**2016 MCO Encounter Pricing Toolkit**

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# Background

## Process Overview

Starting on January 1, 2013 MCO managed care transitioned to submitting encounter data using HIPAA compliant 837 X12 transactions. The Medicaid Fee-for-Service (FFS) program had already been using the 837 format for exchanging transactions with Medicaid certified providers. Managed care has adopted FFS policy with exceptions that are outlined in the MCO contract. FFS policy can be found on [ForwardHealth](https://www.forwardhealth.wi.gov/WIPortal/Default.aspx); however the [MCO contract](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.spage) takes precedence over anything found on [ForwardHealth](https://www.forwardhealth.wi.gov/WIPortal/Default.aspx) where there are differences. This toolkit provides an overview of resources MCOs can use to successfully submit encounters that get priced for rate-setting purposes. It also provides a summary of how to troubleshoot common reasons for denials that have occurred since the transition to the 837 transactions.

Each year the rate setting process begins with an initial extract of data that Hewlett-Packard Enterprise (HPE) extracts for the Department’s actuary to analyze for rate-setting purposes. HPE is the Department’s claims and encounter processing vendor. MCOs have one year from the date of service to submit an encounter that gets priced. The Department requires MCOs to submit encounters at minimum, on a monthly basis with the expectation that the data is complete and accurate in advance of the initial extract. The cut-off for encounter submissions to be included in the final encounter extract is June 1. The Department’s actuary uses the data from the final extract to produce the final utilization memos for each MCO to set rates for the following calendar year. Please see below for a calendar of events:

**February 1**

**April**

**June 1 1**

**July**

**October**

**November**

Initial Encounter Data Extract Cut-off

Initial Utilization/Encounter data memos and data extracts sent to HMOs

Final Encounter Data Extract Cut-off

Final Utilization/Encounter data memos and data extracts sent to HMOs

Draft Rates are presented to HMOs

Final Rates are presented to HMOs

Regular events include monthly technical calls and MCO contract administrator meetings.

## Purpose

The purpose of this tool kit is to:

* Provide an overview of the publications and tools MCOs need to get 5010 837 encounters priced for rate setting purposes.
* Assist technical and policy staff in minimizing denied encounters due to Explanation of Benefit (EOB) errors or edits.
* Assist technical and provider relations staff to use available resources to resolve the most important EOBs/edits causing high dollar and/or high quantity errors.

## Getting Started

The first step is to review the materials in the Managed Care section of [ForwardHealth Portal](https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx). The main document to start with is on this page is the Encounter User Guide, which is key to understanding Wisconsin specific requirements for MCOs to submit encounters. The guide includes definitions, contact information, links to other resources, process flowcharts, policy guidance, and specific technical information MCOs need to submit encounters.

In addition to the [Encounter User Guide](https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx), MCO staff should become familiar with the HIPAA Version 5010 Companion Guides also available on the [ForwardHealth Portal](https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx): <https://www.forwardhealth.wi.gov/WIPortal/Default.aspx?srcUrl=CompanionDocuments.htm&tabid=41>:

* 837D (Dental claims)
* 837P (Professional claims)
* 837I (Institutional claims)
* 999 (Submission acknowledgement)
* TA1 (Submission Interchange level error)

These companion guides are intended for information technology and/or systems staff that will be coding billing systems or software for compliance with federal HIPAA regulations. The guides are designed to provide MCOs and other trading partners with ForwardHealth-specific information required to successfully exchange transactions electronically with ForwardHealth.

The Companion Guides are not to be confused with the HIPAA implementation Guides, which define the national data standards, electronic format and values for each data element within the electronic transaction. Understanding the national standards as outlined in the HIPAA ASC X12 Implementation Guides is a prerequisite to understanding the ForwardHealth Companion Guides since the Wisconsin specific guides are meant to supplement the federal guides without contradicting them.

Another key resource to understand the encounter submission process is the [MCO Report Matrix](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm.spage). This grid provides MCOs with a comprehensive listing of all relevant reports and extracts, links to detailed user guides, information on timing cycles and instructions on how to access files and reports. MCO staff should also become familiar with the encounter processing guide that the Department’s contracted actuary creates to describe how encounters are processed for rate setting purposes.

## Policy

The primary source for policy information is the Online Handbooks on the [ForwardHealth Portal](https://www.forwardhealth.wi.gov/WIPortal/Default.aspx). The Medicaid Managed Care program follows FFS policy except where otherwise specified. The Encounter User Guide includes a summary of managed care policies and is a helpful source to identify where managed care policy differs from FFS policy.

MCOs can also track changes in policy through the [monthly updates](https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Subscriptions/tabid/155/Default.aspx). To subscribe to BadgerCare Plus and Medicaid provider updates, first enter your email address as a new subscriber and then select from available subscriptions.

# Important Guides and Tools to Submit and Troubleshoot Encounters

There are several helpful tools in the [ForwardHealth Managed Care](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx) page that will assist you in submitting encounters that get priced.

Note that Wisconsin-specific guides often contain excerpts from federal documentation. It is always a good practice to access the direct source of this type of information since the Wisconsin-specific guides will not be updated every time there is a change to federal rules, codes or documents.

The following is not an exhaustive listing of resources available to MCOs. For a more complete listing of reports, please review the [MCO Report Matrix](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm.spage).

## 2.1 [Publications and Guide](https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx)s

1. The **Encounter User Guide** is the main guide that provides an overview and process flow for MCOs to submit encounters. An encounter is a service or an item provided through the MCO such as an office visit, institutional stay, or durable medical equipment. This guide is the main resource that outlines requirements that are specific to the Wisconsin Medicaid Managed Care block of business and includes links to the relevant 5010 837 companion guides. Managed Care moved to the 837 starting January 1, 2013 to be more like FFS. MCOs are provided with file submission instructions and the file processing schedule. All technical components of the submission process and the file requirements are detailed in the user guide and appropriate references are made to the companion guides. The Encounter User Guide provides a fair amount of detail on policy that affects covered services and provider requirements.
2. **Managed Care Organization Pricing Administration Guide:** This guide was designed to help MCOs follow how submitted encounters get assigned a Medicaid priced amount. The guide includes a file layout for the max fee rate extract. In general MCOs are not required to pay providers the Medicaid priced amount, however many MCOs choose to pay providers this amount. MCOs should study the CY 2016-2017 Contract for BadgerCare Plus and/or Medicaid SSI to understand which payment types to providers are required to be based on Medicaid pricing. For example, MCOs are required to pay providers at least the FFS rate for serviced rendered by an FQHC. Another example is that out of state emergency stays need to be paid based on a percentage of the allowed amount.
3. The **MCO Monitoring Reports** are published as a PDF and include a comprehensive set of MCO and program specific reports. They are updated on the 15th of each month and placed on the SFTP. The reports include statistics on encounter submissions, MCO Medicaid paid amounts, and member months so that MCOs can readily track Per Member Per Month (PMPM) over time and assess the completeness of their data submissions.

For pricing purposes the percentage of denied versus paid claims is a useful indicator of an MCO’s progress in submitting valid encounters over time. This ratio is not a good measure of the proportion of encounters with a financial indicator of “Y” that get priced since multiple denials resulting from the MCO submitting encounters for the same service will understate the true paid percentage. Thus it is important for MCOs to track their own submissions and account for services that are submitted multiple times. Statistics on the most common EOBs are also provided in this PDF.

1. The Online Handbooks (or access though [ForwardHealth Managed Care](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx)) are the primary source for policy information.
2. The biannual [**MCO Contract**](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.spage) for the BadgerCare Plus and Medicaid SSI programs can be found on ForwardHealth. Current and past contracts as well as contract amendments are also available.
3. **X12 Implementation Guides:** These implementation guides are the national standard and can be found at: <http://www.x12.org/>
4. **X12 Companion Guides** (access though [ForwardHealth Managed Care](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx)): The companion guides provide MCOs with instructions on how to successfully transmit the standard transactions as they specifically relate to Wisconsin ForwardHealth requirements. They are meant to supplement but not contradict the standards outlined in the X12 Implementation Guides.
5. [**EOB Cheat Sheet:**](https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx)  (access though [ForwardHealth Managed Care](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx))

EOB Cheat Sheet is found in the managed care section of ForwardHealth and is one of the main tools to be used to troubleshoot EOBs that are causing denials. Generally speaking, only EOBs that are causing denials or are harder to interpret are included in the cheat sheet. In order to navigate this document, either use the search feature to look up the EOB of interest or click to select from the listing of EOBs that are in numeric order at the beginning of the document. The document is arranged to show you which EOBs tag along with other EOBs and provides you with detailed steps on how to resolve denials for single or groups of related EOBs. Both EOBs that print at the header level and the detail level are covered in this document. Since the Department provided MCOs access to edit information in 2015, the EOB Cheat Sheet is also searchable by edits. Here is a listing of all [EOB codes and descriptions](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/eob_messages.htm.spage).

1. Congress implemented the [**Clinical Laboratory Improvement Amendments (CLIA)**](https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html) to improve the quality and safety of laboratory services. The CLIA Overview Guide (access though [ForwardHealth Managed Care](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx)) was created to assist MCOs in complying with the federal requirements as they relate to submitting encounters through ForwardHealth. The overview document provides specific details on provider requirements and allowable values for submitting encounters. Note that as of December 2014 the Department no longer edits on CLIA certification (EOB 0794: Procedure not allowed for the CLIA Certification Type). It is the MCOs responsibility to follow the federal requirements. The Department will retain EOB and error information for auditing purposes.
2. **Managed Care Rate-Setting Encounter Data Summary Memo:** Each year, the Department actuary provides each MCO their own data that is used for rate-setting purposes. The files include data from the original extract as well as actuary created fields. An initial and final extract are provided each year. The data summary memo provides MCOs with general processing methods, data exclusions, adjustments, carve outs and more. The memo includes a detailed description of all actuary created fields. This memo is transmitted from the Department to the MCOs as it is updated and is not available online.

## 2.2 Tools and Resources

1. [**MCO report matrix**](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage)**:**

This page on ForwardHealth provides MCOs with a comprehensive listing of reports, including a brief description, report schedule and file layouts. Note that the matrix includes reports that are relevant for managed care and for long-term care. There is a field on the matrix that denotes whether the report is available managed care, long-term care or both.

1. **834 Enrollment Reports:** This monthly report provides a detailed listing of members enrolled or dis-enrolled from the MCO.
2. **Capitation Payment Listing** report: This report provides MCOs with a detailed listing of each member for which they receive a capitation payment. This report includes adjustments as well and is produced on a monthly basis. It is the equivalent of the HIPAA 820 report.
3. **Response file:** This file includes encounter status and pricing information and is delivered to the SFTP each week.
4. [**interChange screens**](https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx)**:** (Login to MCO portal is on the right hand side of the page). MCOs should log in to the secure Managed Care Organization Portal to submit or retrieve information about their account or member data which may be sensitive and/or fall under the requirements of the Health Insurance Portability and Accountability Act (HIPAA).
5. **Certified** [**Provider Listing**](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage)**:** This is a weekly listing of all certified Medicaid providers by provider type and specialty showing certification begin and end dates. See the [MCO Report Matrix](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage) for more information. It is imperative that MCOs compare their own provider files to the ones on the portal as provider-related errors are one of the greatest causes of denied encounters. The certified provider listing is updated every Thursday and is available on the SFTP server.
6. **Max Fee Schedules:** These schedules provide a listing of all allowable fees for procedures, services, and equipment such as DME. Other than for a few exceptions such as payments for FQHC providers, MCOs are not bound to follow the fee schedules when making payments to providers. More information on the Max Fee Schedules is available on the [MCO Report Matrix](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage). Note that changes to the Max Fee schedules are expected to be complete in late 2016. The Max Fee Schedule will be combined with the Units Per Day & Diagnosis Restriction Report.
7. **Units Per Day& Diagnosis Restriction Report:**  This extract includes units per day and dx restrictions procedures codes.
8. **CLIA Extract:** This extract lists the CLIA certification information for all Medicaid certified providers.
9. **COB Extract:** This extract includes other insurance information for eligible members. Note that COB edits were turned off for encounter in 2015 and that complying with COB rules is the responsibility of the MCO.
10. **Other Coverage Discrepancy Report:** The [MCO Matrix](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage) includes the file layout that is required for MCOs to report discrepancies in COB.
11. [**Provider trainings**](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/training/TrainingHome.htm.spage)**:** This training page contains training events available to MCOs and other providers and trading partners. Several trainings are provided through live webcasts or virtual room. Archived trainings are also available on the site. Trainings are conducted on a variety of topics such as portal fundamentals, the Online Handbook, policy updates, claims submissions, member enrollment, and more.
12. [**EAPG Trainings**](https://www.forwardhealth.wi.gov/wiportal/tab/42/icscontent/html/EAPG/EAPGhome.htm.spage)**:** As of January 1, 2015 pricing for outpatient encounters follows the Enhanced Ambulatory Patient Groups (EAPG) methodology. Training materials include the slides from presentations that were presented during numerous 2014 MCO technical calls in preparation for the 2015 implementation date.
13. **VEDS MCO support:** [vedsMCOsupport@wisconsin.gov](mailto:vedshmosupport@wisconsin.gov)

MCOs that have questions about the encounters submission process should contact VEDS MCO support via the email address above. Policy questions should also be submitted through the VEDS MCO support email address. They are tracked and routed to the appropriate state staff for review and disposition.

1. **BFM support email:** [DHSDHCAABFM@dhs.wisconsin.gov](mailto:DHSDHCAABFM@dhs.wisconsin.gov)

The Department will sometimes ask MCOs for feedback or to submit reports directly to the DHS BFM support email address.

1. **Contract Administrator Meetings:** These meetings are generally held at 9:30 am on the third Thursday of each month. MCOs can attend in person at 1 West Wilson or by teleconference.
2. **Monthly Encounter Technical Calls**: These calls are generally held from 1pm to 3pm on the first Thursday of each month. The call is sometimes moved to avoid holiday weeks. The monthly encounter technical calls are the main way MCOs can stay up to date on policy and technical changes that affect the encounter submission process and thus are very important to attend regularly. Each month, the Department provides an updated timeline of projects and implementations that are coming up.

# Featured Topics

## Making Adjustments

Only active paid encounters can be adjusted. Inactive or denied encounters cannot be adjusted or voided.  Most adjustment errors can be avoided by submitting resubmitting services that previously denied as an original claim. If adjusting a previously paid claim, the ICN of the active paid claim must be submitted. Note that the provider and the claim type must be the same as the claim being adjusted or it will be denied. Thus if the new submission has a different claim type than the original then it is better to void the original and submit an original claim.

Sequence is another important factor to consider when submitting an adjustment. Only the most recent encounter can be adjusted.  If multiple adjustments are made it is best to wait to see the processing outcome of the first adjustment before making a second adjustment. Related EOBs include:

* 1673: Unable To Process Your Adjustment Request. Claim Has Already Been Adjusted.
  + This error is prevented when you include the most recent ICN when adjusting the claim. Adjusting an ICN that already has been adjusted will cause a denial. See the following example:
    - Original ICN: 20123
    - First adjustment: 50123
    - Second adjustment: 65123
    - In this example, the provider should include the most recent ICN to adjust, 65123. ICNs 20123 or 50123 have already been adjusted and are inactive.
* 1677: Unable To Process Your Adjustment Request. The Claim Type Of The Adjustment Does Not Match The Claim Type Of The Original Claim.
  + When an encounter is being adjusted, the claim type of the original and adjustment must match. The best strategy may be to void the original encounter and submit another original encounter using the correct claim type.
  + There are three different 837 transactions used to submit nine types of encounters: Institutional, Professional and Dental. Examples of claim types include: “I” for “Inpatient” and “O” for “Outpatient”. Please refer to the “ForwardHealth Portal MCO Encounter User Guide” for a full listing of values.
* 1669: Unable To Process Your Adjustment Request. Original ICN Not Present.
* 1670: Unable To Process Your Adjustment Request. Member Not Found.
* 1672: Unable To Process Your Adjustment Request. Original Claim ICN Not Found.

## Submitting Billing and Rendering Provider Information

As of January 1, 2013, billing and rendering provider NPI became required fields. Due to the high volume of denials associated with provider information, the Department included associated errors in the Edits project which was designed to reprocess denied encounters and assign a price. Since the assigned price may be lower that the true Medicaid priced amount, MCOs still have an incentive to work through provider related errors to ensure that the encounter is assigned the Medicaid priced amount.

Numerous denials (and reprocessed encounters) could be avoided by only submitting Medicaid certified billing and rendering provider NPIs. Through the Edits project, the encounter ***may*** get assigned a price due to the enhanced propagation or hierarchy logic. For example, this may involve using the rendering provider NPI in place of the billing provider NPI or assigning a rendering or billing provider NPI where needed based on finding the best match with the provider information available on the encounter.

Research reveals that a large number of the denials due to incorrect provider information are associated with a small number of providers, so MCOs can correct these issues by working with these providers. Generally these providers have multiple taxonomies and multiple locations and most denials (or reprocessed encounters) are caused by failing to provide a unique, valid combination of provider NPI, provider taxonomy, and zip + four for the specific service rendered. The Department has shared specific information with the MCOs on these providers during the MCO technical calls and through the individual EOB profiles that were provided to each MCO. Here are specific steps to avoid or remedy provider related denials:

1. Verify that the biller is Medicaid certified. Sometimes a billing provider will submit using an NPI that is not Medicaid certified. In these cases the provider often has another NPI that is certified that could be submitted to the MCO. In other cases the provider will need to work with Medicaid Provider Relations to obtain certification so that future encounters don’t get denied or reprocessed.

EOB 0424: “Billing Provider ID is Not on File” or other billing provider related EOBs, check the [national registry](https://npiregistry.cms.hhs.gov/) by NPI to see if the provider is Medicaid certified under a different NPI. If you cannot locate the provider by NPI, then you may be able to find them by searching by name. Then take the following steps to identify allowable provider information:

* Enter the NPI submitted on the claim
* Find the 8 byte associated Medicaid provider ID
* If you find a Medicaid provider ID, then look up the taxonomy code and zip + 4 on the provider extract or the provider query on the ForwardHealth Portal.
* Have the provider resubmit using Medicaid certified NPI.

EOB: 1204: “Billing Provider is not certified for the Date(s) of Service” is also common so it is important to not only check whether the provider is currently active but if they were certified at the time the service was rendered.

1. If a billing provider NPI is Medicaid certified, then check the billing status of the provider:

* Biller
* Performer (rendering provider)
* Biller and performer

EOB 0477: “Billing Provider indicated is not certified as a billing provider” can cause institutional claim types to deny.  Sometimes a provider is only certified as a rendering provider and not as a biller. In these cases if the provider submits as the biller the encounter will be denied. Note that for this EOB 0477 has been set to post and pay for professional and dental claims.

1. Check if billing provider NPI/taxonomy/zip + 4 finds a unique row on the weekly provider extract or on the ForwardHealth Portal. Here is a common EOB code 1505: The Billing Provider's taxonomy code in the header is invalid.
2. Check if billing provider contracts effective/end dates cover the dates of service of the encounter submitted.
3. Repeat steps #1 through #4 for the rendering/performing provider. Note the following EOBs that denote a denial due to rendering provider issues:

* EOB 1504: Performing Provider number is not found.
* EOB 1109: Rendering Provider is not a certified provider for ForwardHealth.

It is not always necessary to submit performing/rendering provider information if the rendering provider is also the billing provider. Please see section 5.8 of the Encounter User Guide for a description of provider matching and usage enhancements to assist in identifying a unique biller and/or rendering provider on MCO encounters.

## 3.3 Allowable Type of Bill Codes for Inpatient, Outpatient and other Claim Types

One cause of denials for inpatient and outpatient encounters is an invalid Type of Bill (TOB). Please see the [claim form instructions for **inpatient hospital**](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=32&s=4&c=13&nt=UB-04%20(CMS%201450)%20Claim%20Form%20Instructions%20for%20Inpatient%20Hospital%20Services&adv=Y) services for allowable type of bill information. Search for the CMS 1450 Claim Form Instruction by taking the following steps:

1. Go to the [ForwardHealth homepage](https://www.forwardhealth.wi.gov/WIPortal/Default.aspx).
2. Click on [Online Handbooks](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx) on the left hand side.
3. In the selection options select “Provider” for the first drop down list; select “BadgerCare Plus and Medicaid” for the second drop down list; and select “Hospital Inpatient” for the third drop down list.
4. Select “Advanced Search handbooks” link which is located directly below the selection options.
5. Select “Search within the options selected above” and then type “CMS 1450 inpatient” in the search box and then click on search.
6. Click on the link that appears for the Inpatient Claim Form Instructions.

Here is an excerpt from the claim form instructions that displays the allowable values for the type of bill on an inpatient claim:

**Form Locator 4 — Type of Bill**Exclude the leading zero and enter the three-digit type of bill code. The type of bill codes for inpatient hospital services includes the following:

* 111 = Hospital, inpatient, admit through discharge claim.
* 851 = Special facility, critical access hospital, admit through discharge claim.

You can complete a similar search to find the [claim form instructions for **outpatient hospital** services](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=44&s=4&c=13&nt=UB-04%20(CMS%201450)%20Claim%20Form%20Completion%20Instructions%20for%20Outpatient%20Mental%20Health%20Services&adv=Y) to find the allowable type of bill information displayed below:

**Form Locator 4 — Type of Bill**  
Exclude the leading zero and enter the three-digit type of bill code. The types of bill codes for outpatient hospital services include the following:

* 131 = Hospital, outpatient, admit through discharge claim.
* 851 = Special facility, critical access hospital, admit through discharge claim.

The claim form instructions for other claim types such as for End Stage Renal Disease (ESDR) or Outpatient Mental Health can be located using a similar search as described above.

Associated EOBs:

* 1290: Type of Bill is invalid for the claim type.
* 1289: Type of Bill indicates services not reimbursable or frequency indicated is not valid for the claim type.

## 3.4 Dates of Service

It is important to correctly submit dates of service and know the policy on what is allowable.

* EOB 0051: The header From Date of Service (FDOS) and To Dates of Service (TDOS) cannot be the same.

There are only a limited number of cases in which Medicaid pays for a single day hospital visit, otherwise a single day visit for inpatient claims will be denied. Exceptions include maternity deliveries, the death of a patient, transfer to another hospital, or for x-over claims.

## 3.5 Member Eligibility

MCOs receive two HIPAA 834 eligibility files a month on the portal:

* The Initial Roster Report
* The Final Roster Report

Each file contains new enrollments as well as any retroactive dis-enrollments. The HIPAA 834 user guide and file layout for the roster reports are available on the [report matrix](https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage). In order to avoid denials associated with member eligibility, MCOs should regularly process the Final Roster Report. Furthermore, MCOs should keep current with the demographic information on the files since mismatched names are also a source of numerous denials. Associated EOBs include:

* 1298: Member ID is not on file.
* 0029: Last name does not match Member ID.
* 0614: First name does not match Member ID.

Each month MCOs receive both the Capitation Payment Listing Report and the HIPAA 820 transaction or just the Capitation Payment Listing Report. These reports include capitation payment and adjustment information for each member by month.

# Index of EOB Profiles

This section provides profiles of EOBs that have caused the greatest number of errors according to the Department’s research. The **EOB cheat sheet** (access though [ForwardHealth Managed Care](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx)) focuses on the technical causes and solutions while these profiles provide more in depth information about working with providers to fix and prevent denials. Both resources focus on EOBs that truly cause denials.

## Common Information-only EOBs

There are numerous EOBs that are informational-only because they describe some aspect of how the encounter was processed. For example, there are informational EOBs such as “Max Fee Pricing Applied” and “DRG Pricing Applied” that describe how the encounter was priced. It is important to note that there are some EOBs that seems like they would cause a denial but don’t because one of the following reasons:

* They are information only. They let you know that the encounter has been processed in a certain way.
* The underlying edits have been turned off for MCO, so they just post and pay.
* They automatically tag along with other EOBs which are the real trigger for denials.

An example of an information-only EOB is:

* 1564: Payment may be reduced due to submitted "Present on Admission" (POA) indicator.

## Common Header and Detail Level EOBs that Cause Denials

### 4.21 EOB 1347: Billing provider number is not found or not valid for dates of service. *(Edit 1945-- MULTI PROV LOCS FOR BILLING PROV SPEC – HDR)*

* Header level institutional encounters
* The majority of denials are due to large hospital systems, with multiple service locations, submitting incorrect zip code information and/or taxonomies. A small number of denials are caused by a provider submitting a non-institutional taxonomy.
* These errors can be solved by working with the provider to follow FFS billing procedures.

### 4.22 EOB 1394: From Date of Service is Before Admission Date *(Edit 519-- ADMIT DATE GREATER THAN HEADER FDOS)*

* Inpatient/Inpatient X-over claims and LTC/LTC X-over claims on the header level
* These errors are caused by the FDOS being prior to the admission date. These errors are easily fixed by aligning the dates.
* The MCO should talk to the hospitals and have them resubmit the claims with the correct admission date/from date of service. DHS has provided MCOs with an Excel file with ICNs/Hospital NPIs/Hospital Names.

### 4.23 EOB 1103: The number of covered days is required. *(Edit 282-- COVERED DAYS MISSING)*

* Header level Inpatient/Inpatient X over
* These errors are caused by Hospitals not submitting covered and non-covered days on the 837I, in value codes fields 80 and 81, respectively. Covered/Non-covered days are required fields on the 837I.
* The MCO should talk to the providers for these EOB failures and have them resubmit their claims with value codes 80 and 81 completed, as they do in FFS.

### 4.24 EOB 0477: Billing provider indicated is not certified as a billing provider. *(Edit 1961-- MORE THAN ONE PROVIDER BILLING INDICATOR and Edit 1964-- BILLING PROVIDER IS NOT DESIGNATED AS A "BILLER")*

* Header level – Institutional Claim Types – Inpatient, Outpatient, Home Health, Long Term Care. These edits and EOB no longer set for professional or dental claim types.

### 4.25 EOB 0424: Billing provider ID is not on file. *(Edit 1000-- BILLING PROVIDER I.D. NOT ON FILE and Edit 1004-- BILLING PROVIDER I.D. NOT ON FILE – DENY)*

* Header — All claim types.
* These errors can be caused by providers submitting an NPI that has been cancelled by HPE.
* When the NPI system was implemented providers had a grace period to register their NPI and associate it with the previous 8 byte Medicaid provider number. If during recertification the providers did not make the association, the old Medicaid provider number and the new NPI were cancelled.
* The MCO should talk to the providers for these EOB failures and have them submit NPIs/taxonomy codes as they do in FFS.

### 4.26 EOB 0116: Procedure Code or Drug Code not a benefit on date of service. *(Edit 3363-- NO PROCEDURE REIMBURSEMENT RULE FOR CLAIM REGION and Edit 4801-- NO BILLING RULE FOR PROCEDURE and Edit 4804-- NO BILLING RULE FOR REVENUE CODE)*

* Detail level
* Often posts with the follow detail level EOBs:
  + 0182 – Billing provider type and/or specialty is not allowable for service billed.
  + 0859 – Modifiers submitted are invalid for the dates of service or are missing.
  + 1280 – Rendering provider type and/or specialty is not allowed for service billed.
  + 1521 – Procedure code not allowed on claim form/transaction submitted
  + 1554 – The claim type and diagnosis code submitted are not payable
* This EOB is covered comprehensively in the EOB Cheat Sheet.
* Here is a brief check list to diagnose the most likely causes of denial for this EOB:
  + Is the procedure code a non-covered or a limited covered service?
  + Is the claim type appropriate for the service being claimed?
  + Is there a provider related problem? Can the billing/performing providers bill for/perform the services being rendered?
  + Are there any policy restrictions or max fee limitations associated with the services being claimed?

## Managed Care versus FFS

A common theme that arises as MCOs work through these errors is the question about why particular providers are submitting information differently to MCOs than the very same provider submits directly to ForwardHealth for FFS claims. The reason is that on the FFS side, providers have different claims submission options such as submitting electronically through the portal or using the Provider Electronic Solutions (PES) software. PES is a HIPAA compliant software providers use for submitting claims to ForwardHealth. These tools include front-end edits that do not allow the claim to be submitted without complete and accurate information.

# Key Contractual Requirements and Submission Guides

This section provides an overview of key contractual requirements pertaining to the rate-setting and other MCO payment processes. Please refer to the CY 2016-2017 Contract for BadgerCare Plus and/or Medicaid SSI for more information. The current contract, contract amendments and previous contracts can be found on the [ForwardHealth portal](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Providers/providerContracts.htm.spage).

## Encounter Submissions

The standards for submitting encounter data to the Department is covered in Article XI of the contract. MCOs are required to submit timely, accurate and complete encounter data. MCOs are expected to submit MCO paid amounts and indicate sub-capitated amounts using reason code 24.

When monitoring contractual requirements the Department mainly focuses on the dates of service that will be used for the following year’s rates. MCOs must complete a quarterly progress report due on April 30th, July 30th, October 30th and January 30th. The progress report template is available on the [ForwardHealth portal](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Providers/providerContracts.htm.spage) and requires the MCO’s Chief Operating Officer or designated authority to attest to the metrics submitted to the Department. The progress report may need to be submitted by an MCO more often than quarterly if the MCO is on a corrective action plan.

Although MCOs are expected to submit all encounters, including for services that were not paid for the MCO or that would not be eligible for Medicaid pricing, only encounters that are MCO paid should be included for calculating the metrics in the quarterly progress report. The purpose of the quarterly attestation process is to ensure that the MCO’s data can be used for rate setting purposes. The ultimate measure of whether an MCO has met the standards outlined in the contract is the analysis conducted by the Department’s contracted actuaries. The actuaries work with the Department to compare the encounter data to the financial data submitted to the Department.

## FQHC Payments to Providers

Per Article XIV(D)6 of the contract, MCOs are required to pay providers at least the Medicaid FFS rate or the equivalent amount in aggregate by provider. MCOs must retain records demonstrating that they meet this requirement and make the records available within 30 days of the Department’s request for information. The Department periodically compares MCO paid amounts to the Medicaid priced amounts to ensure that this requirement is being met.

## Maternity KICK Payments

Maternity costs are carved out of the capitated rate and paid in a separate process. A maternity KICK payment includes pre and post-delivery costs encompassing claims for certain diagnosis codes eight months prior to delivery and two months following the delivery. MCOs are required to report deliveries to the Department in a specified format as part of a monthly cash transaction payment procedure. The requirements for reporting eligible births are outlined in the Maternity KICK Payment guide that is available on the [ForwardHealth](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/reportsData.htm.spage) portal.

## MCO Reimbursements

There are different types of reimbursement that the MCOs receive for covering the BadgerCare Plus and SSI populations. The main source of reimbursement is a capitated PMPM premium that covers medical costs as well as dental and chiropractic costs if covered. There are also payments that are made to the MCOs outside of the capitated rate, either because the payments are a pass through to the providers such as with OB Medical Home payments or because the medical costs are carved out and paid in a separate process such as for ventilator report and maternity KICK payments. Article XV of the contract covers payments to MCOs in detail. There is also an MCO Reimbursement Grid on the [Forward Health](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx) portal that provides a listing of each payment type and the source of more information.

## Hospital Pricing and Payments

Starting in January 2015, the Department moved to using EAPG pricing for managed care MCO outpatient claims. Starting with 2017 rate development, the Department moved to using APR-DRG for pricing inpatient claims. MCOs **are not** required to pay providers based on the Department’s pricing and repricing of outpatient and inpatient encounters. Emergency and out of state claims are priced as a percentage of the billed amount and in these cases the MCO is required to pay the Medicaid priced amount.

Starting with CY 2016 rates, ACCESS payments are passed through as part of the capitated rate.

## Financial Reporting

Starting with CY 2016 rates, the Department included MCO reported financial data in the rate-setting process. MCOs are required to submit a template with their financial information in July each year. The most recent version of the template is available on the [Forward Health](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx) portal.