130319*1150*53*X*005010X223A2~
ST*837*000000001*005010X223A2~
BHT*0019*00*PES53*20130319*1150*RP~ NM1*41*2*TRADING
PARTNER*****46*100000000~ PER*IC*PC
MEDIA*EM*NAME@HMO.COM~ NM1*40*2*WISCONSIN
MEDICAID*****46*WISC_TXIX~
HL*1**20*1~ PRV*BI*PXC*282N00000X~
NM1*85*2*BELLINMEMORIALHOSPITAL*****XX*1437152345~
N3*23400 744 S WEBSTER~
N4*GREENBAY*WI*543053505~
REF*EI*123456789~
HL*2*1*22*0~ SBR*A*18*******MC~
NM1*IL*1*LAST*FIRST****MI*9010002215~
N3*ADDRESS~ N4*MADISON*WI*537041234~
DMG*D8*19590718*F~
NM1*PR*2*WISCONSIN MEDICAID*****PI*WISC_TXIX~
CLM*COMMERCIALAND HMO*898.00***13:A:1**A*Y*Y~ DTP*434*RD8*20130303-20130303~
CL1*3*1*01~ REF*4N*3~
HI*BK:6100~ HI*PR:6100~
NM1*71*1*MAZZA*JOSEPH****XX*1609972116~
PRV*AT*PXC*207R00000X~
M1*82*1*KAMINSKY*MELISSA****XX*1225070188~
SBR*P*21*******CI~ AMT*D*45.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*9010002215~
N3*ADDRESS~ N4*MADISON*WI*537041234~
NM1*PR*2*AMERICAN FAMILYINSURANCE GRP*****PI*003~
SBR*S*21*******CI~ AMT*D*55.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*9010002215~
N3*ADDRESS~ N4*MADISON*WI*537041234~
NM1*PR*2*FISERVHEALTH*****PI*015~
SBR*T*18*******HM~

SBR*P*21*******CI~ denotes the primary commercial insurance payer on the encounter.

SBR*S*21*******CI~ denotes the secondary commercial insurance payer on the encounter.

SBR*T*18*******HM~ denotes that the tertiary payer in this instance is the HMO.

AMT*D*8.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*9010002215~
N3*ADDRESS~ N4*MADISON*WI*537041234~
NM1*PR*2*HMONAME*****PI*69000000~
LX*1~
SV2*0401*HC:77056:50:26:0A:0B:MAMMOGRAM
BOTH BREASTS*220.00*UN*1.00~
DTP*472*RD8*20130303-20130303~
NM1*82*1*ONO*ERIKA****XX*1235108606~
SVD*003*15.00*HC:77056:50:26:0A:0B*0401*1~
CAS*OA*93*205.00~
DTP*573*D8*20130311~
SVD*015*25.00*HC:77056:50:26:0A:0B*0401*1~
CAS*OA*93*195.00~
DTP*573*D8*20130311~
SVD*69000000*4.00*HC:77056:50:26:0A:0B*0401*1~
CAS*OA*93*216.00~
DTP*573*D8*20130311~
LX*2~ SV2*0402*HC:76645:TC:26:0A:0B:USEXAM
BREAST(S)*586.00*UN*1.00~
P*472*RD8*20130303-20130303~
NM1*82*1*ONO*ERIKA****XX*1235108606~
SVD*003*15.00*HC:76645:TC:26:0A:0B*0402*1~
CAS*OA*93*571.00~
DTP*573*D8*20130311~
SVD*015*15.00*HC:76645:TC:26:0A:0B*0402*1~
CAS*OA*93*571.00~
DTP*573*D8*20130311~
SVD*69000000*2.00*HC:76645:TC:26:0A:0B*0402*1~
CAS*OA*93*584.00~ DTP*573*D8*20130311~
LX*3~
SV2*0401*HC:77051:50:26:0A:0B:COMPUTER DX MAMMOGRAM ADD-ON*92.00*UN*1.00~
DTP*472*RD8*20130303-20130303~
NM1*82*1*ONO*ERIKA****XX*1235108606~

Detail payment information for each payer

```
SVD*003*15.00*HC:77051:50:26:0A:0B*0401*1~
CAS*OA*93*77.00~
DTP*573*D8*20130311~
SVD*015*15.00*HC:77051:50:26:0A:0B*0401*1~
CAS*OA*93*77.00~
DTP*573*D8*20130311~
SVD*69000000*2.00*HC:77051:50:26:0A:0B*0401*1~
CAS*OA*93*90.00~
DTP*573*D8*20130311~
SE*88*000000001~ GE*1*53~
IEA*1*000000053~
```


Medicare Payer and HMO Payer

```
ISA*00*          *00*          *ZZ*100000000       *ZZ*WISC_DHFS
*130319*1002*^*00501*000000082*0*P*:~
      GS*HC*100000000*WISC_TXIX*20130319*1002*82*X*005010X222A1~
            ST*837*000000001*005010X222A1~
                  BHT*0019*00*PES82*20130319*1002*RP~   NM1*41*2*TRADING
                  PARTNER*****46*100000000~  PER*IC*PC
                  MEDIA*EM*NAME@HMO.COM~   NM1*40*2*WISCONSIN
                  MEDICAID*****46*WISC_TXIX~
                  HL*1**20*1~  PRV*BI*PXC*208100000X~
                  NM1*85*1*THOMAS*J  GEORGE****XX*1194789776~  N3*1945
                  TEST ADDRESS~ N4*MADISON*WI*537170000~
                  REF*SY*123456789~
                  HL*2*1*22*0~  SBR*T*18*******MC~
                  NM1*IL*1*LAST*FIRST****MI*4110779944~
                  N3*ADDRESS~ N4*MADISON*WI*537041234~
                  DMG*D8*19720523*F~
                  NM1*PR*2*WISCONSIN   MEDICAID*****PI*WISC_TXIX~
                  CLM*MEDICAREAND HMO*300.00***11:B:1*Y*C*W*Y*P~
                  HI*BK:64253~
                  SBR*P*18*******MB~
                  AMT*D*200.00~
                  OI***N*P**Y~
                  NM1*IL*1*LAST*FIRST****MI*4110779944~
                  N3*ADDRESS~ N4*MADISON*WI*537041234~
                  NM1*PR*2*MEDICARE*****PI*004~
```

SBR*P*18*******MB~ denotes Medicare B as the primary payer.

```
SBR*S*18*******HM~
AMT*D*10.00~ OI***Y*P**Y~
NM1*IL*1*LAST*FIRST****MI*4110779944~
N3*ADDRESS~ N4*MADISON*WI*537041234~
NM1*PR*2*HMONAME*****PI*69000000~
LX*1~ SV1*HC:S9213:::::HM PREECLAMP PER
DIEM*300.00*UN*1.00***1~
DTP*472*RD8*20130223-20130223~
SVD*004*200.00*HC:S9213**1.00~
CAS*PR*2*30.00**3*20.00**1*50.00~
DTP*573*D8*20130228~
SVD*69000000*10.00*HC:S9213**1.00~
CAS*OA*96*290.00~
DTP*573*D8*20130228~
SE*44*000000001~
GE*1*82~ IEA*1*000000082~
```

SBR*S*18*******HM~ denotes the HMO as the secondary payer.

Detail payment information for each payer

Example 4:

ISA*00*

Medicare Not Covered and HMO Payer

00 *ZZ*100000000 *ZZ*WISC_DHFS
*130321*1531*|*00501*000049318*1*P*:~
GS*HC*100000000*WISC_TXIX*20130321*1531*49318*X*005010X222A1~
ST*837*1001*005010X222A1~ BHT*0019*00*1*20130321*1531*RP~
NM1*41*2*TRADING PARTNER*****46*100000000~
PER*IC*PC MEDIA*EM*NAME@HMO.COM~
NM1*40*2*FORWARDHEALTH*****46*WISC_TXIX~
HL*1**20*1~ PRV*BI*PXC*282N00000X~
NM1*85*2*STCLARE HOSPITAL*****XX*1386641207~ N3*707 14TH ST~
N4*BARABOO*WI*539131539~
REF*EI*123456789~
HL*2*1*22*0~ SBR*T*18*******MC~
NM1*IL*1*LAST*FIRST****MI*4110790140~ N3*ADDRESS~
N4*GREENBAY*WI*543031234~ DMG*D8*19540628*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*MEDICARENOTCOV*30.00***11:B:1*Y*C*Y*Y*P~
HI*BK:71536~ NM1*82*1*BERG*TROY*L***XX*1740216845~
PRV*PE*PXC*207X00000X~
SBR*P*18*******MB~
AMT*A8*30.00~ OI***Y***I~

The AMT*A8 segment denotes that this is a non-covered service for Medicare.

NM1*IL*1*LAST*FIRST****MI*4110790140~ N3*ADDRESS~
N4*GREENBAY*WI*543031234~
NM1*PR*2*MEDICARE PARTB*****PI*001511~
DTP*573*D8*20121204~
SBR*S*18*******HM~ AMT*D*5.00~

HMO header adjudication

OI***Y***I~
NM1*IL*1*LAST*FIRST****MI*4110790140~
N3*ADDRESS~
N4*GREENBAY*WI*543031234~
NM1*PR*2*HMONAME*****PI*69000000~
LX*1~ SV1*HC:99212:25*30*UN*1.0***1~

HMO detail adjudication

Medicare detail adjudication is not required due to use of the AMT*A8 segment.

SVD*69000000*5.00*HC:99212:25**1.0~
CAS*CO*23*20.00**45*5.00~
DTP*573*D8*20130109~
DTP*472*D8*20121112~

Example 5:

ISA*00* *ZZ*WISC_DHFS
SE*44*1001~ GE*1*49318~
IEA*1*000049318~

Linked Chart Review

ISA*00* *00* *ZZ*100000000 *ZZ*WISC_DHFS
*130222*1531*|*00501*000049318*1*P*:~
GS*HC*100000000*WISC_TXIX*20130222*1531*49318*X*005010X222A1~
ST*837*1001*005010X222A1~ BHT*0019*00*1*20130222*1531*RP~
NM1*41*2*TRADING PARTNER*****46*100000000~ PER*IC*PC
MEDIA*EM*NAME@HMO.COM~
NM1*40*2*FORWARDHEALTH*****46*WISC_TXIX~
HL*1**20*1~ PRV*BI*PXC*207R00000X~
NM1*85*2*BOZENA BIERNAT*****XX*1003890864~ N3*555
REDBIRD CIR STE 300~
N4*DEPERE*WI*541157980~ REF*EI*123456789~
HL*2*1*22*0~ SBR*S*18*******MC~
NM1*IL*1*LAST*FIRST****MI*3414027631~ N3*ADDRESS~
N4*GREENBAY*WI*543030000~ DMG*D8*19540628*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*LINKED
CHARTREVIEW*0***11:B:1*Y*C*Y*Y*P~
PWK*09*AA~
REF*F8*7012000000000~ HI*BK:250~
SBR*P*18*******HM~
AMT*D*0~ OI***Y*P**Y~
NM1*IL*1*LAST*FIRST****MI*3414027631~
N3*ADDRESS~
N4*GREENBAY*WI*543030000~
NM1*PR*2*HMONAME*****PI*69000000~
LX*1~
SV1*HC:83036*0*UN*1***1~
DTP*472*D8*20121109~
REF*6R*83851482~

The PWK*09*AA~ segment denotes this is a chart review, and the REF*F8 segment ties it back to a previously submitted encounter.

Example 6:

```
ISA*00*                                    *ZZ*WISC_DHFS
                    SVD*69000000*0*HC:83036**1~
                    DTP*573*D8*20130221~
              SE*36*1001~  GE*1*49318~
IEA*1*000049318~
```


Unlinked Chart Review

```
                *00*          *ZZ*100000000
*130222*1531*|*00501*000049318*1*P*:~
        GS*HC*100000000*WISC_TXIX*20130222*1531*49318*X*005010X222A1~
              ST*837*1001*005010X222A1~ BHT*0019*00*1*20130222*1531*RP~
              NM1*41*2*TRADING    PARTNER*****46*100000000~  PER*IC*PC
                    MEDIA*EM*NAME@HMO.COM~
                    NM1*40*2*FORWARDHEALTH*****46*WISC_TXIX~
                    HL*1**20*1~  PRV*BI*PXC*207R00000X~
                   NM1*85*2*BOZENA   BIERNAT*****XX*1003890864~ N3*555
                    REDBIRD CIR STE 300~
                    N4*DEPERE*WI*541157980~ REF*EI*123456789~
                    HL*2*1*22*0~  SBR*S*18*******MC~
                    NM1*IL*1*LAST*FIRST****MI*3414027631~  N3*ADDRESS~
                    N4*GREENBAY*WI*543030000~ DMG*D8*19540628*F~
                    NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
                    CLM*UNLINKED CHART REVIEW*0***11:B:1*Y*C*Y*Y*P~
```

Example 7:

ISA*00* *ZZ*WISC_DHFS

PWK*09*AA~ HI*BK:250~
SBR*P*18*******HM~
AMT*D*0~ OI***Y*P**Y~
NM1*IL*1*LAST*FIRST****MI*3414027631~
N3*ADDRESS~
N4*GREENBAY*WI*543030000~
NM1*PR*2*HMONAME*****PI*69000000~
LX*1~ SV1*HC:83036*0*UN*1***1~
DTP*472*D8*20121109~
REF*6R*83851482~
SVD*69000000*0*HC:83036**1~
DTP*573*D8*20130221~
SE*35*1001~
GE*1*49318~
IEA*1*000049318~

The PWK*09*AA~ segment denotes this is a chart review. In this scenario, there is no associated ICN.

*ZZ*WISC_DHFS

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Example 6: Adjustment-Change

ISA*00* *00* *ZZ*100000000
*130205*1503*^*00501*000000051*0*P*:~
GS*HC*100000000*WISC_TXIX*20130205*1503*51*X*005010X223A2~
ST*837*000000001*005010X223A2~ BHT*0019*00*PES51*20130205*1503*RP~
NM1*41*2*TRADING PARTNER*****46*100000000~
PER*IC*PCMEDIA*EM*NAME@HMO.COM~ NM1*40*2*WISCONSIN
MEDICAID*****46*WISC_TXIX~
HL*1**20*1~ PRV*BI*PXC*251E00000X~
NM1*85*2*MERITERHOMECAREAGENCY*****XX*1427038777~
N3*PO BOX 25993*2180 W BELTLINE HWY~ N4*MADISON*WI*537141234~
REF*EI*123456789~
HL*2*1*22*0~
SBR*S*18*******MC~
NM1*IL*1*LAST*FIRST****MI*1110772718~
N3*ADDRESS~
N4*MADISON*WI*537041234~
DMG*D8*19910823*M~
NM1*PR*2*WISCONSIN MEDICAID*****PI*WISC_TXIX~
CLM*ADJUST*200.00***33:A:7**A*Y*Y~
DTP*434*RD8*20121218-20121218~
CL1*3*1*01~
REF*4N*3~
REF*F8*7013036001002~
HI*BK:70724~ HI*PR:V536~
HI*BF:V536~
NM1*71*1*MAZZA*JOSEPH****XX*1609972116~
PRV*AT*PXC*207R00000X~
NM1*82*1*SUTO*BONNIE****XX*1124079876~
SBR*P*18*******HM~
CAS*CO*1*197.50~
AMT*D*2.50~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*1110772718~
N3*ADDRESS~
N4*MADISON*WI*537041234~

A frequency value of 7 denotes this as an adjustment. The REF*F8 segment denotes the ICN to be adjusted.

```
                NM1*PR*2*HMONAME*****PI*69000000~
                LX*1~
                SV2*0551*HC:99600:0A:0B:0C::HOME    VISIT
          NOS*200.00*UN*1.00~
                DTP*472*D8*20121218~
                SVD*69000000*2.50**0551*1.00~
                CAS*OA*96*197.50~
                DTP*573*D8*20130102~
            SE*45*000000001~
      GE*1*51~
IEA*1*000000051~
```


7: Adjustment-Void

```
              *00*          *ZZ*100000000
*130206*1503*^*00501*000000051*0*P*:~
      GS*HC*100000000*WISC_TXIX*20130206*1503*51*X*005010X223A2~
            ST*837*000000001*005010X223A2~
                  BHT*0019*00*PES51*20130206*1503*RP~
                  NM1*41*2*TRADING PARTNER*****46*100000000~
                  PER*IC*PC MEDIA*EM*NAME@HMO.COM~
                  NM1*40*2*WISCONSINMEDICAID*****46*WISC_TXIX~
                  HL*1**20*1~
                  PRV*BI*PXC*251E00000X~
                  NM1*85*2*MERITERHOMECAREAGENCY*****XX*1427038777~
                  N3*PO BOX 25993*2180 W BELTLINE HWY~
                  N4*MADISON*WI*537141234~
                  REF*EI*123456789~
                  HL*2*1*22*0~
                  SBR*S*18*******MC~
                  NM1*IL*1*LAST*FIRST****MI*1110772718~
                  N3*ADDRESS~ N4*MADISON*WI*537041234~
                  DMG*D8*19910823*M~
                  DTP*434*RD8*20121218- 20121218~
                  NM1*PR*2*WIS
                  CONSIN
                  MEDICAID*****
```

A frequency value of 8 denotes this as a void. The REF*F8 segment

PI*WISC_TXIX~ denotes the ICN to be
CLM*VOID*20
0.00***33:A:8*
*A*Y*Y~
CL1*3*1*01~
REF*4N*3~
REF*F8*7213036001001~
HI*BK:70724~
HI*PR:V536~
HI*BF:V536~

NM1*71*1*MAZZA*JOSEPH****XX*1609972116~
PRV*AT*PXC*207R00000X~
NM1*82*1*SUTO*BONNIE****XX*1124079876~
SBR*P*18*******HM~
CAS*CO*1*197.50~
AMT*D*2.50~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*1110772718~
N3*ADDRESS~ N4*MADISON*WI*537041234~
NM1*PR*2*HMO*****PI*69000000~
LX*1~
SV2*0551*HC:99600:0A:0B:0C:0D:HOME VISIT
NOS*200.00*UN*1.00~ DTP*472*D8*20121218~

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SVD*69000000*2.50**0551*1.00~ CAS*OA*96*197.50~
DTP*573*D8*20130102~
SE*45*000000001~
GE*1*51~
IEA*1*000000051~

Example

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8: Atypical/Non-Healthcare Provider

ISA*00* *00* *ZZ*100000330 *ZZ*WISC_DHFS *120831*1252*^*00501*000000070*0*P*:~
GS*HC*100000330*WISC_TXIX*20120831*1252*70*X*005010X223A2~
ST*837*000000001*005010X223A2~
BHT*0019*00*PES70*20120831*1252*RP~
NM1*41*2*HP*****46*100000330~
PER*IC*DEB CRIST*TE*6082246762~
NM1*40*2*WISCONSIN
MEDICAID*****46*WISC_TXIX~
HL*1**20*1~
PRV*BI*PXC*3747P1801X~
NM1*85*2*INTERIM HEALTHCARE~
N3*702 N BLACKHAWK AVE*MADISON INC~
N4*MADISON*WI*537051234~
REF*EI*391305086~
HL*2*1*22*0~
SBR*S*18*******MC~
NM1*IL*1*CRIST*ATYPICAL****MI*3110740630~
N3*ADDRESS~
N4*MADISON*WI*537041234~
DMG*D8*19471017*M~
NM1*PR*2*WISCONSIN MEDICAID*****PI*WISC_TXIX~
REF*G2*43103700~
(partial submission)

Loop 2010AA

Loop 2010BB

Example 9: SSI Care Management

```
ST*837*000000001*005010X222A1~
    BHT*0019*00*PES69*20170531*1049*RP~ NM1*41*2*HP*****46*100000330~
                        PER*IC*DEB CRIST*TE*6082246762~
                    NM1*40*2*WISCONSIN MEDICAID*****46*WISC_TXIX~
      HL*1**20*1~
                    NM1*85*2*TESTING HMO~
                    N3*516 MAIN~
          N4*ARLINGTON*WI*539111234~ REF*EI*123654789~
      HL*2*1*22*0~
                    SBR*P*18*******MC~
                    NM1*IL*1*CRIST*ATYPICAL****MI*3110740630~
                    N3*ADDRESS~
                    N4*MADISON*WI*537041234~
                    DMG*D8*19471017*M~
                    NM1*PR*2*WISCONSIN MEDICAID*****PI*WISC_TXIX~
                    REF*G2*69000000~
              CLM*SSI TESTING EXAMPLE*73.26***99:B:1*Y*C*W*Y*P~
                    HI*ABK:Z742~
                LX*1~
                    SV1*HC:G9002:TG::::MCCD, INITIAL RATE*73.26*UN*1.00***1~
                    DTP*472*RD8*20170501-20170501~
SE*24*000000001~
```

Example 10: Sub Capitated “Shadow” Pricing

```
ISA*00*          *00*          *ZZ*100000354      *ZZ*WISC_DHFS
  *140408*1653*^*00501*000000505*0*P*:~
        GS*HC*100000354*WISC_TXIX*20141103*1653*505*X*005010X222A1~
              ST*837*000000001*005010X222A1~
                    BHT*0019*00*PES505*20141103*1653*RP~
                    NM1*41*1*WHITENS*ANDY****46*100000354~
                   PER*IC*ANDY*TE*9207379354~
                    NM1*40*2*WISCONSIN MEDICAID*****46*WISC_TXIX~
              HL*1**20*1~
                    PRV*BI*PXC*193200000X~
                    NM1*85*2*UW HEALTH EAST                    N4*MILWAUKEE
                    TOWNE*****XX*1699750992~                     *WI*53201~
        N3*4122 EAST TOWNE BLVD~  N4*MADISON*WI*537043732~
                    REF*EI*391824444~
              HL*2*1*22*0~
                    SBR*S*18*******MC~
                    NM1*IL*1*WHITENS*FIRSTNAME****MI*4111119140~
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8*19760101*F~
NM1*PR*2*WISCONSIN MEDICAID*****PI*WISC_TXIX~
CLM*SHADOW PAYMENT*200.00***11:B:1*Y*C*W*Y*P~
CN1*05*50~
HI*BK:Z23*BF:E119*BF:I10*BF:G4734~
NM1*82*1*OGDEN*MEGHAN****XX*1205805512~
PRV*PE*PXC*207V00000X~
SBR*P*18*******HM~
CAS*CO*24*200~
AMT*D*0~
OI***Y*P**Y~
NM1*IL*1*WHITENS*FIRSTNAME****MI*4111119140~
N3*7 GRANT ST~
N4*MILWAUKEE*WI*53201~
NM1*PR*2*HMO TESTING NAME*****PI*69001234~
DTP*573*D8*20141020~
LX*1~
SV1*HC:99214:AQ:25*200.00*UN*1.00***1:3:4:2~

CN1 Segment at the header designating the Shadow Priced amount.

December 26, 2024

DTP*472*RD8*20141015-20141015~
CN1*05*50~
SVD*69001234*0*HC:99214**1~
CAS*CO*24*200~
DTP*573*D8*20141020~

CN1 Segment at the detail designating the Shadow Priced amount.

```
                SE*40*000000001~
          GE*1*505~
IEA*1*000000505~
```

Example 11: Commercial Insurance Not Covered and HMO Payer

ISA*00* *00* *ZZ*100000000 *ZZ*WISC_DHFS
*130321*1531*|*00501*000049318*1*P*:~
GS*HC*100000000*WISC_TXIX*20130321*1531*49318*X*005010X222A1~
ST*837*1001*005010X222A1~
BHT*0019*00*1*20130321*1531*RP~
NM1*41*2*TRADING PARTNER*****46*100000000~
PER*IC*PC MEDIA*EM*NAME@HMO.COM~
NM1*40*2*FORWARDHEALTH*****46*WISC_TXIX~
HL*1**20*1~ PRV*BI*PXC*282N00000X~
NM1*85*2*STCLARE HOSPITAL*****XX*1386641207~
N3*707 14TH
ST~
N4*BARABOO*WI*539131539~
REF*EI*123456789~
HL*2*1*22*0~ SBR*T*18*******MC~ NM1*IL*1*LAST*FIRST****MI*4110790140~
N3*ADDRESS~ N4*GREENBAY*WI*543031234~
DMG*D8*19540628*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*MEDICARENOTCOV*30.00***11:B:1*Y*C*Y*Y*P~
HI*BK:71536~ NM1*82*1*BERG*TROY*L***XX*1740216845~
PRV*PE*PXC*207X00000X~
SBR*P*18*******CI~
AMT*A8*30.00~
OI***Y***I~
NM1*IL*1*LAST*FIRST****MI*41
10790140~ N3*ADDRESS~
N4*GREENBAY*WI*543031234~
NM1*PR*2*COMMERCIAL INSURER*****PI*001~
DTP*573*D8*20121204~
SBR*S*18*******HM~
AMT*D*5.00~
OI***Y***I~
NM1*IL*1*LAST*FIRST****MI*4110790140~
N3*ADDRESS~
N4*GREENBAY*WI*543031234~
NM1*PR*2*HMONAME*****PI*69000000~ LX*1~ SV1*HC:99212:25*30*UN*1.0***1~
DTP*472*D8*20121112~
SVD*69000000*5.00*HC:99212:25**1.0~
CAS*CO*23*20.00**45*5.00~
DTP*573*D8*20130109~
SE*44*1001~

The AMT*A8 segment denotes that this is a non-covered service for the Commercial payer.

GE*1*49318~
IEA*1*000049318~

Example 12: Commercial Insurance Not Covered and HMO Payer

ISA*00* *00* *ZZ*100000000 *ZZ*WISC_DHFS
*130321*1531*|*00501*000049318*1*P*:~
GS*HC*100000000*WISC_TXIX*20130321*1531*49318*X*005010X222A1~
ST*837*1001*005010X222A1~
BHT*0019*00*1*20130321*1531*RP~
NM1*41*2*TRADING PARTNER*****46*100000000~
PER*IC*PC MEDIA*EM*NAME@HMO.COM~
NM1*40*2*FORWARDHEALTH*****46*WISC_TXIX~
HL*1**20*1~
PRV*BI*PXC*282N00000X~
NM1*85*2*STCLARE HOSPITAL*****XX*1386641207~
N3*707 14THST~ N4*BARABOO*WI*539131539~
REF*EI*123456789~
HL*2*1*22*0~
SBR*T*18*******MC~
NM1*IL*1*LAST*FIRST****MI*4110790140~
N3*ADDRESS~
N4*GREENBAY*WI*543031234~
DMG*D8*19540628*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*MEDICARENOTCOV*30.00***11:B:1*Y*C*Y*Y*P~
HI*BK:71536~
NM1*82*1*BERG*TROY*L***XX*1740216845~
PRV*PE*PXC*207X00000X~
SBR*P*18*******CI~
AMT*D*0~
OI***Y***I~
NM1*IL*1*LAST*FIRST****MI*41
10790140~ N3*ADDRESS~
N4*GREENBAY*WI*543031234~
NM1*PR*2*COMMERCIAL INSURER*****PI*001~
DTP*573*D8*20121204~
SBR*S*18*******HM~
AMT*D*5.00~
OI***Y***I~
NM1*IL*1*LAST*FIRST****MI*4110790140~
N3*ADDRESS~

The commercial insurer did not make a payment.

N4*GREENBAY*WI*543031234~ NM1*PR*2*HMONAME*****PI*69000000~
LX*1~ SV1*HC:99212:25*30*UN*1.0***1~
DTP*472*D8*20121112~
*HC:99212:25**1.0~ SVD*001*) **45*5.00~
CAS*PR*25*20.00 DTP*573*D8*20130109~
SVD*69000000*5.00*HC:99212:25**1.0~
CAS*CO*23*20.00**45*5.00~
DTP*573*D8*20130109~ SE*44*1001~
GE*1*49318~ IEA*1*000049318~

CAS*PR*25*20.00 is an adjustment reason code within group 1000 which would allow the COB editing to be bypassed

Example 13: Medicare Patient Responsibility Scenario and HMO Payer

```
ISA*00*          *00*          *ZZ*100000000      *ZZ*WISC_DHFS
  *130321*1531*|*00501*000049318*1*P*:~
        GS*HC*100000000*WISC_TXIX*20130321*1531*49318*X*005010X222A1~
            ST*837*1001*005010X222A1~
                BHT*0019*00*1*20130321*1531*RP~
  NM1*41*2*TRADING PARTNER*****46*100000000~  PER*IC*PC MEDIA*EM*NAME@HMO.COM~
                    NM1*40*2*FORWARDHEALTH*****46*WISC_TXIX~
                     HL*1**20*1~  PRV*BI*PXC*282N00000X~
                     NM1*85*2*STCLARE HOSPITAL*****XX*1386641207~
                     N3*707 14TH ST~
                     N4*BARABOO*WI*539131539~
                     REF*EI*123456789~
                     HL*2*1*22*0~
                     SBR*T*18*******MC~
                    NM1*IL*1*LAST*FIRST****MI*4110790140~
                     N3*ADDRESS~
                     N4*GREENBAY*WI*543031234~
                     DMG*D8*19540628*F~
            NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
                     CLM*MEDICARENOTCOV*30.00***11:B:1*Y*C*Y*Y*P~
                     HI*BK:71536~
                    NM1*82*1*BERG*TROY*L***XX*1740216845~
                     PRV*PE*PXC*207X00000X~
                     SBR*P*18*******MB~
                     AMT*D*0~
                     OI***Y***I~
                     NM1*IL*1*LAST*FIRST****MI*41107901~
                     N3*ADDRESS~
                     N4*GREENBAY*WI*543031234~
                     NM1*PR*2*MEDICARE*****PI*001~
                     DTP*573*D8*20121204~
                     SBR*S*18*******HM~
                    AMT*D*5.00~
                     OI***Y***I~
                     NM1*IL*1*LAST*FIRST****MI*4110790140~
                     N3*ADDRESS~
                     N4*GREENBAY*WI*543031234~
                     NM1*PR*2*HMONAME*****PI*69000000~
                     LX*1~
```

The Medicare insurer did not make a payment.

```
                SV1*HC:99212:25*30*UN*1.0***1~
                                    DTP*472*D8*20121112~
                SVD*001*  )       *HC:99212:25**1.0~
                CAS*PR*1*25.00              **45*5.00~
                DTP*573*D8*20130109~
                SVD*69000000*5.00*HC:99212:25**1.0~
                CAS*CO*23*20.00**45*5.00~
                DTP*573*D8*20130109~
SE*44*1001~
GE*1*49318~
IEA*1*000049318~
```

CAS*PR*1*25.00 is an adjustment reason code showing patient responsibility was responsible for Medicare uncovered portion of payment.

Appendix E: COB/Medicare FAQs

Common COB/Medicare Questions and Answers:

Q: My encounter is failing for EOB 0278 but I believe the information on the Wisconsin file is inaccurate. I don't believe they actually have other insurance. What should I do?
A: HMOs submit a TPL discrepancy form. This is completed and submitted on the Managed
Care Portal. After logging in to the Portal, the discrepancy form is found under the Quick Links portion of the page. (Effective 4/28/2015 encounters are not denied for commercial insurance. It is the responsibility of the HMOs to verify all commercial insurance is billed.)

Q: I see a number of encounters failing for EOB 0683 (Member enrolled in QMB-Only Benefit Plan) as well as 1257 (Member is enrolled in Part B on date of service). Is there something specific to QMB that we should be concerned with?
A: Both of these failures basically boil down to the same issue. The member is enrolled in Part B and the encounter did not include it. HMOs re-submit the encounter with the Medicare adjudication information.

Q: What if I know the service is non-covered by the other insurance or Medicare? Do I need to submit all charges to the other insurance or Medicare provider even if I know it's going to deny?
A: In the case of non-covered services, HMOs use a disclaimer in the AMT segment to show the service is non-covered. Refer to the implementation guide Loop 2310 for specifics, for example: AMT*A8*273~. This segment is used to show the member does have Medicare/OI but it was not billed since the service is uncovered.

Q: Where can I find COB information for members enrolled in my HMO?
A: There are two main sources for HMOs to find COB information which Wisconsin Medicaid has on file. The Coordination of Benefits (COB) Extract is available on the managed care Portal monthly (layout available on the report matrix). The same information is also found on the 834 each month.

Q: How do I handle encounters that come in on paper which contain Medicare or other insurance information?
A: The encounter is mapped into the HMO system so it can be submitted as an electronic 837. In the case of paper Medicare information, it is imperative that the patient responsibility information is mapped accurately and populated on the 837. The same is true for commercial insurance information; all adjudication information must be included.

Appendix F: Adjustment Reason Code Group 1000

ANSI Group 1000: Adjustment Reason OI-D

RSN_CDE	DSC_ADJ_RSN	DTE_EFF	DTE_END
26	Expenses incurred prior to coverage.	19950101	22991231
27	Expenses incurred after coverage terminated.	19950101	22991231
29	The time limit for filing has expired.	19950101	22991231
31	Patient cannot be identified as our insured.	19950101	22991231
32	Our records indicate the patient is not an eligible dependent.	19950101	22991231
33	Insured has no dependent coverage.	19950101	22991231
34	Insured has no coverage for newborns.	19950101	22991231
35	Lifetime benefit maximum has been reached.	19950101	22991231
44	Prompt-pay discount.	19950101	22991231
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
51	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
53	Services by an immediate relative or a member of the same household are not covered.	19950101	22991231
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	19950101	22991231

61	Adjusted for failure to obtain second surgical opinion	19950101	22991231
78	Non-Covered days/Room charge adjustment.	19950101	22991231
85	Patient Interest Adjustment (Use Only Group code PR)	19950101	22991231
89	Professional fees removed from charges.	19950101	22991231

RSN_CDE	DSC_ADJ_RSN	DTE_EFF	DTE_END
90	Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.	19950101	22991231
91	Dispensing fee adjustment.	19950101	22991231
94	Processed in Excess of charges.	19950101	22991231
95	Plan procedures not followed.	19950101	22991231
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
100	Payment made to patient/insured/responsible party.	19950101	22991231
102	Major Medical Adjustment.	19950101	22991231
106	Patient payment option/election not in effect.	19950101	22991231
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	19950101	22991231
114	Procedure/product not approved by the Food and Drug Administration.	19950101	22991231
116	The advance indemnification notice signed by the patient did not comply with requirements.	19950101	22991231
117	Transportation is only covered to the closest facility that can provide the necessary care.	19950101	22991231
119	Benefit maximum for this time period or occurrence has been reached.	19950101	22991231
128	Newborn's services are covered in the mother's Allowance.	19970228	22991231
130	Claim submission fee.	19970228	22991231
131	Claim specific negotiated discount.	19970228	22991231

132	Prearranged demonstration project adjustment.	19970228	22991231
134	Technical fees removed from charges.	19981031	22991231
138	Appeal procedures not followed or time limits not met.	19990630	20180501
139	Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.	19990630	22991231
142	Monthly Medicaid patient liability amount.	20000630	22991231
143	Portion of payment deferred.	20010228	22991231
144	Incentive adjustment, e.g. preferred product/service.	20010630	22991231
147	Provider contracted/negotiated rate expired or not on file.	20020630	22991231
149	Lifetime benefit maximum has been reached for this service/benefit category.	20021031	22991231
157	Service/procedure was provided as a result of an act of war.	20030930	22991231
158	Service/procedure was provided outside of the United States.	20030930	22991231

RSN_CDE	DSC_ADJ_RSN	DTE_EFF	DTE_END
159	Service/procedure was provided as a result of terrorism.	20030930	22991231
160	Injury/illness was the result of an activity that is a benefit exclusion.	20030930	22991231
161	Provider performance bonus	20040229	22991231
164	Attachment referenced on the claim was not received in a timely fashion.	20040630	22991231
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	20050228	22991231
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	20050630	22991231
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	20050630	20180501
169	Alternate benefit has been provided.	20050630	22991231
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	20050630	22991231
171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	20050630	22991231
178	Patient has not met the required spend down requirements.	20050630	22991231

179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	20050630	22991231
180	Patient has not met the required residency requirements.	20050630	22991231
186	Level of care change adjustment.	20050630	22991231
188	This product/procedure is only covered when used according to FDA recommendations.	20050630	22991231
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	20050630	22991231
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	20051031	22991231
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	20060228	22991231
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	20060228	22991231
195	Refund issued to an erroneous priority payer for this claim/service.	20060228	22991231
197	Precertification/authorization/notification/pre-treatment absent.	20061031	22991231
198	Precertification/notification/authorization/pre-treatment exceeded.	20061031	22991231
200	Expenses incurred during lapse in coverage	20061031	22991231

RSN_CDE	DSC_ADJ_RSN	DTE_EFF	DTE_END
202	Non-covered personal comfort or convenience services.	20070228	22991231
203	Discontinued or reduced service.	20070228	22991231
204	This service/equipment/drug is not covered under the patient's current benefit plan	20070228	22991231
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	20080601	22991231
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)	20080601	22991231
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	20080921	22991231

231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	20090701	22991231
232	Institutional Transfer Amount. Usage: Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	20091101	22991231
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	20120301	22991231
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration. Notes: Use CARC 290 if the claim was forwarded.	20130701	22991231
256	Service not payable per managed care contract.	20130701	22991231
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	20131101	22991231
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	20150301	22991231
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	20171101	22991231
286	Appeal time limits not met	20171101	22991231
287	Referral exceeded	20171101	22991231
288	Referral absent	20171101	22991231

RSN_CDE	DSC_ADJ_RSN	DTE_EFF	DTE_END
289	Services considered under the dental and medical plans, benefits not available. Notes: Also see CARCs 254, 270, and 280.	20171101	22991231
293	Payment made to employer.	20171101	22991231
294	Payment made to attorney.	20171101	22991231
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	20180701	22991231
A0	Patient refund amount.	19950101	22991231

A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	19950101	22991231
A5	Medicare Claim PPS Capital Cost Outlier Amount.	19950101	22991231
A6	Prior hospitalization or 30 day transfer requirement not met.	19950101	22991231
B1	Non-covered visits.	19950101	22991231
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	19950101	22991231
B14	Only one visit or consultation per physician per day is covered.	19950101	22991231
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
B16	'New Patient' qualifications were not met.	19950101	22991231
B20	Procedure/service was partially or fully furnished by another provider.	19950101	22991231
B22	This payment is adjusted based on the diagnosis.	19950101	22991231
B4	Late filing penalty.	19950101	22991231
B8	Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231
B9	Patient is enrolled in a Hospice.	19950101	22991231
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	20131101	22991231
P12	Workers' compensation jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	20131101	22991231

RSN_CDE	DSC_ADJ_RSN	DTE_EFF	DTE_END

P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	20131101	22991231
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	20131101	22991231
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	20131101	22991231
P27	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	20171101	22991231
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only.	20131101	22991231

P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	20131101	22991231
RSN_CDE	**DSC_ADJ_RSN**	**DTE_EFF**	**DTE_END**
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	20131101	22991231
P6	Based on entitlement to benefits. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	20131101	22991231
P8	Claim is under investigation. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	20131101	22991231