ForwardHealth Portal

HMO Encounter User Guide

Date Last Updated: March 1, 2016

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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 examples in Appendix D.	1.1
5/23/2013	Andy Whiten s	Updated examples in Appendix D. Added Appendix E for COB/Medicare FAQ.	2.0
8/9/2013	Andy Whitens/ Deb Crist	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 process.	5.0
1/6/2014	Andy Whitens/ Deb Crist	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 Appendix B ANSI Codes used in assigning financial indicator.	8.0
6/24/2015	Andy Whitens/ Deb Crist	Updated password guidelines in 4.6.1. Added Encounter Testing section 4.7. Modified Atypical 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 thoughout the guide that effective 4/28/2015 encounter 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 12.2 to include all currently recognized filenames.	10.0
03/01/2016	Bouskill Xiong	Updated "Surgical" procedures to "ICD" procedures in Section 1.1 Introduction.	11.0

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.

Term	Description
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.
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). *http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA/*
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.

Term	Description
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.
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.
PPACA	Patient Protection and Affordable Care Act
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.
RIN	The Record Identification Number (RIN) is a unique identification number assigned by an HMO to each encounter in order to distinguish it from all other encounters sent.
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 encounter, including provider details, member details, encounter information, and other payer information.
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 status processing of an encounter header and trailer.

Term	Description
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 - *www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx*.
- 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*
- Wisconsin ForwardHealth Portal – *www.forwardhealth.wi.gov/WIPortal/*
- ForwardHealth Online Handbooks – *www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx*
- Provider Updates – *www.forwardhealth.wi.gov/WIPortal/content/Provider/Updates/index.htm.spage*

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*.

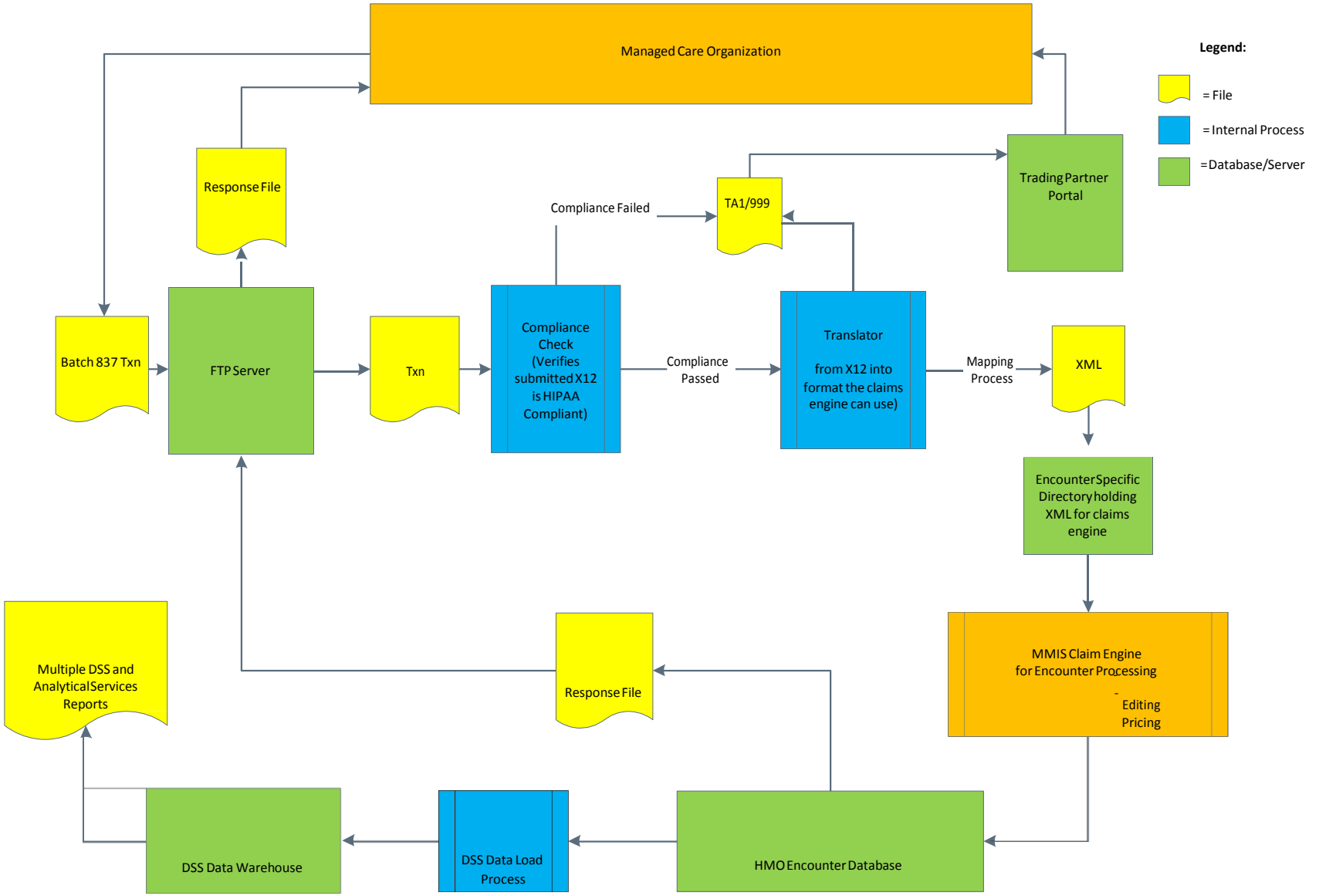
3 Overall Encounter Transaction Flow

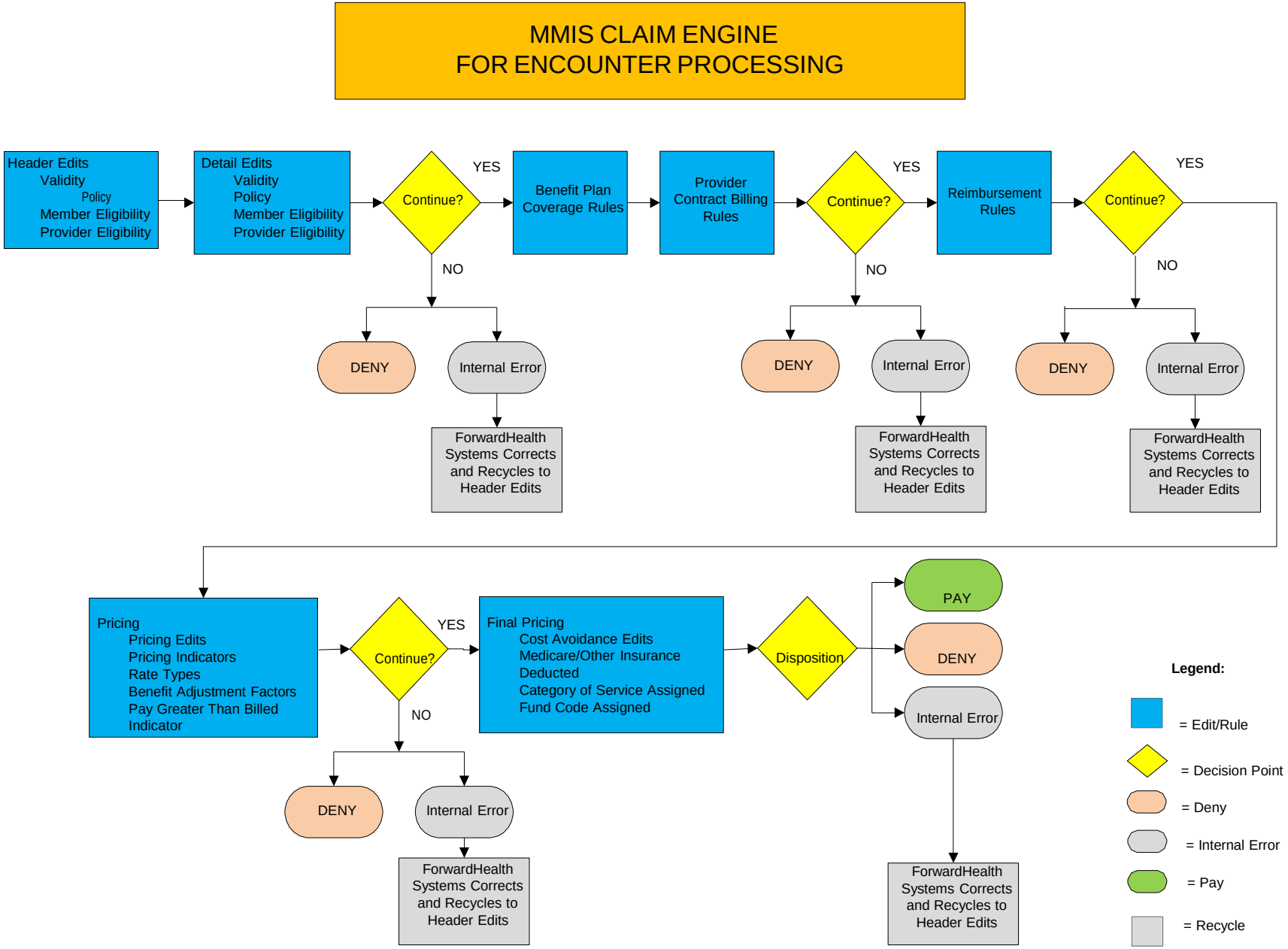
3.1 Summary and Claims/Encounter Engine Process

The following two flowcharts display encounter processing. Flowchart 1 is a summary of the process from start to finish. Flowchart 2 is a more detailed look at 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




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 explains the various encounter types along with the guidelines and processes for submitting encounters.

Effective for process date on or after January 1, 2013, all HMO encounter data, including encounters submitted to the HMO on paper, are required to be submitted to ForwardHealth in the 837 format.

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 Xover
  - C - Outpatient Xover
- **837P - Professional**
  - M - Professional
  - B - Professional Xover
- **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 may 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 detailed 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

HMOs submit files on the SFTP server to individual directories using SFTP. 837 transactions are created and submitted based on the trading partner. HMOs with multiple lines of business under the same trading partner, for example BadgerCare Plus and Supplemental Security Income (SSI) create files based on the trading partner and not the specific HMO IDs. In these cases, the 837 transaction files may be submitted to either the BadgerCare Plus or SSI directory on the SFTP server. HMOs have the option to create separate files for their different lines of business, or they can create one file combining them. Compliant HMO encounter files are processed by ForwardHealth.

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	
SFTP IP	192.85.128.129
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. This conserves storage space and limits the amount of personal health information on the SFTP server. This is a rolling date deletion. For example, any files posted on June 1 delete on June 16; any files posted on June 2 delete June 17, etc.

4.6.3 SFTP Transmission Process

ForwardHealth automatically picks up files meeting the anticipated naming convention from the FTP server. HMOs ensure that files are renamed during the FTP transmission process to prevent a file being picked up before it is fully transmitted. For example, many FTP clients will append a .tmp extension onto the file during transmission.

4.7 Encounter Testing

HMOs submit test files on the SFTP server to their test directory. Test files are processed using the same processes and timeline as production file submissions. 999s will be available on the test portal on the same day. Test response files and status reports will run over the weekend and be returned to the test directory on the SFTP.

5 Encounter Policy Overview

5.1 Policy Introduction

This section provides an explanation of where HMOs can find policy information. It gives a high-level policy overview as well as highlighting any policy pertaining to encounters that would differ from standard fee-for-service policy. The main sources for all Wisconsin Medicaid and BadgerCare Plus policy questions or clarifications are the ForwardHealth Online Handbooks and provider updates, which can be found at:

www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx
and

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

5.2 In Lieu of Services

"In lieu of services" are services that are not allowed for fee-for-service claims, but are allowed for encounter pricing. An *in lieu of service* must be health related, cost-effective, and similar to the covered Medicaid state plan service for which it is substituted. All *in lieu of services* must be approved by Centers for Medicare and Medicaid Services (CMS). ForwardHealth accepts encounters for two *in lieu of services* – Institution for Mental Disease (IMD) and Sub-acute Psychiatric Services.

An IMD may be used in lieu of traditional psychiatric intervention for members ages 22-64.

Sub-acute community-based clinical treatment may be used in lieu of inpatient psychiatric hospitalization. This treatment can be used either as an alternative to inpatient hospitalization through the emergency room or as a step-down stabilization from acute inpatient hospitalization. It must be deemed appropriate by the treatment center admission staff and authorized as medically necessary by the HMO.

5.3 National Provider Identifier Exempt Provider Types

Certain provider types are exempt from submitting National Provider Identifiers (NPIs) to ForwardHealth, and certain providers are ineligible to receive an NPI. These providers are often referred to as atypical providers. They are exempt from the NPI requirement, and encounters submitted for them continue to indicate their 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 dos 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).

See Appendix D – Example 8

5.4 Member ID

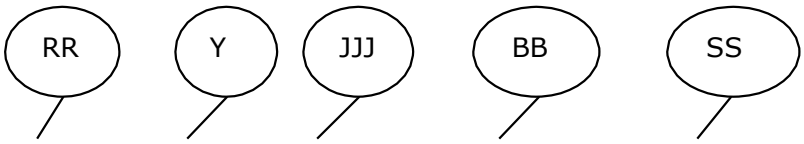
The Member ID is the subscriber's identification number as assigned by ForwardHealth. The Member ID is populated in Loop 2010BA NM109 Subscriber Primary Identifier (NM108=MI).

5.5 Encounter ID Numbers

The Claim submitter's identifier is populated in Loop 2300 CLM01 Claim Submitter's identifier in the 837 encounter header. The Line Item Control Number (previously Record Identification Number-RIN) is populated in Loop 2400, REF02 (REF01=6R), Line Item Control Number. The concept of the RIN is applicable for the HMOs when identifying their encounters when they are returned and for adjustments that need to occur on encounters submitted in the legacy system. Refer to *Section 7* for further information on encounter adjustments.

With HMO Encounter Process project implementation, the ForwardHealth ICN is used for HMO encounter identification. The Claim Submitter's Identifier and Line Item Control Number are stored for inclusion on the response file. Each encounter and subsequent adjustments are assigned a unique 13-digit ICN.

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



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.

5.6 Encounter Region Descriptions:

The region code makes up the first two digits of the encounter ICN. The following is a detailed explanation of the information the region code provides:

- *Region 41* – Converted Encounter: Region 41 is assigned to encounters which were converted from the legacy encounter system.

- *Region 70* — Original Encounter: Region 70 is assigned to new day encounter submissions.
- *Region 72* — Adjusted Encounter: Region 72 is assigned to HMO initiated adjustments. *Section 7 — Encounter Adjustment Process* explains the encounter adjustment process in detail.
- *Region 73* — Mass Adjustment Encounter: Region 73 is assigned to state initiated adjustments of paid encounters.
- *Region 74* — State Re-submitted Encounter: Region 74 is assigned to state initiated adjustments of denied encounters.
- *Region 79* — Member Linking Encounter: Region 79 is assigned to state initiated adjustments where those adjustments are used to update the member ID stored on the encounter. This happens in scenarios where a member has multiple IDs merged within the ForwardHealth system.

5.7 Provider Propagation Logic

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.

ForwardHealth utilizes propagation logic on Medicaid professional and dental encounters and adjustments for the billing provider to assist in adjudicating encounters. This propagation logic is not used for crossover encounters. ForwardHealth policy dictates that each provider service location is assigned a billing status. The valid values for billing status are:

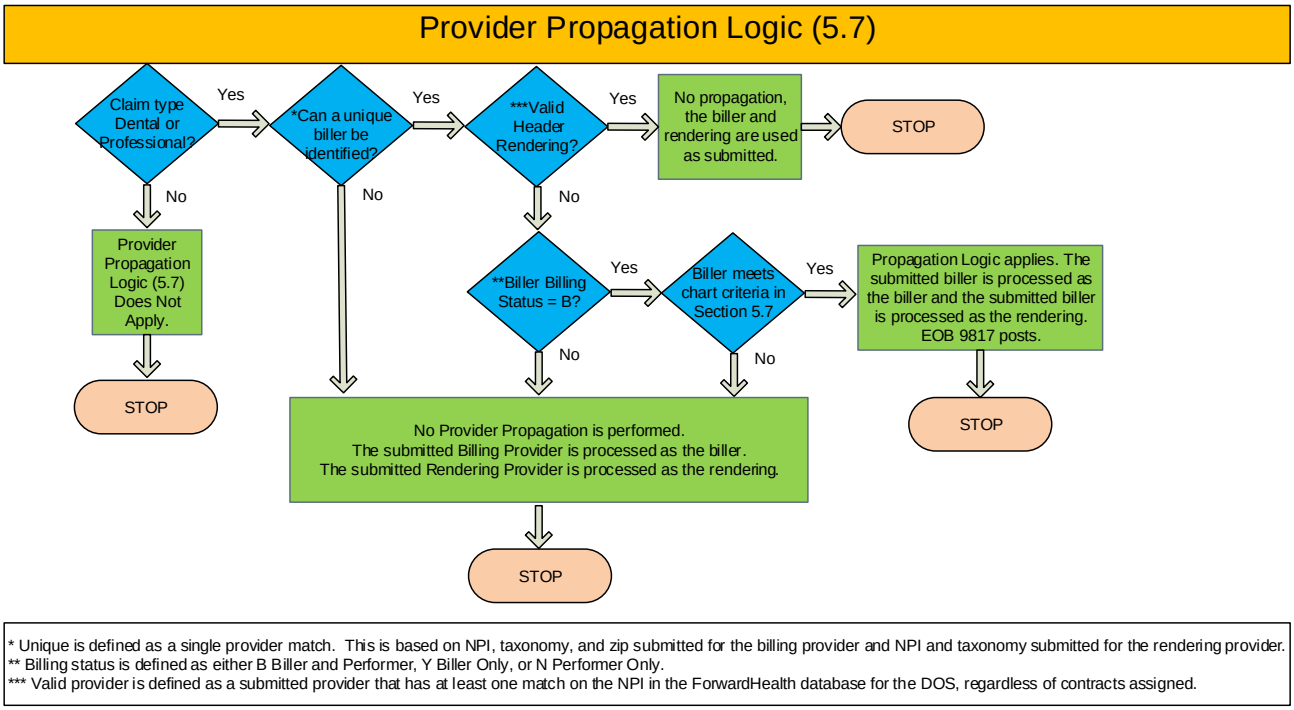
- B – Biller and Performer.
- Y – Biller.
- N – Performer.

Certain providers are designated to be both billing and rendering (performing) providers. In some cases where the rendering provider is not certified in the ForwardHealth system, the billing provider is used as the rendering provider. Modified encounter processing logic validates the submitted billing provider's billing status. When the provider billing status is B (both billing and performing), and the billing provider's type and primary specialty are in the group that is designated to use the billing provider as rendering, and 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 each provider's 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.

5.8 Provider Matching and Usage Enhancements

ForwardHealth implemented provider reverse propagation and hierarchy logic enhancements to assist in identifying a unique biller and/or rendering provider on HMO encounters. 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. These steps are taken in instances where the encounter would have hit 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) or Step #4 for institutional claim types (I, O, H, A or C).
2. ForwardHealth determines for professional or dental claim types if a header rendering provider is present. If a header rendering provider is present, proceed to Step #3. If a header rendering provider is not present or the rendering that is present is not found, proceed to Step #4.
3. ForwardHealth determines for professional or dental claim types if a unique header rendering provider, certified as either a biller and performer or performer only, can be determined.
    a. If ForwardHealth determines a unique header rendering provider, certified as either a biller and performer or performer only, can be identified using a combination of submitted NPI and taxonomy, ForwardHealth performs provider reverse propagation logic (Section 5.8.1). The header rendering provider is treated as the header billing and rendering provider.
    b. If ForwardHealth cannot determine a unique header rendering provider, certified as either a biller and performer or performer, using the submitted NPI and taxonomy, ForwardHealth performs provider service location hierarchy logic (Section 5.8.2) on the header rendering provider. If the hierarchy logic determines a match, ForwardHealth performs provider reverse propagation logic (Section 5.8.1). The header rendering provider is treated as the header billing and rendering provider.
    c. If the header rendering provider is certified as a biller only or prescribing/referring/ordering provider, proceed to Step #4.
4. ForwardHealth performs provider service location hierarchy logic (Section 5.8.2) on the header billing provider. If the hierarchy logic determines a match, ForwardHealth uses that biller to process the encounter. If the hierarchy cannot determine a match, ForwardHealth processes and denies the encounter with the submitted biller.

5.8.1 Provider Reverse Propagation Logic

ForwardHealth performs provider reverse propagation logic on professional and dental claim types when a unique billing provider cannot be determined. If a unique rendering provider can be determined using a combination of submitted NPI and taxonomy or by using provider service location hierarchy logic (Section 5.8.2), and the unique renderer is certified as a biller and performer or performer, the renderer is processed as the 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

ForwardHealth performs provider service location hierarchy logic 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 uses the first detail on the encounter and tries to match, one by one, in the order of the hierarchy logic until a match is found. When a match is found, ForwardHealth processes all details of the encounter using that provider. 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 the specific scenarios and provider types used within the hierarchy logic:

https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx

5.8.3 Procedure Billing Rule Hierarchy Logic

ForwardHealth performs provider procedure billing rule service location hierarchy logic when a procedure billing rule related error sets within the ForwardHealth system on professional and dental claim types. The following errors will trigger the system to try the hierarchy logic:

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

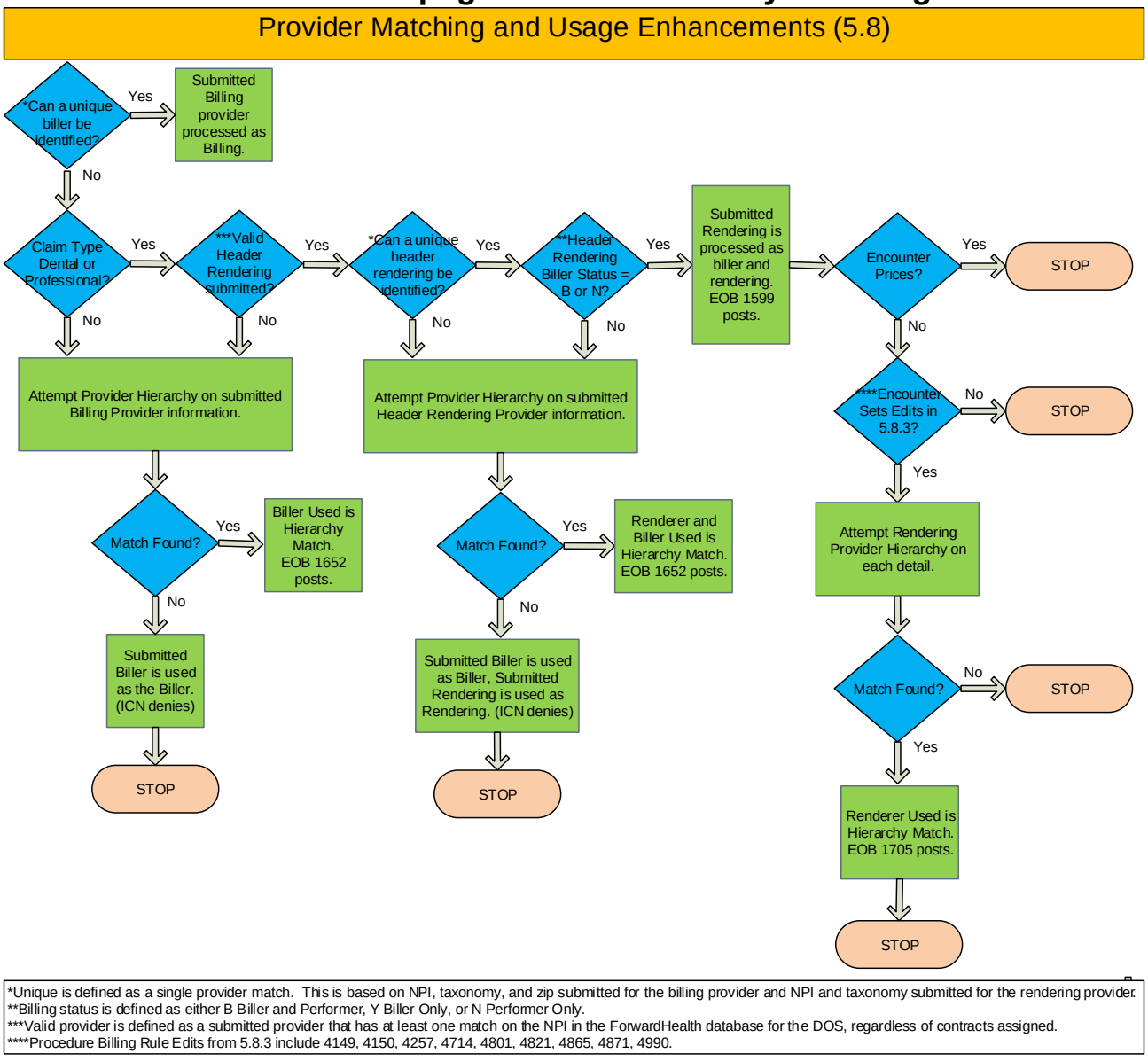
4990 – Benefit plan restriction for procedure billing rule

The procedure billing rule hierarchy checks each detail within the encounter in an attempt to assign a more appropriate provider service location. If the rendering provider used on the detail has more than one provider location, 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 Hierarchy document found on the MCO Portal for the specific scenarios and provider types used within the hierarchy logic:

https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx

5.8.4 Provider Reverse Propagation and Hierarchy flow diagrams



*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. These edits consist of checks for required presence, format, consistency, reasonableness, and allowable values. Edit disposition for encounters are set 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 either inactive, price, or deny.

Some of the fee-for-service claims edits are set to active for encounter processing. The following edits are examples of those that are set for encounter processing:

- 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 not billed. (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.)
  - Medicare Insurance not billed.
- Benefit Plan Rule Edits (the following are not applicable to HMOs):
  - PE Presumptive Eligibility – Pregnancy.
  - AE Alien Emergency Services Only.
  - TB Tuberculosis Services Only.
  - FPW Family Planning Services Only.
  - QMB Qualified Medicare Beneficiary.
  - SC1 Senior Care Level 1 – 0 to 200% FPL.
  - SC2 Senior Care Level 2 – Over 200% FPL.
  - CRSW Community Recovery Services Waiver:
    - H0043 (with a modifier) – Community Living Supportive Services Per Diem.
    - H0043 (with a modifier) – Community Living Supportive Services Hourly.
    - H2023 Supported Employment (member age 14 and above only).
    - H0038 Peer Supports.
- 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.

➢ Family Planning Service restrictions are enforced.

➢ Encounter Balancing:

- Total header and total detail submitted amounts.
- Total header and total detail paid amounts.

Appendix A includes additional information pertaining to the general policy and editing guidelines in place for encounter.

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).

➢ Patient Liability.

- Spenddown.
- Cost share. (Copayment implemented 10/11/2013 effective for Dates of Service on or after 1/1/2013. PPACA encounters retroactively adjusted.)
- Coinsurance.

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 shall 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 with *42 CFR 441 Subpart E* – Abortions.
- Hysterectomies and sterilizations must comply with *42 CFG 441. Subpart F* – Sterilizations. Sanctions in the amount of $10,000 may be imposed for noncompliance with the above compliance requirements. The HMO must abide by *s. 609.30, Wis. Stats*.

HMOs should obtain and be able to provide the necessary supporting documentation if audited 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

ForwardHealth will continue the use of the MCO Pricing Administration Guide to provide guidance to the HMOs. We will update that document as needed throughout the implementation process. This guide is available at: *www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.as px*.

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
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
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
NDCLOW	Lowest Available Rate
OPPRVR	Percentage & per diem
PAY0	Allowed amount pay 0
RBRVS	Resource Based Relative Value Scale
SMAC	State Max Allowable Cost
SYSMAN	Reimbursement rules price

Pricing Indicator	Description
UCBILL	Billing providers UCC
UCCALL	Billing or providers UCC
UCPERF	Performing providers UCC
WAC	Wholesale Acquisition Cost

5.13.3 Pricing Inclusions and Exclusions

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

- 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
- Other insurance payments are accounted for during the pricing process.
- Medicare payments (crossover encounters) 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.
- Member Cost Share. (Copayment implemented 10/11/2013 effective for Dates of Service on or after 1/1/2013. PPACA encounters retroactively adjusted.)
- Patient Liability. (Copayment implemented 10/11/2013 effective for Dates of Service on or after 1/1/2013. PPACA encounters retroactively adjusted.)
- 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 are limited to those providers who are 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.

For the non-certified out-of-state provider to have his or her NPI or provider ID entered into the state's provider file as a certified Wisconsin Medicaid provider, the out-of-state provider applies through the ForwardHealth Portal at *www.forwardhealth.wi.gov*. The provider selects 'Become a Provider', 'Start or Continue Your Enrollment', and 'Medicaid In-State Emergency/Out-of-State Provider Enrollment.' The provider is guided through a series of screens. Affordable Care Act out-of-state provider requirements and potential fees apply. For assistance in completing the application process, providers call Provider Services at 800-947-9627. Upon submission, the provider receives an application tracking number (ATN). From the portal, a provider selects 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 and will receive a mailed notice when it is time to do so.

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

Encounter uses manual pricing at a percent of billed amount 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

Encounter uses manual pricing at a percent of billed amount for hearing aid encounters. Rentals use existing max fee pricing.

5.13.10 Vision Pricing

Any manually priced vision services are priced at a percent of billed amount.

5.13.11 Carved Out Services

Encounters for services that are carved out of encounter processing are denied. HMOs can find these carved out services in the HMO contract, Article III.E.1.

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*. Further clarifications and changes are laid out in 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 and Utilization Logic

Encounters are priced if the encounter passes through all edits. Assignment of Financial and Utilization indicators determine whether an encounter is used in rate setting and/or reporting.

Each encounter header and detail is assigned both a Financial and Utilization Indicator:

- A "Y" (Yes) for Financial Indicator designates that the encounter header or detail will be used in rate setting for the HMO.
- A "Y" (Yes) for Utilization Indicator designates that the encounter header or detail will be included in utilization reports for the HMO.

If the encounter header or detail is assigned a "Y" for Financial Indicator, it is also assigned a "Y" for Utilization Indicator. An encounter header or detail may be assigned a "Y" for Utilization Indicator even if it does not receive a "Y" for Financial Indicator.

Chart reviews are used for reporting only.

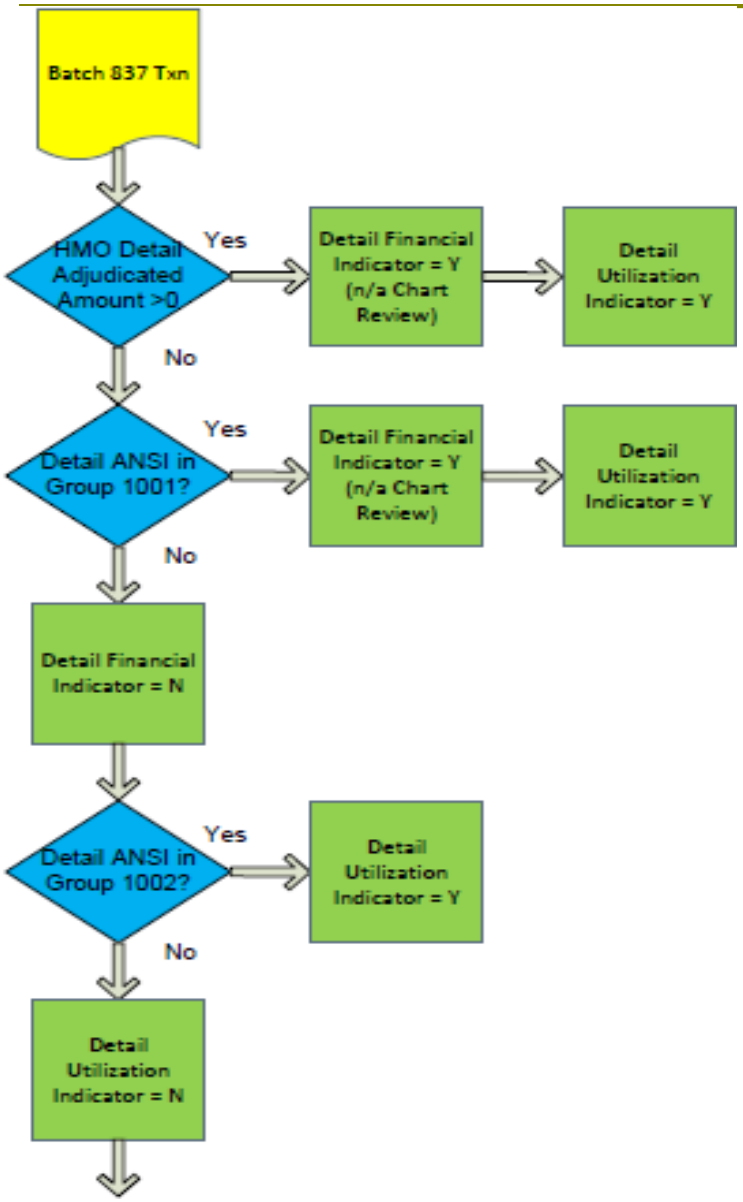
The financial indicator is assigned by first looking at the HMO paid amount submitted on the encounter. A paid amount > 0 at the header level will result in the header and all details receiving a financial indicator of 'Y'. If no HMO paid amount is submitted at the header each detail will be evaluated independently. All details with a paid amount > 0 would receive a 'Y' financial indicator. If any details within an encounter have a financial indicator of 'Y' assigned the header would also get a 'Y' indication. In instances where the HMO does not submit a paid amount the adjustment reason codes submitted within the HMO payment loop on the 837 are used for the financial and utilization indicators.

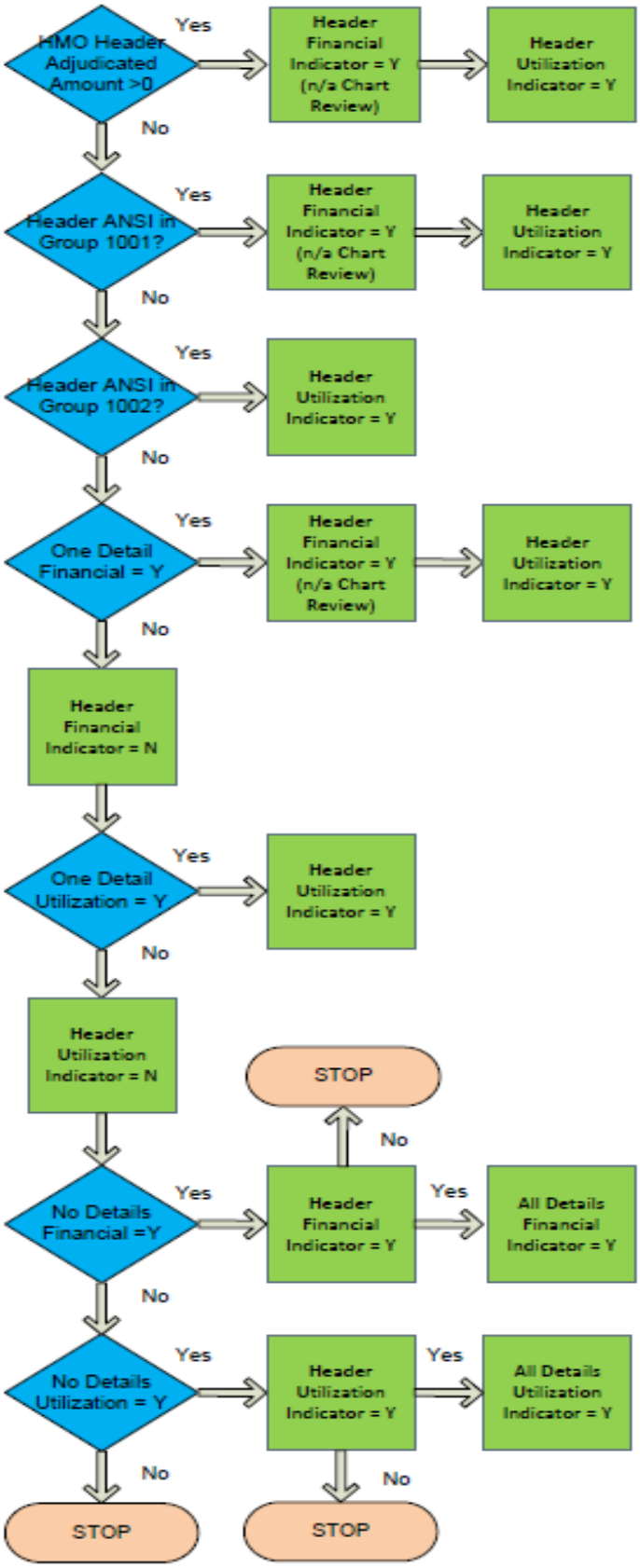
Group 1001 contains all American National Standards Institute (ANSI) codes that indicate both Financial and Utilization.

Group 1002 contains all ANSI codes that indicate Utilization only.

See *Appendix B — ANSI Code Groups*

The following flowchart displays the logic for setting Financial and Utilization Indicators.


Batch 837 Txn
HMO Detail Adjudicated Amount >0
Yes
Detail Financial Indicator = Y (n/a Chart Review)
Detail Utilization Indicator = Y
No
Detail ANSI in Group 1001?
Yes
Detail Financial Indicator = Y (n/a Chart Review)
Detail Utilization Indicator = Y
No
Detail Financial Indicator = N
Detail ANSI in Group 1002?
Yes
Detail Utilization Indicator = Y
No
Detail Utilization Indicator = N


HMO Header Adjudicated Amount >0
Yes
Header Financial Indicator = Y (n/a Chart Review)
Header Utilization Indicator = Y
No
Header ANSI in Group 1001?
Yes
Header Financial Indicator = Y (n/a Chart Review)
Header Utilization Indicator = Y
No
Header ANSI in Group 1002?
Yes
Header Utilization Indicator = Y
No
One Detail Financial = Y
Yes
Header Financial Indicator = Y (n/a Chart Review)
Header Utilization Indicator = Y
No
Header Financial Indicator = N
One Detail Utilization = Y
Yes
Header Utilization Indicator = Y
No
Header Utilization Indicator = N
STOP
No
No Details Financial =Y
Yes
Header Financial Indicator = Y
Yes
All Details Financial Indicator = Y
No
No Details Utilization = Y
Yes
Header Utilization Indicator = Y
Yes
All Details Utilization Indicator = Y
No
No
STOP
STOP

5.15 Duplicate Monitoring

Encounters are monitored for duplicates in the current encounter submission, as well as against 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	Member ID Provider Procedure Code FDOS TDOS Billed Quantity Billed Amount
Dental	Member ID Performing Provider FDOS TDOS Procedure Code Tooth Number
Dental	Member ID Performing Provider FDOS TDOS Procedure Code Area of the Oral
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 their paid service and coordination of benefits information on the 837 encounter transaction. This information provides Wisconsin ForwardHealth the ability to compare, by service category, aggregate costs of interChange priced amounts based on the Medicaid fee schedule to the HMO paid amounts. The following sections detail specific 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 details 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/Default.aspx?srcUrl=CcompanionDocuments.htm&tabid=41

5.16.3 Proprietary Information

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

5.16 Sub-Capitated Encounter Information

Sub-Capitated providers are providers who 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 Shadow Pricing on Sub-Capitated Encounters

When an encounter is sub-capitated, the 837 Medicaid HMO payer loops include a zero paid amount and Adjust Reason Code 24. The HMO assigns a shadow price they would have 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. It is only available at the header levelfor institutional services. The CN101 element is populated with 05 – 'Capitated' and the CN102 element contains the shadow priced amount that was applied to the encounter.

5.18 Medicare Adjudication Information

HMOs are required to submit Medicare adjudication information on the 837 encounter transaction. This 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. It is also currently permissible for the paid and patient responsibility info to be submitted at the detail level. With the implementation of the EAPG pricing methodologies that will no longer be acceptable.
    - 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 both the encounter and ForwardHealth priced amount, an HMO may determine that an allowed encounter needs to be adjusted. HMOs may 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 which 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. Previously denied encounters cannot be adjusted or voided and attempting to do so results 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 re-submitted 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.

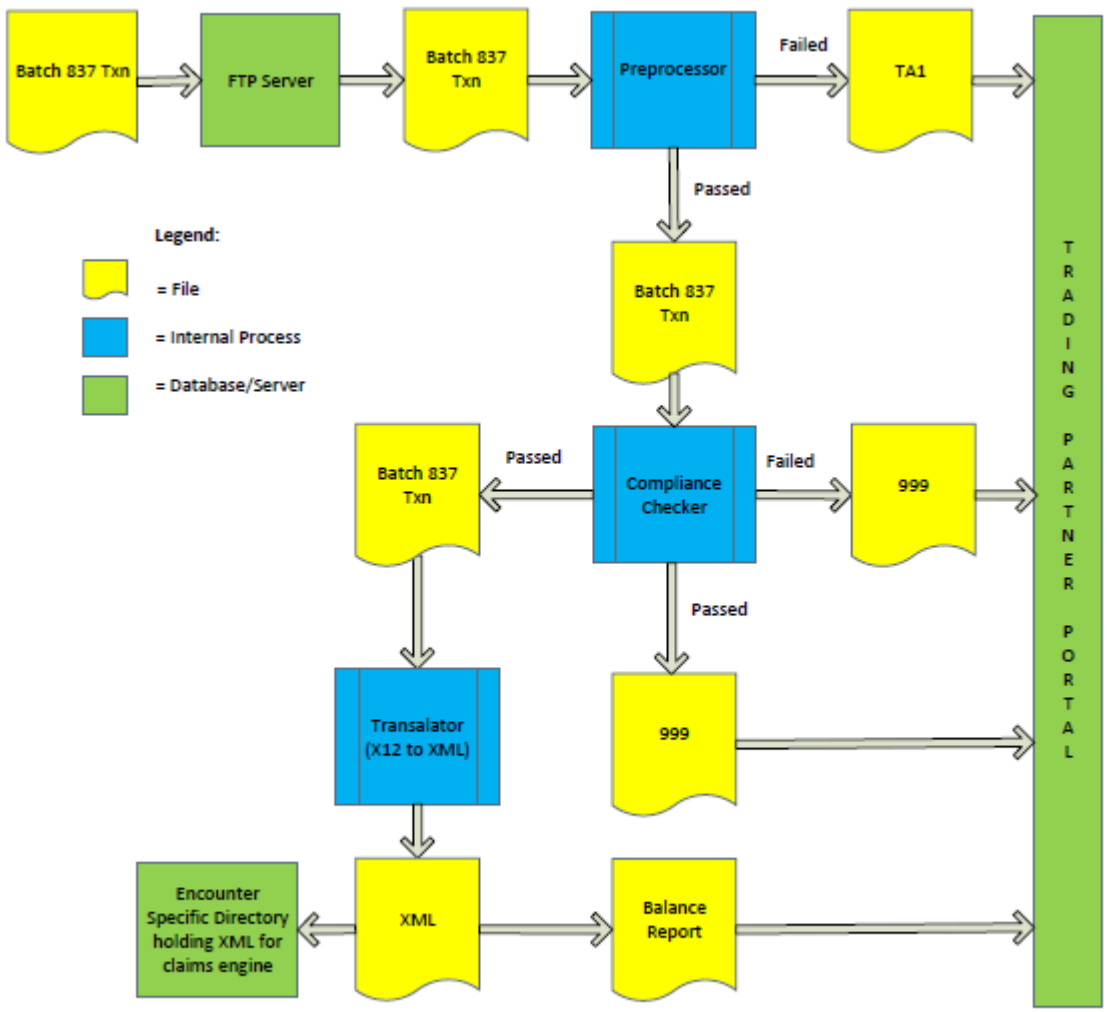
7.4 Evaluating Adjustment/Void Responses

HMOs evaluate results of an attempted encounter adjustment/void by looking at the weekly response file. 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. That region 72 assignment means that the original ICN has been adjusted or voided and is no longer active. Future adjustments/voids submitted reference the new region 72 ICN, unless that ICN is denied, in which case 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 in an attempt to adjust ICN 7012345678901 the response ICN populated is a 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 explains 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

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 gives 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 specific transaction and contact information as the first step in the EDI enrollment process. This is completed online at *www.forwardhealth.wi.gov*. Current trading partners add the 837 transaction to their Trading Partner Profile. Assistance in updating the Trading Partner Profile is available from EDI Support at *VEDSWIEDI@wisconsin.gov* or (866) 416-4979.

9 Encounter File Response

9.1 Encounter File Format

HMO encounter error and pricing information is in the encounter response file on the SFTP server. The layout for the encounter response file is on the Report Matrix, *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*. The encounter response file includes encounter status, pricing information, EOB codes and information submitted on the 837 encounter. The encounter response file is the main source of evaluating the processing and pricing of encounters by ForwardHealth interChange.

Explanation of Benefit Codes can be found at *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. It is available the first working day each week. The response file contains all encounter records which finalized in the previous week. Those finalized records could contain records that were submitted that 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 explanation on region codes.

ForwardHealth initiated adjustments show up on the response file with a blank 150 record. HMOs identify ForwardHealth adjustments on each week's 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

Encounter response file records 520 (header) and 620 (detail) return Error and EOB information for processed encounters. HMOs use these Errors and EOBs as a resource for additional information about the encounter. The Errors and EOBs displaying on the same 520 or 620 records should be used in conjunction to help determine the true meaning.

HMOs evaluate all the Errors and EOBs as a group to determine the true reason for encounter denial. 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 as 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 the encounter records submitted. The report layout can be found on the report matrix at: 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. It 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/Complnce – 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. This guide focuses on HMO encounter reports. The layouts for most reports available to the HMOs are on the report matrix at: *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*

11.2 Encounter Reports

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

Certified Provider Listing — Listing of all certified Medicaid providers by provider type and specialty showing certification begin and end dates. All providers with a valid certification within the previous two years are included. This report also displays the NPI, taxonomy, and ZIP code information for all certified Medicaid providers.

HMO Max Fee Extract — An extract showing all Medicaid procedure codes which are paid on a max fee basis. It gives a comprehensive look at the provider types, POS values and contracts covered for each procedure in addition to other information. The full layout for this extract is in the HMO Pricing Administration Guide at: *www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx*.

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.

CLIA Extract – Detailed in *Section 14* of this user guide.

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 back-up contact.

To update the HMO contact information, the HMO emails *vedshmosupport@wisconsin.gov* including the name, email address and phone number for both the primary and back-up contact.

12.2 HMO Contact Usage

An automated process scanning the SFTP directories notifies the HMOs and HMO Support when files are present that do not meet anticipated naming conventions. This process ensures any files submitted with an invalid name are identified and the appropriate individuals are notified.

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).

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

The HMO receives 2 files detailing member Third Party Liability (TPL) information:

- The TPL MCO Coordination of Benefit (COB) extract runs monthly and contains HMO members and their 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 if the HMO has verified that 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.

A HMO Portal Link will be available for the 'Other Coverage Discrepancy Report – Form F-1159 by the end of 2012. 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. Once HP staff review and make the appropriate member TPL updates, the encounter record will need to either be adjusted or resubmitted.

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 detailed information on CMS requirements:

http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA/

14.2 CLIA Enforcement

Encounters are not monitored during processing to ensure the providers have the appropriate CLIA certification. 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. The layout for the CLIA report is included on the HMO Report Matrix available at:

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

The extract is posted to both 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

This report contains current ForwardHealth restrictions on procedure codes that limit the units allowed per date of service. It also lists diagnosis codes that are required or excluded when the ForwardHealth procedure code is billed, and other ForwardHealth procedure and revenue codes that must be billed for the service to be a covered service.

The report is created quarterly following the quarterly HCPCS updates and is available on the SFTP as well as the Managed Care portal.

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 along with the procedure code on restriction.
- Revx – ForwardHealth revenue codes required to be billed along with the procedure code on restrictions.

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 plan has in their system. These 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

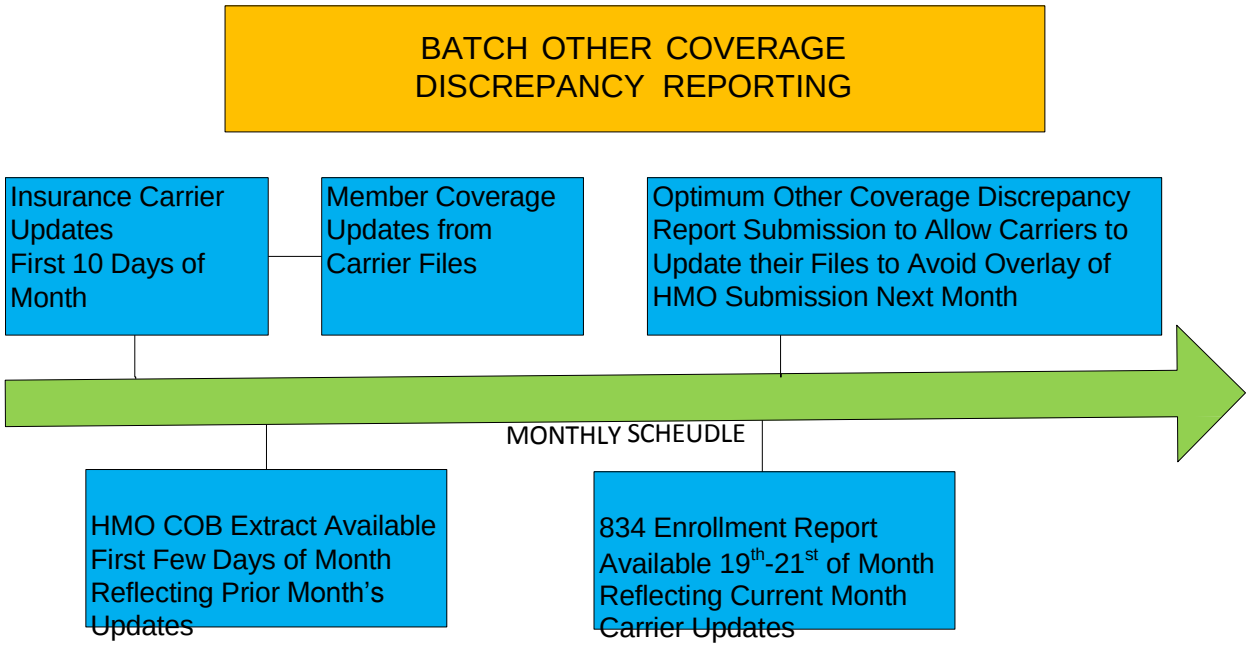
HMOs complete the Other Coverage Discrepancy Report on the Managed Care Portal. After logging in to the Managed Care Portal, HMOs select the Other Coverage Discrepancy Report option under Quick Links.

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.



16.4 Other Coverage Discrepancy Report Layout

The layout for the other discrepancy report can be found in the HMO Report Matrix on the portal: *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*

17 HMO PPACA Primary Care Report

17.1 Overview

HMOs are notified of encounters submitted that are eligible for PPACA incentive on the monthly HMO PPACA Primary Care Cash Report to HMOs. The report will include each eligible detail of each eligible encounter. Eligible details are defined as those that:

- Include a PPACA procedure where the PPACA incentive price is greater than the current price.
- Include a rendering provider that has the proper certification and at least one contract active on the date of service.
- Include a date of service on or after 1/1/2013.
- Include a member with a medical status code eligible for PPACA incentive.
- Result in a priced encounter.
- Result in an encounter with a Financial Indicator of 'Y.' See *Section 5.13*.

HMOs return the report attesting the amount of payment given to their providers.

17.2 Monthly PPACA Report and HMO Attestation via the SFTP

The HMO PPACA Primary Care Cash Report to HMOs is posted to the SFTP server on the second weekend of the month. The PPACA report contains two unpopulated fields when delivered. The 'Distributed to Prov by HMO (Y/N)' and 'AMT Distributed to Provider' fields are populated by the HMO and the entire report returned via the SFTP. HMOs use the same naming convention as the received report when returning the report, ensuring the submitted file is zipped.

17.3 Monthly PPACA Report Layout

The layout for the PPACA report is included on the HMO Report Matrix available at: *www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage*

17.4 PPACA and Encounter Response File

Encounter pricing incentives will not be included on the HMO Encounter Response File. See *Section 9*.

17.5 PPACA Timeline and Provider Attestation

ACA enhanced provider funding expires on 12/31/2014. Encounters with a date of service after 1/1/2015 will no longer receive the enhanced ACA funding. Providers can no longer attest for PPACA purposes.

Appendix A: Encounter Editing Overview

I. Overview

I.I Introduction

ForwardHealth requires HMOs to report encounter data to analyze and monitor medical utilization and ensure quality of care. This document highlights various policy areas HMOs need to be aware of as they prepare to submit encounters via 837 transactions to ForwardHealth. This document focuses on the editing and pricing of encounters. These policies do not refer to the guidelines required for the 837 transactions to pass compliance. HMOs refer to the implementation guides for the guidelines around building compliant 837 transactions.

I.II Audience

The target audiences for this document are HMOs, to aid in any clarification needed 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. A detailed explanation of submitting encounter chart reviews is included in the encounter user guide.

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 as well as in the monthly max fee extract. Birth to 3 example: *https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=83&s=6&c=141*
- 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/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=15&s=2&c=10*
- 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/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=64&s=2&c=10*
- 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. Mental Health example: *https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=84&s=2&c=10*
- 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 the User Guide 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. Vision specificity example: *https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=64&s=2&c=10&nt=Diagnosis+Codes*
- 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 in the monthly max fee extract. Podiatry POS example: *https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=52&s=2&c=10&nt=Place%20of%20Service%20Codes&adv=Y*
- If the Provider Type/Provider Specialty (PT/PS) is not within the policy guidelines for the services provided, the encounter denies. Encounters not meeting this criterion 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 also included on 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 one-time report will be produced illustrating the appropriate quantity limits for the HMOs to reference. DMS quantity limit example: *https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=16&s=3&c=11&nt=Supplies%20that%20Exceed%20Quantity%20Limits&adv=Y*

- Encounters for Outpatient Hospital Therapy Services 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 instead processed as they are 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/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=18&s=2&c=61*
- 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. This also holds true if an occurrence code is 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/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=40&s=4&c=13&nt=UB-04%20(CMS%201450)%20Claim%20Form%20Instructions%20for%20Nursing%20Home%20Services&adv=Y*
- 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 headerlevel. 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/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=1&s=1&c=1&nt=CLIA%20Certification%20or%20Waiver&adv=Y*

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 1001: Financial and Utilization Indicator Assigned

ANSI Code	WPC Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
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.
215	Based on subrogation of a third party settlement

ANSI Group 1002: Utilization Indicator Assigned

ANSI Code	WPC Description
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.
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.

ANSI Code	WPC Description
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.
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)
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.

ANSI Code	WPC Description
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.
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.

ANSI Code	WPC Description
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.
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 Payment Information REF), if present.
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.

ANSI Code	WPC Description
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
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.

ANSI Code	WPC Description
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.
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.

ANSI Code	WPC Description
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.
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 theprovider 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

ANSI Code	WPC Description
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)
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
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.

ANSI Code	WPC Description
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
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 toa 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 tothe 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.

ANSI Code	WPC Description
A6	Prior hospitalization or 30 day transfer requirement not met.
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

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

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

SECTION IV | REPORT INFORMATION

Name | Individual Completing This Report		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 additional 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*BELLIN MEMORIAL HOSPITAL*****XX*1437152345~
                        N3*23400 744 S WEBSTER~
                        N4*GREEN BAY*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*COMMERCIAL AND 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 FAMILY INSURANCE 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*FISERV HEALTH*****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.

```
                AMT*D*8.00~
                OI***Y***Y~
                NM1*IL*1*LAST*FIRST****MI*9010002215~
                N3*ADDRESS~
                N4*MADISON*WI*537041234~
                NM1*PR*2*HMO NAME*****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:US EXAM
                      BREAST(S)*586.00*UN*1.00~
                DTP*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~
                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~
```

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

Detail payment information for each payer

Example 2: 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*MEDICARE AND 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*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*HMO NAME*****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*P*18*******MB~ denotes Medicare B as the primary payer.

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

Detail payment information for each payer

Example 3: Medicare 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*ST CLARE 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*GREEN BAY*WI*543031234~
                        DMG*D8*19540628*F~
                        NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
                        CLM*MEDICARE NOT COV*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~
                        NM1*IL*1*LAST*FIRST****MI
                        *4110790140~
                        N3*ADDRESS~
                        N4*GREEN BAY*WI*543031234~
                        NM1*PR*2*MEDICARE PART B*****PI*001511~
                        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*GREEN BAY*WI*543031234~
                        NM1*PR*2*HMO NAME*****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~
        GE*1*49318~
      IEA*1*000049318~
```

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

HMO header adjudication

HMO detail adjudication

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

Example 4: 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*DE PERE*WI*541157980~
                        REF*EI*123456789~
                        HL*2*1*22*0~
                        SBR*S*18*******MC~
                        NM1*IL*1*LAST*FIRST****MI*3414027631~
                        N3*ADDRESS~
                        N4*GREEN BAY*WI*543030000~
                        DMG*D8*19540628*F~
                        NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
                        CLM*LINKED CHART REVIEW*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*GREEN BAY*WI*543030000~
                        NM1*PR*2*HMO NAME*****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*36*1001~
        GE*1*49318~
IEA*1*000049318~
```

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 5: Unlinked 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*DE PERE*WI*541157980~
                        REF*EI*123456789~
                        HL*2*1*22*0~
                        SBR*S*18*******MC~
                        NM1*IL*1*LAST*FIRST****MI*3414027631~
                        N3*ADDRESS~
                        N4*GREEN BAY*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~
                        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*GREEN BAY*WI*543030000~
                        NM1*PR*2*HMO NAME*****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.

Example 6: Adjustment-Change

```
ISA*00*          *00*          *ZZ*100000000      *ZZ*WISC_DHFS
*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*PC MEDIA*EM*NAME@HMO.COM~
                    NM1*40*2*WISCONSIN     MEDICAID*****46*WISC_TXIX~
                    HL*1**20*1~
                    PRV*BI*PXC*251E00000X~
                    NM1*85*2*MERITER HOMECARE AGENCY*****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~
                    NM1*PR*2*HMO NAME*****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~
```

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

Example 7: Adjustment-Void

```
ISA*00*          *00*          *ZZ*100000000      *ZZ*WISC_DHFS
*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*MERITER HOMECARE AGENCY*****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*VOID*200.00***33:A:8**A*Y*Y~
                        DTP*434*RD8*20121218-20121218~
                        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~
                        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~
```

A frequency value of 8 denotes this as a void. The REF*F8 segment denotes the ICN to be voided.

Example 8: Atypical Provider

*ISA*00* *00* *ZZ*100000330 *ZZ*WISC_DHFS *120831*1252*^*00501*00*
*0000070*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

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.