ForwardHealth Portal

HMO EOB Cheat Sheet

Date Last Updated: December 4, 2015

Document Navigation

Option 1: Search for the EOB Code using the Microsoft Word search features.

Option 2: Search for the Edit Code using the Microsoft Word search features.

Option 3: Click the EOB below for the most relevant link in this document.

EOB	Description
0025	Billing or rendering provider enrollment is cancelled from date of service.
0029	Last name does not match member ID.
0051	The header from and to dates of service cannot be the same.
0080	Diagnosis code submitted does not indicate medical necessity or is not appropriate for service billed.
0100	Denied as a duplicate claim.
0116	Procedure code or drug code not a benefit on date of service.
0175	Rendering provider indicated is not certified as a rendering provider.
0182	Billing provider type and/or specialty is not allowable for the service billed.
0184	Procedure code is restricted by member age.
0221	The detail billed amount is required.
0229	The type of bill is invalid.
0273	Resubmit charges for ForwardHealth covered service(s) denied by Medicare on a ForwardHealth claim.
0278	Member is covered by commercial health insurance on the date(s) of service.
0363	This obstetrical service was previously paid for this date of service for this member.
0378	Tooth number or letter is not valid with the procedure code for date of service.
0424	Billing provider ID is not on file.
0477	Billing provider indicated is not certified as a billing provider.
0558	The service requested is not allowable for the diagnosis indicated.
0614	First name does not match member ID.
0656	An ICD-9-CM diagnosis code of greater specificity must be used for the first diagnosis code.
0657	An ICD-9-CM diagnosis code of greater specificity must be used for the second diagnosis code.
0664	An ICD-9-CM diagnosis code of greater specificity must be used for the third diagnosis code.
0668	An ICD-9-CM diagnosis code of greater specificity must be used for the

	fourth diagnosis code.
0669	An ICD-9-CM diagnosis code of greater specificity must be used for the fifth diagnosis code.
0697	The number of tooth surfaces indicated is insufficient for the procedure billed.
0749	Routine foot care diagnoses must be billed with valid routine foot care procedure codes.
0770	The revenue code is not allowed for the type of bill indicated on the claim.
0859	Modifiers submitted are invalid for the date of service or are missing.
0860	An ICD-9-CM diagnosis code of greater specificity must be used for the sixth diagnosis code.
0861	An ICD-9-CM diagnosis code of greater specificity must be used for the seventh diagnosis code.
0862	An ICD-9-CM diagnosis code of greater specificity must be used for the eighth diagnosis code.
0863	An ICD-9-CM diagnosis code of greater specificity must be used for the ninth diagnosis code.
0901	The from date of service and to date of service must be in the same calendar month and year.
0941	This unbundled procedure code and billed charge were rebundled to another code, which was either billed by the provider on this claim or added by ClaimCheck.
0962	Member does not have commercial insurance for the date(s) of service.
1103	The number of covered days is required.
1116	The revenue code requires an appropriate corresponding procedure code.
1128	A tooth number or letter is required.
1145	Area of the oral cavity is required for procedure code.
1198	A National Drug Code (NDC) is required for this HCPCS Code.
1204	Billing provider is not certified for the date(s) of service.
1238	The rendering provider's taxonomy code in the header is invalid.
1256	Member is enrolled in Medicare Part A on the date(s) of service.
1257	Member is enrolled in Medicare Part B on the date(s) of service.
1260	The sum of the accommodations days is not equal to the sum of covered plus non-covered days.
1270	The header total billed amount is required and must be greater than zero.
1271	The total billed amount is missing or incorrect.

1275	Quantity billed is restricted for this procedure code.
1280	Rendering provider type and/or specialty is not allowable for the service billed.
1290	Type of bill is invalid for the claim type.
1347	Billing provider number is not found or not valid for dates of service.
1374	An ICD-9-CM diagnosis code of greater specificity must be used for the diagnosis code in position 10 through 24.
1491	The attending provider's taxonomy code in the header is invalid.
1504	Performing provider number is not found.
1505	The billing provider's taxonomy code in the header is invalid.
1521	Procedure code is not allowed on the claim form/transaction submitted.
1531	Indicator for present on admission (POA) is not a valid value.
1554	The claim type and diagnosis code submitted are not payable.
1599	Header rendering provider used as billing provider.
1644	Valid other payer date required.
1649	Revenue code requires submission of associated HCPCS Code.
1652	HMO hierarchy logic used to determine service location.
1665	Unable to processes your adjustment request. Member ID not present.
1667	Unable to processes your adjustment request. Provider ID not present.
1668	Unable to processes your adjustment request. Claim ICN not found.
1669	Unable to process your adjustment request. Original ICN not present
1670	Unable to processes your adjustment request. Member not found.
1671	Unable to processes your adjustment request. Provider not found.
1672	Unable to process your adjustment request. Original claim ICN not found.
1673	Unable to processes your adjustment request. Claim has already been adjusted.
1677	Unable to processes your adjustment request. The claim type of the adjustment does not match the claim type of the original claim.
1678	Unable to processes your adjustment request. Member ID number on the claim and on the adjustment request do not match.
1679	Unable to processes your adjustment request. Provider ID number on the claim and on the adjustment request do not match.
1685	Billing provider type and specialty is not allowable for place of service.
1705	HMO hierarchy logic used to determine service location for detail rendering provider.
1824	HMO ID is invalid or not present on encounter claim.
3204	Denied. Service is not covered for the diagnosis indicated.
8188	MASS ADJUSTMENT – VOID TRANSACTIONS
9817	Billing provider number was used to adjudicate the service(s).
9956	Services have been carved out of HMO encounter processing.

EOB 0116 Procedure code or drug code not a benefit on date of service.

The following EOBs often post with EOB 0116. Other EOBs may also post. Note that the fact the EOB posts means there are restrictions, not necessarily that the restrictions were not met. Each encounter is evaluated using the steps below.

0182 Billing Provider Type and/or Specialty is not allowable for the service billed.
0184 Procedure Code is restricted by member age.
0229 The Type of Bill is invalid.
0770 The Revenue Code is not allowed for the Type of Bill indicated on the claim.
0859 Modifiers submitted are invalid for the Date of Service or are missing.
1280 Rendering Provider Type and/or Specialty is not allowable for the service billed.
1521 Procedure Code is not allowed on the claim form/transaction submitted.
1554 The Claim Type and Diagnosis Code submitted are not payable.

EOB 0116 sets with Edit 3363 NO PROCEDURE REIMBURSEMENT RULE FOR CLAIM REGION
EOB 0116 also sets with Edit 4801 NO BILLING RULE FOR PROCEDURE
EOB 0116 also sets with Edit 4804 NO BILLING RULE FOR REVENUE CODE
EOB 0182 sets with Edit 4149 BILLING PT/PS RESTRICTION ON PROC BILLING RULE
EOB 0184 sets with Edit 4714 AGE RESTRICTION ON PROC BILLING RULE
EOB 0229 sets with Edit 274 TYPE OF BILL CODE INVALID
EOB 0229 sets also sets with Edit 802 FREQUENCY CLAIM TYPE INVALID
EOB 0770 sets with Edit 4874 CLAIM TYPE RESTRICTION ON REV CODE BILLING RULE
EOB 0859 sets with Edit 4257 MODIFIER RESTRICTION FOR PROC BILLING RULE
EOB 1280 sets with Edit 4150 PERF/FACILITY PT/PS RESTRICTION PROC BILLING RULE
EOB 1521 sets with Edit 4871 CLAIM TYPE RESTRICTION ON PROC BILLING RULE
EOB 1554 sets with Edit 4314 CLAIM TYPE RESTRICTION ON DIAG CVG RULE

Note: Effective with date of submission 6/15/2015, additional provider logic was implemented for EOB 0182/Edit 4149, EOB 1280/Edit 4150, EOB 0859/Edit 4257, EOB 0184/Edit 4714, EOB 0116/Edit 4801, and EOB 1521/Edit 4871 . Please refer to Section 5.8.3 Provider Procedure Billing Rule Hierarchy Logic of the HMO encounter user guide for additional information.

Step 1 – Check for Known Non-covered Procedures or Drug Codes.

A noncovered service is a service, item, or supply for which reimbursement is not available. DHS 101.03(103) and 107, Wis. Admin. Code, contains more information about noncovered services. In addition, DHS 107.03, Wis. Admin. Code contains a general list of noncovered services.

Check the Online Handbooks. If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME delivery

charges are included in the reimbursement for DME items. (Topic #51 Online Handbook)

Coverage for Medicaid noncovered services is limited to Medicare copay/deduction reimbursement for a Medicare covered service.

Step 2 – Check Transaction Type.

Consult the Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx for information. Choose Program BadgerCare Plus and Medicaid. Choose the applicable service. Select Claims, Submission, Electronic Claims Submission.

Electronic claims for dental services must be submitted using the 837D transaction. Electronic claims for dental services submitted using any transaction other than the 837D will be denied. (Topic #2684 Online Handbook)

Electronic claims for inpatient hospital services must be submitted using the 837I transaction. Claims for inpatient hospital services submitted using any transaction other than the 837I will be denied. (Topic #1433 Online Handbook)

Electronic claims for physician services must be submitted using the 837P transaction. Electronic claims for physician services submitted using any transaction other than the 837P will be denied. (Topic #641 Online Handbook)

Step 3 – Check Encounter Type.

See Section 4.2 Encounter Types in the Encounter User Guide to determine which encounter types are included in Transactions 837D, 837I, and 837P. For Transaction Types 837P and 837I, consider the member's Medicare status. For example, if the member has Medicare A on the DOS, the encounter type will be A Inpatient Crossover. Medicare adjudication must be included. See EOBs 1256 and 1257.

Step 4 – Determine the Billing Provider.

Billing providers must be certified as a Biller or a Biller and Performer. Providers certified only as a Performer but submitted as a billing provider will cause the encounter to deny.

For billing providers with multiple taxonomies, HMOs submit the desired taxonomy. Note that Biller and Performer certification is not always consistent among taxonomies for the same NPI. Note also that PT/SP differs for the same NPI.

Billing providers must have valid contracts and certification for the DOS.

Step 5 – Determine the Rendering Provider.

Rendering providers must be certified as a Performer or a Biller and Performer. Providers certified only as a Biller but submitted as a rendering provider will cause the encounter to deny.

For rendering providers with multiple taxonomies, HMOs submit the desired taxonomy. Note that Biller and Performer certification is not always consistent among taxonomies for the same NPI. Note also that PT/SP differs for the same NPI.

See Section 5.7 Provider Propagation Logic in the Encounter User Guide. Note that in some cases a billing provider is considered the rendering provider even if a separate rendering provider is submitted. In this case, the rendering provider submitted is not used to price the encounter.

If a separate rendering provider is not submitted, the billing provider is also considered the rendering provider. In this case, the billing provider must be a Biller and Performer.

Rendering providers must have valid contracts and certification for the DOS.

Step 6 – Determine Restrictions.

Consult the Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx for information. Choose Program BadgerCare Plus and Medicaid. Choose the applicable service. Select Covered and Noncovered Services, Codes, All Information. Example 1, Search for Dental, Covered and Noncovered Services, Codes, All Information. Note restrictions for drugs, procedures, procedure modifiers, dental hygienist allowable services, diagnosis codes, and POS codes. Example 2, Search for Hospital, Inpatient Covered and Noncovered Services, Codes, All Information. Note restrictions for diagnosis codes, procedure codes, and revenue codes. Example 3, Search for Outpatient Mental Health, Covered and Noncovered Services, Codes, All Information. Note restrictions for diagnosis, POS, procedure, professional level and other modifiers, and revenue codes.

Step 7 – Max Fee Schedule.

Online Handbook restrictions may refer the user to the max fee schedule. Consult the procedure restrictions at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeSearch.aspx. Search for the Procedure Code, Financial Payer Medicaid, Service Area and DOS. Select 'Show All' to see all restrictions. For example, Search for the Procedure Code 96150, Financial Payer Medicaid, Service Area MENTAL HEALTH - MENTAL HEALTH AND MENTAL HEALTH FOR ALCOHOL AND OTHER DRUG ADDICTIONS, and DOS 11/1/2012. Note the modifier and Place of Service (POS) restrictions for rendering provider type/specialty (PT/SP). Note the financial impact of each modifier. Note also that there are Diagnosis restrictions. See EOB 0080.

EOB 1290 Type of bill is invalid for the claim type.

EOB 1290 sets with Edit 801 TYPE OF BILL/CLAIM TYPE INVALID

Check Official UB-04 Data Specifications Manual or Online Handbook.

The UB-04 manual includes restrictions on Type of Bill (TOB) codes.

Information is also available in the Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx. Choose Program BadgerCare Plus and Medicaid. Choose the applicable service. Select Claims, Submission, UB- 04… . For example, from the Home Health service, select Claims, Submission, UB-04 (CMS 1450) Claim Form Instructions for Home Health Services.

The TOB is a 3-digit code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit indicates the billing frequency.

The TOB is made up of values CLM05-1 and CLM05-3. In this example, the TOB is 111.

CLM*8929694*8188***11>A>1**A*Y*Y~

EOB 0080 Diagnosis code submitted does not indicate medical necessity or is not appropriate for service billed.

AND/OR

EOB 0558 The service requested is not allowable for the diagnosis indicated.

EOB 0080 sets with Edit 3373 DIAG HDR ANY GROUP RSTCN FOR PROC BILLING RULE
EOB 0080 also sets with Edit 3374 DIAG HDR ANY GROUP RSTCN FOR REV BILLING RULE
EOB 0080 also sets with Edit 4315 ANY HDR DIAG RSTCN FOR PROC BILLING RULE
EOB 0080 also sets with Edit 4322 ANY HDR DIAG RSTCN FOR REV BILL RULE
EOB 0558 sets with Edit 3369 DIAG DTL ANY GROUP RSTCN FOR PROC BILLING RULE

Check Units Per Day & Diagnosis Restriction Report.

The report includes restrictions on procedure codes that limit the units allowed per date of service, 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.

Consult the Units Per Day & Diagnosis Restriction Report on the HMO Report Matrix at https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage. The Report itself is published quarterly to the FTP server.

Search the report by Procedure Code. Note that the procedure may be listed under more than one contract. Select the applicable contract. Note restrictions for Claim Type, POS, Units per Day, Diagnosis Header Any, Diagnosis Detail Any, Procedure on Same Detail and Revenue. Effective dates for the restrictions are also included.

For example, Search for Procedure 96153 under the MHAOD contract. Note the Diagnosis Header Any restrictions. Any header diagnosis that does not meet the restrictions will cause the encounter to deny.

EOB 3204 <u>Denied. Service is not covered for the diagnosis indicated</u>.

EOB 3204 sets with Edit 3331 DIAGNOSIS HDR PRIMARY (DHP) RESTRICTION INPAT CT EOB 3204 also sets with Edit 3333 DIAGNOSIS HDR PRIMARY (DHP) RESTRICTION OUTPAT CT

Investigate Member Benefit Plans and Primary Diagnosis.

This EOB displays for institutional claims if member's benefit plan on the DOS is BCCP, BCCCO, or BCBAS with a primary header diagnosis in the Range 29000 to 31600. The header primary diagnosis is in 837I Loop 2300, Segment HI-Principal Diagnosis.

EOB 3204 will not set after 3/31/2014 as benefit plans BCCP, BCCCO, and BCBAS were discontinued.

EOB 0749 Routine foot care diagnoses must be billed with valid routine foot care procedure codes.

EOB 0749 sets with Edit 3330 ROUTINE FOOT CARE PROCEDURES

Professional encounters for POS 1, 3, 4, 5, 6, 7, 8, 9, 11, 12, 14, 15, 20, 21, 22, 23, 25, 26, 31, 32, 33, 34, 49, 50, 51, 54, 56, 57, 60, 61, 71, 72, 99

AND

Billing provider contract Medical Services for Billing Provider Type/Specialty 14/000

AND

Procedures

11000	DEBRIDE INFECTED SKIN
11040	DEBRIDE SKIN, PARTIAL
11041	DEBRIDE SKIN, FULL
11042	DEB SUBQ TISSUE 20 SQ CM/<
11043	DEB MUSC/FASCIA 20 SQ CM/<
11720	DEBRIDE NAIL 1-5
11721	DEBRIDE NAIL 6 OR MORE

Are restricted for the following diagnoses

ICD-9 Dx Range From	ICD-9 Dx Range To
2506	2508
335	236
337	337
340	3419
343	3439
3441	3441
353	3539
355	3579
4409	4409
443	4439
7101	7101
7140	7140
80600	8069

ICD-10 Dx Range From	ICD-10- Dx Range
A5215	A5215
E0800	E089
E0940	E0942
E0944	E0944
E0951	E0952
E1010	E139
G041	G041
G1220	G1229
G130	G131
G320	G320
G35	G379
G540	G545
G548	G55
G5700	G5702
G5781	G5782
G5791	G5792
G588	G652
G800	G802
G804	G8383
G8389	G839
G8921	G8928
G893	G9009
G904	G904
G90521	G90523
G950	G959
G990	G992
H540	H540
H5411	H543
H548	H548
I7301	I731
I7389	I739
M0550	M0559
M340	M349
O24011	O2493
O99810	O99815
S1200A	S12001S
S12100A	S12101S
S12200A	S12201S
S12300A	S12301S
S12400A	S12401S
S12500A	S12501S

S12600A	S12601S
S14101A	S14117S
S14121A	S14127S
S14131A	S14137S
S14151A	S14157S
S22019A	S22019S
S22029A	S22029S
S22039A	S22039S
S22049A	S22049S
S22059A	S22059S
S22069A	S22069S
S22079A	S22079S
S22089A	S22089S
S24101A	S24104S
S24111A	S24114S
S24131A	S24134S
S24151A	S24154S
S32009A	S32009S
S32019A	S32019S
S32029A	S32029S
S32039A	S32039S
S32049A	S32049S
S32059A	S32059S
S3210XA	S3210XS
S34101A	S34139S
S343XXA	S343XXS

EOB 0656 An ICD-9-CM diagnosis code of greater specificity must be used for the first diagnosis code.

OR

EOB 0657 An ICD-9-CM diagnosis code of greater specificity must be used for the second diagnosis code.

OR

EOB 0664 An ICD-9-CM diagnosis code of greater specificity must be used for the third diagnosis code.

OR

EOB 0668 An ICD-9-CM diagnosis code of greater specificity must be used for the fourth diagnosis code.

OR

EOB 0669 An ICD-9-CM diagnosis code of greater specificity must be used for the fifth diagnosis code.

OR

EOB 0860 An ICD-9-CM diagnosis code of greater specificity must be used for the sixth diagnosis code.

OR

EOB 0861 An ICD-9-CM diagnosis code of greater specificity must be used for the seventh diagnosis code.

OR

EOB 0862 An ICD-9-CM diagnosis code of greater specificity must be used for the eighth diagnosis code.

OR

EOB 0863 An ICD-9-CM diagnosis code of greater specificity must be used for the ninth diagnosis code.

OR

EOB 1374 An ICD-9-CM diagnosis code of greater specificity must be used for the diagnosis code in position 10 through 24.

EOB 0656 sets with Edit 4891 DISCHARGE DIAGNOSIS CODE 1 ICD-9 SPECIFICITY
EOB 0657 sets with Edit 4892 DISCHARGE DIAGNOSIS CODE 2 ICD-9 SPECIFICITY
EOB 0664 sets with Edit 4893 DISCHARGE DIAGNOSIS CODE 3 ICD-9 SPECIFICITY
EOB 0668 sets with Edit 4894 DISCHARGE DIAGNOSIS CODE 4 ICD-9 SPECIFICITY
EOB 0669 sets with Edit 4895 DISCHARGE DIAGNOSIS CODE 5 ICD-9 SPECIFICITY
EOB 0860 sets with Edit 4896 DISCHARGE DIAGNOSIS CODE 6 ICD-9 SPECIFICITY
EOB 0861 sets with Edit 4897 DISCHARGE DIAGNOSIS CODE 7 ICD-9 SPECIFICITY
EOB 0862 sets with Edit 4898 DISCHARGE DIAGNOSIS CODE 8 ICD-9 SPECIFICITY
EOB 0863 sets with Edit 4899 DISCHARGE DIAGNOSIS CODE 9 ICD-9 SPECIFICITY
EOB 1374 sets with Edit 4890 DISCHARGE DIAGNOSIS CODE 10-24 ICD-9 SPECIFICITY

These EOBs display if a diagnosis code is submitted that is not specific. For example, ICD-9-CM Diagnosis Code 7270 SYNOVITIS AND TENOSYNOVITIS is not specific. Diagnosis Codes 72700 SYNOVITIS AND TENOSYNOVITIS UNSPECIFIED, 72701 SYNOVITIS AND TENOSYNOVITIS IN DISEASES CLASSIFIED ELSEWHERE, and 72709 OTHER SYNOVITIS AND TENOSYNOVITIS are specific.

EOB 1116 The revenue code requires an appropriate corresponding procedure code.
OR
EOB 1649 Revenue code requires submission of associated HCPCS Code.

EOB 1116 sets with Edit 3896 PROCEDURE RSTCN FOR REV BILL RULE EOB 1649 sets with Edit 4088 REVENUE CODE REQUIRES HCPCS FOR TYPE OF BILL

EOB 1116 displays if the submitted Procedure Code does not meet Revenue Code restrictions. EOB 1649 displays when a Procedure Code is not submitted when required to meet Revenue Code restrictions.

Consult the Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx for information. Choose Program BadgerCare Plus and Medicaid. Choose the applicable service. Select Covered and Noncovered Services, Codes, Revenue Codes.

Example, for service 'Hospital, Outpatient', a list of outpatient hospital revenue codes that are exempt from the requirement to have a corresponding HCPCS or CPT is included.

EOB 1103 The number of covered days is required.

EOB 1260 The sum of the accommodations days is not equal to the sum of covered plus non-covered days.

EOB 1103 sets with Edit 282 COVERED DAYS MISSING
EOB 1260 sets with Edit 572 ACCOMM UNITS NOT EQUAL TO HDR DATE RANGE

Step 1 – Check 837 X12 for Covered Days in Header.

Covered days is indicated on the 837 with Value Code 80. Non-covered days is indicated with Value Code 81. Non-covered days could indicate a bed hold for long-term-care patients. When counting the DOS for inpatient or inpatient crossover encounters, the discharge date is not counted. For DOS 6/14/2012 to 6/15/2012 there is one DOS. The sum of covered days and non-covered days equals the DOS.

Step 2 – Check 837 X12 for Accommodation Days in the Detail.

Assuming no breaks in admission, the covered days submitted in the header should match the days submitted in the accommodation detail(s). Accommodation revenue codes include:

Revenue From	Revenue To	Effective Date	End Date
0101	0180	1/1/1900	12/31/2299
0183	0183	1/1/1900	12/31/2299
0185	0185	1/1/1900	12/31/2299
0190	0194	1/1/1900	12/31/2299
0199	0219	1/1/1900	12/31/2299
1000	1005	1/1/1900	12/31/2299

CLM*8929694*8188***11>A>1**A*Y*Y~
DTP*096*TM*1800~
DTP*434*RD8*20120614-20120615~
DTP*435*D8*20120614~
CL1*3*1*01~
HI*BK>66131~
HI*BJ>V221~
HI*DR>373~
HI*BF>66331>>>>>>>Y*BF>V270>>>>>>>Y~

HI*BR>7359>D8>20120614~
HI* BE>80>>>1~
HI*BG>C1~
SBR*P*18*4444000******HM~
AMT*D*8188~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*A***MI*1419806416~
N3*ADDRESS~
N4*CITY*WI*500000000~ NM1*PR*2*MEDICAID
HMO*****PI*69000000~
LX*1~
SV2*0110**1325*DA*1**0~
DTP*472*RD8*20120614-20120615~
REF*6R*8929694-34684741~
SVD*69000000*1325**0110*1~
DTP*573*D8*20120904~

EOB 0901 <u>The from date of service and to date of service must be in the same calendar month and year.</u>

EOB 0901 sets with Edit 577 SERV DATES ARE NOT IN SAME MONTH-DETAIL

On long term care encounters, the header FDOS must be in the same month/year as the header TDOS. The detail FDOS must be in the same month/year as the header TDOS.

EOB 0051 The header from and to dates of service cannot be the same.

EOB 0051 sets with Edit 518 HDR DATES OF SERVICE CANNOT BE EQUAL

Inpatient and inpatient crossover encounters with Revenue Codes 0720, 0721, 0722, 0724, or 0729 present are exempt from EOB 0051.

EOB 0051 will set on Claim Type I or A if the following criteria are met:
Header from date of service and to date of service are equal AND
Patient status code is anything other than 02, 03, 04, 05, 08, 20, 62, 63, 64, 66, 70, 82, 83, 84 or 85 AND
The encounter was not priced using DRG pricing OR
The encounter was priced using DRG but the DRG Group is not one of the following

DRG Code Range From	DRG Code Range To	Effective Date	End Date
767	768	7/1/2008	12/31/2299
774	775	7/1/2008	12/31/2299
776	776	7/1/2008	12/31/2299

CLM*14024E13801*17682.65***11:A:1**A*Y*Y~
DTP*096*TM*1500~
DTP*434*RD8*20140118-20140118~
DTP*435*D8*20140118~
CL1*2*1*01~
REF*D9*14024E13801~
REF*EA*316998~
REF*LX*02916-1714097339~
HI*BK:78659:::::::Y~

EOB 0051 will set on Claim Type L if the following criteria are met:
Header from date of service and to date of service are equal AND
Patient status code is not 30

EOB 0278 Member is covered by commercial health insurance on the date(s) of service.

EOB 0278 sets with Edit 2504 RECIPIENT COVERED BY PRIVATE INSURANCE

Note: Effective with date of submission 4/28/2015, encounters are no longer monitored for commercial insurance.

Step 1 – Investigate commercial insurance coverage for the member on the DOS.

See Transaction 834 for member's other coverage. The HMO or provider contacts the other insurance carrier(s) for payment.

Step 2 – Add commercial insurance adjudication to the 837 X12.

Private payer is the primary payer. The private payer is identified by its carrier number or another ID. Claim filing indicator HM (SBR09) is used specifically in Wisconsin to represent Wisconsin Contracted HMOs submitting payment information as a prior payer on 837 HMO encounters. Private insurance, either proprietary or under the HMO organization umbrella, must choose a different value for this field when indicating commercial insurance as a prior payer on 837 HMO encounters. Claim filing indicator CI – Commercial Insurance would be an accurate value to represent private insurance.

The Medicaid HMO is the secondary payer. ForwardHealth is the tertiary payer. Potential private pay segments are added as an example.

HL*830*172*22*0~
SBR*T*18*4444000******MC~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19630126*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*8689841*115***11>B>1*N*A*Y*Y*P~
HI*BK>30000*BF>311~
NM1*82*1*FROELICHMD*RALPH***MD.*XX*1275558165~
PRV*PE*PXC*2084P0800X~
SBR*P*18*4444000******CI~
AMT*D*5~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*COMMERCIAL PAYER*****PI*092~

SBR*S*18*7025024******HM~
CAS*CO*223*115~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~ NM1*PR*2*MEDICAID
HMO*****PI*69000000~
LX*1~
SV1*HC>90862*115*UN*1***1>2~
DTP*472*D8*20120420~
REF*6R*8689841-33455095~
SVD*092*5*HC>90862**1~
CAS*CO*18*10~
CAS*PI*23*100~
DTP*573*D8*20120501~
SVD*69000000*0*HC>90862**1~
CAS*CO*18*10~
CAS*PI*23*105~
DTP*573*D8*20120503~

EOB 0962 Member does not have commercial health insurance for the date(s) of service.

EOB 0278 sets with Edit 2516 OTHER INSURANCE NOT ON FILE

Note: Effective with date of submission 4/28/2015, encounters are no longer monitored for commercial insurance.

The member does not have commercial insurance in the ForwardHealth database. The HMO can inform ForwardHealth of other insurance by completing the TPL discrepancy form on the MCO Portal.

EOB 1256 Member is enrolled in Medicare Part A on the date(s) of service.
OR
EOB 1257 Member is enrolled in Medicare Part B on the date(s) of service.

EOB 1256 sets with Edit 2500 RECIPIENT COVERED BY MEDICARE A EOB 1257 sets with Edit 2502 RECIPIENT COVERED BY MEDICARE B

Add Medicare insurance adjudication to the 837 X12.

Medicare is the primary payer. The Medicaid HMO is the secondary payer. ForwardHealth is the tertiary payer. Potential Medicare B payer segments are added as an example. SBR09 is MA for Medicare A, MB for Medicare B.

HL*119*104*22*0~
SBR*T*18*4446002******MC~
NM1*IL*1*LAST*FIRST*P***MI*6424798161~
N3*ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19790226*M~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*8754642*309***23>B>1*N*A*Y*Y*P~
HI*BK>7821*BF>V0189~
NM1*82*1*SILVER MD*SARAH*S**MD.*XX*1396736740~
PRV*PE*PXC*207P00000X~
SBR*P*18*4446002******MB~
AMT*D*22.98~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*P***MI*6424798161~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICARE B*****PI*999~
SBR*S*18*4446002******HM~
AMT*D*22.98~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*P***MI*6424798161~
N3*ADDRESS~
N4*CITY*WI*500000000~ NM1*PR*2*MEDICAID
HMO*****PI*69000000~
LX*1~
SV1*HC>99283*309*UN*1***1>2~

DTP*472*D8*20120409~
REF*6R*8754642-33799034~
SVD*999*22.98*HC>99283**1~
CAS*PR*2*130.00**3*120.00**1*36.02~
DTP*573*D8*20120501~
SVD*69000000*22.98*HC>99283**1~
CAS*CO*45*286.02~
DTP*573*D8*20120529~

EOB 1275 Quantity billed is restricted for this procedure code.

EOB 1275 sets with Edit 4163 QUANTITY RESTRICTION ON PROC BILLING RULE

Check Units Per Day & Diagnosis Restriction Report.

The report includes restrictions on procedure codes that limit the units allowed per date of service, 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.

Consult the Units Per day & Diagnosis Restriction Report on the HMO Report Matrix at https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage. The Report itself is published quarterly to the FTP server.

Search the report by Procedure Code. Note that the procedure may be listed under more than one contract. Select the applicable contract. Note restrictions for Claim Type, POS, Units per Day, Diagnosis Header Any, Diagnosis Detail Any, Procedure on Same Detail and Revenue. Effective dates for the restrictions are also included.

For example, Search for Procedure 64487 under the OUTPA contract. Note the Units per Day restriction of 0-1. Units billed in excess of one do not meet the restrictions and will cause the encounter to deny.

EOB 0029 Last name does not match member ID.

AND/OR

EOB 0614 First name does not match member ID.

EOB 0029 sets with Edit 238 RECIPIENT LAST NAME IS MISSING EOB 0614 sets with Edit 237 RECIPIENT FIRST NAME IS MISSING

ForwardHealth matches the first two characters of the last name and first two characters of the first name of those submitted to the ForwardHealth database. Due to a ForwardHealth system issue, HMOs do not submit a blank in the first two characters of the member's last name. For example, O BRIEN is submitted as OBRIEN.

EOB 0221 The detail billed amount is required.

AND/OR

EOB 1270 The header total billed amount is required and must be greater than zero.

EOB 0221 sets with Edit 268 BILLED AMOUNT MISSING EOB 1270 sets with Edit 270 HEADER TOTAL BILLED AMOUNT MISSING

Although zero is an EDI compliant value, it is not valid for pricing. HMOs submit a non-zero value for the header total billed amount and the detail billed amount.

CLM*8753412*0***11>B>1*N*A*Y*Y*P~
HI*BK>30002*BF>29630~
NM1*82*1*SHELDONMD*EDWIN***MD.*XX*1427085737~
PRV*PE*PXC*2084P0800X~
SBR*P*18*4444000******HM~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*N***MI*4406736948~
N3*ADDRESS~
N4*CITY*WI*500000000~ NM1*PR*2*MEDICAID
HMO*****PI*69000000~
LX*1~
SV1*HC>99442>UA*0*UN*1***1>2~
DTP*472*D8*20120525~
REF*6R*8753412-33796848~
SVD*69000000*0*HC>99442>UA**1~
DTP*573*D8*20120531~

EOB 1271 The total billed amount is missing or incorrect.

EOB 1271 sets with Edit 508 BILLED AMT NOT EQUAL TO DTL BILLED AMT SUM

The header billed amount must equal the sum of the detailed billed amounts.

CLM*BILLEDAMT*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~
NM1*82*1*KAMINSKY*MELISSA****XX*1225070188~
SBR*P*18*******HM~
AMT*D*8.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*9010002215~
N3*ADDRESS~
N4*MADISON*WI*537041234~
NM1*PR*2*HMONAME*****PI*69000000~
LX*1~
SV2*0401*HC:77056:50:26:0A:0B:MAMMOGRAM BOTH BREASTS*220.00*UN*1.00~
DTP*472*RD8*20130303-20130303~
NM1*82*1*ONO*ERIKA****XX*1235108606~
SVD*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*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*69000000*2.00*HC:77051:50:26:0A:0B*0401*1~
CAS*OA*93*90.00~
DTP*573*D8*20130311~

EOB 9956 <u>Services have been carved out of HMO encounter processing.</u>

EOB 9956 sets with Edit 3361 DENY ENCOUNTER FOR SVCS CARVED OUT OF MANAGED CARE

See Update 2014-79 Changes to Provider Administered Drugs Carve-Out Policy effective 1/1/2015 DOS.

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.

Encounter Types B, D, H, and M contain procedure codes that are not covered for the member benefit or assignment plans. Assignment plans may exclude services. For example, HMOMM (Medical) does not cover dental. Encounter Types A, I, L, and O contain revenue codes that are not covered for member benefit or assignment plans.

Several benefit plans are completely carved out of Managed Care:

- ADAP AIDS Drug Assistance Program
- AE Alien Emergency Services
- BCBAS BadgerCare Plus Basic Plan
- BCBEE BC+ Benchmark EE for Pregnant Women
- BCSEE BC+ Standard EE for Pregnant Women
- CRSW Community Recovery Services Waiver
- CTS State Supplemental Payment - Caretaker Supplement
- FC Family Care Non-MA
- FPW Family Planning Services Only
- MAPW Medicaid Purchase Plan Waiver < Waiver Medicaid>
- PE Presumptive Eligibility - Pregnancy Only
- QDWI Qualified Disabled Working Individuals
- QMB Qualified Medicare Beneficiary
- SC1 Senior Care Level 1- 0 to 200% FPL
- SC2 Senior Care Level 2- Over 200% FPL
- SLB Specified Low-income Medicare Beneficiary
- SLB+ Specified Low-income Medicare Beneficiary Plus
- SSI State Supplemental Payment - State Supplemental In
- SSIE State Supplemental Payment - State Supplemental In
- TB Tuberculosis Services Only
- WCDC Wisconsin Chronic Disease-Adult Cystic Fibrosis
- WCDH Wisconsin Chronic Disease-Hemophilia HomeCare
- WCDK Wisconsin Chronic Disease-Renal Disease
- WWMA Wisconsin Well Woman Medicaid
- WWWP Wisconsin Well Woman Program

EOB 0941 <u>This procedure code and billed charge were rebundled to another code, which was either billed by the provider on this claim or added by ClaimCheck.</u>

EOB 0941 sets with Edit 7217 PROCEDURE CODE HAS BEEN REBUNDLED

Encounters correctly recycle when ClaimCheck determines that the procedure should be bundled under another procedure code. While in the recycle status, the encounter will not appear on the encounter response report. The encounter will appear on a future encounter response report, most likely that of the next date. Adjudication will be included when the encounter is included on the encounter response report.

EOB 1347 Billing provider number is not found or not valid for dates of service.

EOB 1347 sets with Edit 1945 MULTI PROV LOCS FOR BILLING PROV SPEC - HDR

Note: Effective with date of submission 5/12/2015, additional provider logic was implemented for EOB 1347/Edit 1945. Please refer to Section 5.8 Provider Matching and Usage Enhancements of the HMO encounter user guide for additional information.

When multiple service locations exist under one NPI, taxonomy and zip information is needed to determine the appropriate service location. EOB 1347 is returned when a unique billing provider cannot be determined. HMOs provide taxonomy and zip that match that of the provider in the ForwardHealth database.

EOB 1347 sets for providers with multiple NPIs. In the case of multiple NPIs, the system will first attempt to find a unique Medicaid ID by using taxonomy, if submitted. If a unique Medicaid ID cannot be found by using the NPI and taxonomy, the system will next look to the zip code to find a unique match. If a unique Medicaid ID cannot be determined, EOB 1347 will set. If an NPI is submitted and exists only once in the system, the taxonomy and zip code match is not performed. If a unique Medicaid ID is found using NPI and taxonomy, the zip code match is not performed.

PRV*BI*PXC*<taxonomy here>~
NM1*85*2*MERCY WALWORTH HOSPITAL AND MEDICAL*****XX*1699728550~
N3*1000 MINERAL POINT AVE~
N4*JANESVILLE*WI*500000000~

Professional and professional crossover encounters will initially suspend while a unique billing provider match is attempted. While in the suspend status, the encounter will not appear on the encounter response report. The encounter will appear on a future encounter response report, most likely that of the next week. Adjudication will be included when the encounter is included on the encounter response report. Other encounter types will deny without moving to a suspend status if a unique billing provider is not found.

EOB 1504 Performing provider number is not found.

EOB 1504 sets with Edit 1946 MULTI PROV LOCS FOR PERFORMING PROV SPEC - HDR EOB 1504 also sets with Edit 1952 MULTI PROV LOCS FOR PERFORM PROV SPEC - DTL

Note: Effective with date of submission 5/12/2015, additional provider logic was implemented for EOB 1504/Edit 1952. Please refer to Section 5.8 Provider Matching and Usage Enhancements of the HMO encounter user guide for additional information.

When multiple service locations exist under one NPI, taxonomy information is needed to determine the appropriate service location. EOB 1504 is returned when a unique performing provider cannot be determined. HMOs provide the taxonomy that matches that of the provider in the ForwardHealth database in the PRV Segment. Providers may update taxonomy on the provider portal.

CLM*L333BHE00056*181***11:B:1*Y*A*Y*Y~
HI*BK:29572~
NM1*82*1*ROY*DONNA****XX*1922245604~
PRV*PE*PXC*TAXONOMYHERE~

EOB 0477 Billing provider indicated is not certified as a billing provider.
AND/OR
EOB 0175 Rendering provider indicated is not certified as a rendering provider.

EOB 0477 sets with Edit 1964 BILLING PROVIDER IS NOT DESIGNATED AS A "BILLER" EOB 0175 sets with Edit 1963 RENDERING PROVIDER IS NOT DESIGNATED TO RENDER

A ForwardHealth provider is certified as a “biller,” “perfomer,” or “biller and performer.” The submitted billing provider must be certified as a “biller” or “biller and performer.” The submitted performing provider must be certified as a “perfomer” or “biller and performer.”

See Section 5.7 Provider Propagation Logic in the Encounter User Guide. Note that in some cases a billing provider is considered the rendering provider even if a separate rendering provider is submitted. In this case, the rendering provider submitted is not used to price the encounter.

If a separate rendering provider is not submitted, the billing provider is also considered the rendering provider. In this case, the billing provider must be a “biller and performer.”

EOB 1238 The rendering provider's taxonomy code in the header is invalid.
AND/OR
EOB 1491 The attending provider's taxonomy code in the header is invalid.
AND/OR
EOB 1505 The billing provider's taxonomy code in the header is invalid.

EOB 1238 sets with Edit 1901 TAXONOMY IS INVALID PERFORMING PROVIDER - HDR EOB 1491 sets with Edit 1916 TAXONOMY IS INVALID ATTENDING PROVIDER - HDR EOB 1505 sets with Edit 1900 TAXONOMY IS INVALID BILLING PROVIDER - HDR

The Healthcare Provider Taxonomy Code set is maintained by the National Uniform Claim Committee and available from the Washington Publishing Company. It is the only code set that may be used in HIPAA standard transactions, including the 837 transactions, to report the type/classification/specialization of a health care provider. All other taxonomy submissions are invalid.

EOB 0025 Billing or rendering provider enrollment is cancelled from date of service.
AND/OR
EOB 0424 Billing provider ID is not on file.
AND/OR
EOB 1204 Billing provider is not certified for the date(s) of service.

EOB 0025 sets with Edit 1048 PROVIDER TERMINATED - DTL DOS
EOB 0424 sets with Edit 1000 BILLING PROVIDER I.D. NOT ON FILE
EOB 0424 also sets with Edit 1004 BILLING PROVIDER I.D. NOT ON FILE - DENY
EOB 1204 sets with Edit 1806 BILLING PROV NOT ELIG ON DTL DOS - OOS

Note: Effective with date of submission 5/12/2015, additional provider logic was implemented for EOB 0424/Edit 1000. Please refer to Section 5.8 Provider Matching and Usage Enhancements of the HMO encounter user guide for additional information.

These EOBs are returned when a valid* NPI is submitted but there is no match in the ForwardHealth database, or no match for the DOS.

These EOBs often set when a provider uses an NPI that belongs to the provider but is not the NPI used to certify as a Medicaid provider.

*Valid NPIs meet algorithm or mathematical formula restrictions.

EOB 1685 Billing provider type and specialty is not allowable for place of service.

EOB 1685 sets with Edit 856 MH PT/PS 11/120, 11/121 HAS POS 11 BILLING RSTCN

Please refer to Update 2010-14. Although licensed psychotherapists were given the ability to submit claims independently for mental health services provided outside a Medicaid-certified outpatient mental health clinic, the only allowable POS is 11 (office). Travel is not able to be submitted independently.

EOB 0678 Billing provider type and specialty is not allowable for the rendering provider .

EOB 0678 sets with Edit 1801 PERFORMING PROVIDER TYPE TO BILLING PROVIDER TYPE

Professional encounters verify the billing provider type and/or specialty PT/SP against the rendering provider type and/or specialty.

Performing PT/SP 32/000 requires one of the following Biller PT/SP: 32/094, 32/101, 32/900, 33/310, 33/311, 33/312, 33/314, 33/315, 33/316, 33/317, 33/318, 33/319, 33/320, 33/322, 33/324, 33/325, 33/326, 33/327, 33/328, 33/329, 33/330, 33/331, 33/332, 33/333, 33/336, 33/337, 33/338, 33/339, 33/340, 33/341, 33/342, 33/343, 33/345, 33/354, 33/900, or 75/080.

If the Performer PT/SP is 32/000 and the Biller PT/SP is 32/094 or 32/101, the NPIs must be the same.

Performer PT/SP 11/117, 11/122, 11/123, or 11/124 requires one of the following Biller PT/SP: 11/080, 11/801, 11/802, 11/803, or 52/900.

Performer PT/SP 11/126 requires one of the following Biller PT/SP: 11/080, 11/801, or 11/803.

If the Performer PT/SP is 11/112 and the Biller PT/SP is 11/112, the NPIs must be the same.

If the Performer PT/SP is 11/120 and the Biller PT/SP is 11/120, the NPIs must be the same.

If the Performer PT/SP is 11/121 and the Biller PT/SP is 11/121, the NPIs must be the same.

If the Performer PT/SP is 11/125 and the Biller PT/SP is 11/125, the NPIs must be the same.

If the Performer PT/SP is 77/170 and the Biller PT/SP is 77/170, the NPIs must be the same.

If the Performer PT/SP is 78/171 and the Biller PT/SP is 78/171, the NPIs must be the same.

If the Performer PT/SP is 79/173 and the Biller PT/SP is 79/173, the NPIs must be the same.

EOB 9817 Billing provider number was used to adjudicate the service(s).

EOB 9817 is informational and does not have a corresponding edit.

Note: Effective with date of submission 6/21/2015, additional provider logic was implemented for EOB 9817. Please refer to Section 5.7 Provider Propagation Logic of the HMO encounter user guide for additional information.

EOB 1599 Header rendering provider used as billing provider.

OR

EOB 1652 HMO hierarchy logic used to determine service location.

OR

EOB 1705 HMO hierarchy logic used to determine service location for detail rendering provider.

EOB 1599, EOB 1652, and EOB 1705 are informational and do not have a corresponding edits.

Note: Effective with dates of submission 5/12/2015 through 6/22/2015, additional provider logic was implemented. Please refer to Section 5.8 Provider Matching and Usage Enhancements of the HMO encounter user guide for additional information.

EOB 0378 Tooth number or letter is not valid with the procedure code for date of service.
AND/OR
EOB 0697 The number of tooth surfaces indicated is insufficient for the procedure billed.
AND/OR
EOB 1128 A tooth number or letter is required.

EOB 0378 sets with Edit 4211 TOOTH NUMBER/PROCEDURE CODE COMBINATION INVALID EOB 0697 sets with Edit 266 INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES EOB 1128 sets with Edit 261 TOOTH NUMBER MISSING EOB 1128 also sets with Edit 262 TOOTH NUMBER INVALID

Segment TOO indentifies tooth number and surfaces for the procedure submitted.

LX*1~
SV3*AD:D2150*45****1~
TOO*JP*12*L:O~

EOB 1145 Area of the oral cavity is required for procedure code.

EOB 1145 sets with Edit 4120 PROCEDURE CODE REQUIRES AREA OF ORAL CAVITY

Element SV304 indentifies oral cavity for the procedure submitted. An area of oral cavity code (01=Maxillary or 02=Mandibular) is required.

LX*1~
SV3*AD:D1515*288.80*<oral cavity>*1**1~

EOB 1824 HMO ID is invalid or not present on encounter claim.

EOB 1824 sets with Edit 310 HMO ID INVALID

HMOs submit payment information on the encounter. The HMO is the second to the last payer, in this case the primary payer. Medicaid is the last payer, in this case the secondary payer. The HMO Medicaid assigned ID is used to identify the Medicaid HMO payer. Claim filing indicator HM (SBR09) is used specifically in Wisconsin to represent Wisconsin contracted HMOs submitting payment information as a prior payer on 837 HMO Encounters.

HL*6*5*22*0~
SBR*S*18*******MC~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19960210*U~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*1450707A*45***11:B:1*Y*A*Y*Y~
DTP*472*D8*20120827~
SBR*P*18*******HM~
AMT*D*40~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV3*AD:D2150*45****1~
TOO*JP*13*M:O~
SVD*69000000*40*AD:D2150**1~
CAS*OA*45*5*1~
DTP*573*D8*20120928~

EOB 1644 Valid other payer date required.

EOB 1644 sets with Edit 3365 THE HEADER HMO DATE IS INVALID EOB 1644 also sets with Edit 941 THE HMO PAID DATE IS INVALID

HMOs submit their payment information on the encounter, including the date paid.

The HMO paid date must meet these restrictions:
The paid date must be after the TDOS.
The paid date must be before the ICN encounter date.
The paid date must be in CCYYMMDD format.
The paid date cannot be null or contain spaces.

HL*6*5*22*0~
SBR*S*18*******MC~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19960210*U~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*1450707A*45***11:B:1*Y*A*Y*Y~
DTP*472*D8*20120827~
SBR*P*18*******HM~
AMT*D*40~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV3*AD:D2150*45****1~
TOO*JP*13*M:O~
SVD*69000000*40*AD:D2150**1~
CAS*OA*45*5*1~
DTP*573*D8*20120928~

EOB 1668 Unable to processes your adjustment request. Claim ICN not found.
OR
EOB 1669 Unable to process your adjustment request. Original ICN not present.
OR
EOB 1672 Unable to process your adjustment request. Original claim ICN not found.

EOB 1668 sets with Edit 549 INVALID ADJUSTMENT TCN NOT FOUND
EOB 1669 sets with Edit 551 INVALID ADJUSTMENT REQUEST HAS NO ORIGINAL ICN
EOB 1672 sets with Edit 557 INVALID ADJUSTMENT ORIGINAL CLAIM NOT FOUND

When an encounter is being adjusted (CLM05-3 = 7) or voided (CLM05-3 = 8), the ICN being adjusted or voided is included in the REF Segment.

CLM*12345678*200***11>B>8*N*A*Y*Y*P~
REF*F8*7013120001001~
REF*9C*7731293~
NTE*ADD*VENDOR RETURNED CHECK~
HI*BK>V7240~

Only paid, active ICNs can be adjusted. Once an ICN has been adjusted, that ICN cannot be adjusted again as it is no longer active. Two examples follow.

Paid ICN A is adjusted by denied ICN B. ICN A can no longer be adjusted as it is not active. Active ICN B cannot be adjusted as it is denied. A new-day encounter is submitted.

Paid ICN AA is adjusted by paid ICN BB. ICN AA can no longer be adjusted as it is not active. Active ICN BB can be adjusted.

EOB 1665 Unable to processes your adjustment request. Member ID not present.
OR
EOB 1670 Unable to processes your adjustment request. Member not found.
OR
EOB 1678 Unable to processes your adjustment request. Member ID number on the claim and on the adjustment request do not match.

EOB 1665 sets with Edit 546 INVALID ADJUSTMENT MEMBER MEDICAID ID NOT SUBMITT EOB 1670 sets with Edit 552 INVALID ADJUSTMENT MEMBER NOT FOUND EOB 1678 sets with Edit 564 INVALID ADJUSTMENT MEMBER IDS DO NOT MATCH

When an encounter is being adjusted or voided, the Member ID must be present and match the Member ID on the original encounter.

HL*830*172*22*0~
SBR*T*18*4444000******MC~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19630126*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~

EOB 1667 Unable to processes your adjustment request. Provider ID not present.
OR
EOB 1671 Unable to processes your adjustment request. Provider not found.
OR
EOB 1679 Unable to processes your adjustment request. Provider ID number on the claim and on the adjustment request do not match.

EOB 1667 sets with Edit 548 INVALID ADJUSTMENT PROVIDER ID NOT PRESENT
EOB 1671 sets with Edit 553 INVALID ADJUSTMENT PROVIDER NOT FOUND
EOB 1679 sets with Edit 566 INVALID ADJUSTMENT PROVIDERS DO NOT MATCH

When an encounter is being adjusted or voided, the Provider ID must be present and match the Provider ID on the original encounter. An adjustment may contain an updated taxonomy as long as the Provider ID is present and matches the Provider ID on the original encounter.

PRV*BI*PXC*<taxonomy here>~
NM1*85*2*MERCY WALWORTH HOSPITAL AND MEDICAL*****XX*1699728550~
N3*1000 MINERAL POINT AVE~
N4*JANESVILLE*WI*500000000~

EOB 1677 Unable to processes your adjustment request. The claim type of the adjustment does not match the claim type of the original claim.

EOB 1677 sets with Edit 563 INVALID ADJUSTMENT CLAIM TYPES DO NOT MATCH

When an encounter is being adjusted, the encounter 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 encounter type.

EOB 1673 <u>Unable to processes your adjustment request. Claim has already been adjusted</u>.

EOB 1673 sets with Edit 558 INVALID ADJUSTMENT CLAIM HAS BEEN ADJUSTED

Once an original encounter has been adjusted, whether the adjustment denied or priced, the original adjustment cannot be adjusted again. In the case of a denied adjustment, the HMO submits another original encounter if the services need to be reported. A priced adjustment can be adjusted again.

EOB 1531 Indicator for present on admission (POA) is not a valid value.

EOB 1531 sets with Edit 851 POA CODE IS INVALID

Valid POA values are as follows:
N No
U Unknown
W Not Applicable
Y Yes

HI*BF:36811::::::Y*BF:67482::::::Y*BF:64901::::::Y*BF:V252::::::Y*BF:V270::::::Y~

EOB 0273 Resubmit charges for ForwardHealth covered service(s) denied by Medicare on a ForwardHealth claim.

EOB 0273 sets with Edit 452 CALCULATED DETAIL MEDICARE ALLOWED AMOUNT IS ZERO

If services covered by both Medicare and Medicaid are paid zero by Medicare, Medicaid also pays zero. If services are not covered by Medicare but are covered by Medicaid, Medicaid may price. Each category of service must be submitted as a separate encounter. To designate the services on the encounter are not covered by Medicare, include Loop 2320 Amt – Coordination of Benefits (COB) Total Non-Covered Amount. In this example, Medicare paid zero and the HMO paid $6.00 of the $39.00 total. Once Loop 2320 Amt – Coordination of Benefits (COB) Total Non-Covered Amount is used, the encounter must meet requirements of the non-crossover encounter type. For example, an encounter that would have been submitted as a professional crossover encounter if Medicare had covered, must now meet the requirements of a professional encounter.

CLM*12240E000008*39.00***13:A:1**A*Y*Y~
DTP*434*RD8*20120731-20120731~
CL1*3*1*01~
HI*BK:25000~
HI*PR:25000~
HI*BF:36570*BF:37157:::::::U~
HI*BH:11:D8:20120731~
NM1*71*1*LAMB*GEOFFREY****XX*1962453712~
PRV*AT*PXC*282N00000X~
SBR*P*18*******MB~
AMT*A8*39.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*L***MI*9415708891~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICARE B*****PI*004~
SBR*S*18*******HM~
AMT*D*6.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*L***MI*9415708891~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV2*0300*HC:83036*39*UN*1.00~
DTP*472*D8*20120731~
SVD*69000000*6*HC:83036*0300*1.00~
CAS*CO*45*33~
DTP*573*D8*20120904~

EOB 1198 A National Drug Code (NDC) is required for this HCPCS Code.

EOB 1198 sets with Edit 870 HCPCS PROCEDURE REQUIRES A VALID NDC

The NDC for the procedure is identified in Loop 2410 Segment LIN.

LX*1~
SV1*HC:A9579*59.8*UN*20***1~
DTP*472*D8*20121108~
REF*6R*2~
LIN**4N*NDCHERE~

EOB 0100 Denied as a duplicate claim.

EOB 0100 sets with Edit 5000 PROV PROC EXD M1 M2 M3 M4 B/QTY B/AMT - DENY
EOB 0100 also sets with Edit 5001 PROV PROC EXD M1 M2 M3 M4 B/QTY
EOB 0100 also sets with Edit 5003 PROV PROC EXD TOOTH NUMBER
EOB 0100 also sets with Edit 5004 PROV PROC EXD ORAL CAVITY/QUADRANT
EOB 0100 also sets with Edit 5005 PROV PROC EXD M1 M2 M3 M4 B/QTY
EOB 0100 also sets with Edit 5006 PROV PROC EXD M1 M2 M3 M4 B/AMT
EOB 0100 also sets with Edit 5007 SAME RPROV SAME PROC SAME DDOS - DENY
EOB 0100 also sets with Edit 5029 PROV AMT EXD - CLAIM TYPES EQUAL
EOB 0100 also sets with Edit 6934 PROV EXACT HEADER DATES OF SERVICE - DENY
EOB 0100 also sets with Edit 6935 SAME RPROV SAME PROC SAME DDOS
EOB 0100 also sets with Edit 6937 PROV PROC PD M1 M2 M3 M4 - DENY
EOB 0100 also sets with Edit 6938 ESRD SAME PROVIDER SAME DETAIL FROM DOS

Note: Effective with the 6/13/2015 encounter response file, the ICN causing the duplicate EOB is included on Record 600.

EOB 0100 indicates the encounter cannot be processed because it has been at least partially paid already. Possible variables causing EOB 0100 include: encounter type, billing provider, performing provider, procedure code, procedure modifier, from date of service, to date of service, billing quantity, billed amount, tooth number, and area of oral cavity.

EOB 0100 can set because the assignment of the financial flag and pricing are separate, independent processes. A claim denied by the HMO when submitted as an encounter is assigned a financial flag of N (no), but can be priced. A similar claim later paid by the HMO when submitted as an encounter is denied as a duplicate. One resolution is to void the priced encounter that the HMO denied as a claim prior to submitting the encounter that the HMO paid as a claim. A denied encounter cannot be adjusted or voided.

EOB 0363 <u>This obstetrical service was previously paid for this date of service for this member.</u>

EOB 0363 sets with Edit 5043 DUPLICATE OBSTETRICAL SERVICES

Although the wording on the EOB suggests a single date of service, the criteria actually monitors obstetrical care codes against office visit codes where there is a pregnancy on both encounters 270 days before and 42 after the obstetrical care codes. This enforces the policy that pregnancy-related office visits are included in the obstetrical care codes.

EOB 8188 MASS ADJUSTMENT – VOID TRANSACTIONS.

EOB 8188 indicates the encounter has been successfully voided. The encounter will be in a deny status.