Encounter Based Payment Guide

Version Number: 3.1 March 12, 2018

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Version	Date	Change Log
1.0	3/22/2017	Initial Guide
2.0	8/1/2017	Add HIV/AIDS
3.0	11/7/2017	Add clarification that MCOs are expected to pay their providers for applicable services prior to receiving reimbursement, Add NTS
3.1	3/12/2018	Add ICD-10 Procedure Code 0UH90HZ to ICD-10 Diagnosis Code Z30430 for LARC enhancement.

Encounter Based Payment Introduction

Background

This guide is designed for use by Managed Care Organizations (MCOs) to understand the reporting for encounter based payments. Encounter based payments are paid to MCOs as an incentive or add-on for providing designated services that are not included in the monthly capitation rate. MCOs are expected to pay their providers for applicable services prior to receiving reimbursement.

Encounter based payment reporting includes a report from the Department of Health Services (Department) to the MCOs and may also include a report from the MCOs to the Department. The report to the MCOs contains information submitted on encounters and information about the encounter based payment itself. The return report to the Department, when required, contains information about how the encounter based payment was distributed.

Contract

Contract Language for BadgerCare Plus and Supplemental Security Income (SSI) encounter based payments is found in:

Dental Pilot – Article IV, A – BadgerCare Plus and/or Medicaid SSI Services
SSI Care Coordination – 2017 Policy and Rates Amendment, Article III, B – Care Management Model for the Medicaid SSI Population
LARC – TBD
HIV/AIDS – Article IV, G – HIV/AIDS – Health Home
Narcotic Treatment Services – Article IV, B – Services

File Format and Naming Convention

The encounter based payment reports are pipe-delimited, csv files without header or trailer rows using the following naming conventions where 6900XXXX is the MCO payee ID:

ENC_BASED_PAYMENT_6900XXXX_YYYYMMDD.csv

ENC_BASED_PAYMENT_6900XXXX_YYYYMMDD_RETURN.csv

Report Distribution

The encounter based payment report is posted to the MCO SFTP server directory weekly by Tuesday morning if the MCO had any qualifying encounters processed the prior week. The encounter based payment return report, when required, is posted to the MCO SFTP server directory upon completion. MCO(s) are required to pay their providers the enhancement or indicate that the Department should recoup and submit the return report to the Department within 30 days of receiving the encounter based payment report.

Encounter Based Payment Questions

Questions concerning encounter based payments should be directed to MCO Support via email at VEDSHMOSupport@wisconsin.gov.

Guide and File Layout Location

The Encounter Based Payment Guide can be found on the ForwardHealth portal at:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/ManagedCareLogin.aspx

The encounter based payment report file layout can be found on the HMO Report Matrix at:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm.spage

The file layout can also be found on later pages of this guide.

Encounter Response File

All encounters which appear on the Encounter Based Payment Report will also appear on the weekly encounter response file. The ICN or ADJ-ICN described in Appendix 1 allows the MCO to link the file to the report. For enhanced payments to be distributed to providers by the MCO, only the encounter BASE-PAID-AMT appears on the encounter response file. For enhanced payments to be retained by the MCO, the full pricing appears on the encounter response file.

Encounter Based Payment - Adjustments

The following encounter based payment logic applies to adjustments:

- A voided encounter that originally was included on the encounter based payment report again appears on the encounter based payment report with the same values, except that the PAYABLE-AMT is negative.
- An adjusted encounter that results in a daughter ineligible for increased pricing when the mother was results in the previously eligible mother again appearing on the encounter based payment report with the same values, except that the PAYABLE-AMT is negative.
- An adjusted encounter that results in a daughter being eligible for increased pricing when the mother was also results in the eligible mother again appearing on the encounter based payment report with the same values, except that the PAYABLE-AMT is negative. The daughter appears on the encounter based payment report and includes the mother ICN in Field ADJ-ICN.
- An adjusted encounter that results in a daughter being eligible for the dental pilot increased pricing when the mother was not results in the daughter appearing on the encounter based payment report with the mother ICN in Field ADJ-ICN.

Encounter Based Payment File Layout

Encounter Based Payment Layout

The majority of the information provided on the encounter based payment report, including the billing tax identification, is the information submitted by the MCO on the encounter. The following fields are populated by the Department and vary in use depending on the reason for the encounter based payment. Specific expected values can be found on later pages of this guide. A full encounter based payment file layout is included in this guide as Appendix 1.

Field Name	Description
RSN-CDE	Reason code for the financial transaction being applied
RSN-CDE-DESC	Reason code description for the financial transaction applied to the encounter
BASE-PAID-AMT	The base fee schedule payment amount for the encounter built into the capitation rate
ENH-PAID-AMT	Value added payment amount
PAYABLE-AMT	The amount to be paid out for the given encounter detail, value added payment amount less the based payment amount (ENH-PAID-AMT – BASE-PAID-AMT)
HMO-RETURN-REQ	Indication based on reason code whether the MCO needs to report back their value added payment information A Y value indicates the MCO is required to submit the encounter based payment return report.

Encounter Based Payment Return Layout

The values for the first four fields can be taken from the encounter based payment report. The other two fields report on the distribution of the encounter based payment. A full encounter based payment file layout is included in this guide as Appendix 2.

Field Name	Description
DISTRIBUTED INDICATOR	Fields values are Y/N. A "Y" should be the default value as it indicates that the Department should not recoup the payment. A "N" value will cause the original payment to be automatically recouped as the MCO was unable to make payment to the provider
AMOUNT DISTRIBUTED	Value added payment distributed to the provider

Encounter Based Payment – Dental Pilot

Dental Pilot Introduction

The 2015-2017 Wisconsin State Budget (2015 Wisconsin Act 55) was enacted to create a Medicaid dental pilot program with the goal of increasing the number of dentists in Brown, Marathon, Polk and Racine counties. The dental pilot program increases reimbursement rates for pediatric dental care and adult emergency dental services provided in the pilot counties. The difference between the base rate for these services included in the capitation rate and the increased reimbursement is the encounter based payment.

Dental providers eligible for the increased reimbursement are identified in the weekly Certified Provider Listing as follows:

Field 30 Value Added Payment Start - Date which the provider was first eligible to receive payment

Field 31 Value Added Payment End Date - Date which the provider is no longer eligible to receive payment

Field 34 Eligible for Value Added Payment - Indicates what type of value added payment the provider is eligible to receive (Dental Pilot 0128)

The complete Certified Provider Listing layout is found on the HMO report matrix at https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm.spage.

Resources for the dental pilot program, including rates for orthodontic and manually priced services, are available on the Managed Care portal at https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage#rfeds.

Encounter Based Payment Fields – Dental Pilot

The following file fields vary in use depending on the reason for the encounter based payment. Specific expected values for Dental Pilot are below.

RSN-CDE: 0128
RSN-CDE-DESC: Dental Enhancement
BASE-PAID-AMT: The fee-for-service reimbursement amount
ENH-PAID-AMT: The enhanced reimbursement amount
PAYABLE-AMT: ENH-PAID-AMT less BASE-PAID-AMT
HMO-RETURN-REQ: Y

An HMO-RETURN-REQ value of Y (yes) indicates that the encounter based payment return report is required.

Encounter Based Payment Logic – Dental Pilot

The following encounter based payment logic applies to the Dental Pilot project:

- The MCO reports payment or shadow pricing at the detail to be qualify for dental pilot rate.
- Non-DNTL Benefit Adjustment Factors are applied to the base and dental pilot rates.
- DNTL Benefit Adjustment Factors are applied to the base rate but not the dental pilot rate.
- If the base rate is higher than the dental pilot rate, pricing is at the higher base rate and services are not included on the encounter based payment report.
- The dental pilot rate is cut back to the amount billed.
- Other insurance and member copay is deducted from the dental pilot rate.
- Member copay is based on the base rate.

Encounter Based Payment – SSI Care Coordination

SSI Care Coordination Introduction

Effective 1/1/2017, the department is paying MCOs outside of the capitation payment for member care coordination. MCOs submit encounters for services they provide. The MCO is the biller for the services. For more information on the SSI Care Coordination project, refer to the user guide at https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage#ssicmbg.

Encounter Based Payment Fields – SSI Care Coordination

The following file fields vary in use depending on the reason for the encounter based payment. Specific expected values for SSI Care Coordination are below.

RSN-CDE: 0437
RSN-CDE-DESC: SSI Care Management
BASE-PAID-AMT: 0.00
ENH-PAID-AMT: The fee-for-service reimbursement amount
PAYABLE-AMT: The fee-for-service reimbursement amount
HMO-RETURN-REQ: N

An HMO-RETURN-REQ value of N (no) indicates that the encounter based payment return report is not required. MCOs void ICNs for which recoupment is required, for example because a member was retroactively dis-enrolled.

Encounter Based Payment – LARC

LARC Introduction

The Department implemented a change in pricing methodology for hospital inpatient MCO encounters with a Date of Discharge, or To Date of Service, on or after January 1, 2017 from the Medicare Severity Diagnosis Related Group (MS-DRG) to the All Patient Refined Diagnosis Related Group (APR DRG).

Included in the APR DRG implementation was a change to inpatient and inpatient crossover hospital pricing policy to improve the availability and acceptability of LARCs (long-acting reversible contraceptives) for women by providing reimbursement for the insertion of an IUD or implant immediately postpartum.

Encounter Based Payment Fields – LARC

The following file fields vary in use depending on the reason for the encounter based payment. Specific expected values for LARC are below.

RSN-CDE: 0438
RSN-CDE-DESC: Managed Care - LARC Enhancement
BASE-PAID-AMT: APR-DRG payment amount less $721.87*
ENH-PAID-AMT: APR-DRG payment amount plus $721.87*
PAYABLE-AMT: $721.87
HMO-RETURN-REQ: N

An HMO-RETURN-REQ value of N (no) indicates that the encounter based payment return report is not required.

*HMOs can also see any change in rates for LARC in these fields.

Encounter Based Payment Logic – LARC

The following encounter based payment logic applies to the LARC project:

- The LARC payment is applied after all member-related cutbacks to pricing (third party liability, copay).
- The MCO reports payment or shadow pricing at the header or detail to qualify for LARC payment.
- As shown in the table below, a combination of certain ICD-10 procedure codes, ICD-diagnosis codes and APR DRGs assigned by ForwardHealth is required to receive an add-on payment for providing a LARC immediately postpartum.

ICD-10 Procedure Codes	ICD-10 Diagnosis Codes	APR DRGs
0UH90HZ, 0UH97HZ	Z30430	540, 542, 545, 560, 564
0JHD3HZ, 0JHF3HZ, 0JHG3HZ, 0JHH3HZ, 0JHL3HZ, 0JHM3HZ, 0JHN3HZ, 0JHP3HZ	Z30017, Z30018, Z30019, Z3040, Z3046, Z3049	

Encounter Based Payment – HIV/AIDS

HIV/AIDS Introduction

The Affordable Care Act of 2010, Section 2703 created an optional Medicaid benefit that allows states to establish health homes to coordinate care for people who have chronic conditions. The goals of health homes are to improve health outcomes while lowering Medicaid costs, and to reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members.

Members must have a diagnosis of HIV and at least one other chronic condition, or be at risk of developing another chronic condition. Member participation in the health home is voluntary.

Wisconsin has used the flexibility allowed by federal law to designate AIDS Service Organizations (funded by the DHS under s. 252.12(2)(a)8, Wis. Stats., for purposes of providing life care services to members diagnosed with HIV infection) as health home providers. The AIDS Resource Center of Wisconsin (ARCW) is the only organization that meets this requirement. The designated health home provider has clinic locations in Dane, Kenosha, Brown, and Milwaukee counties. Reimbursable health home services are those provided in accordance with the ForwardHealth online handbook.

AIDS Resource Center of Wisconsin has only one billing location certified to provide service: NPI 1134367063, Taxonomy 251B00000X, Zip Code 53203-1802 (Milwaukee). No other locations are on file.

HMOs should work directly with ARCW to get all of the correct billing information necessary to assure submitted encounters are processed correctly.

HIV/AIDS Health Home Reimbursable Services – HIV/AIDS

HMOs are required to pay the health home provider for care coordination services provided in accordance with the policies stated in the ForwardHealth online handbook. HMOs must ensure there is no duplication with care coordination or disease management programs performed by the HMO. Payment under this arrangement is limited to the two health home activities listed below.

HMOs are required to use the following Healthcare Common Procedure Coding System (HCPCS) procedure codes for reporting AIDS/HIV Health Home services:

- S0280 (Medical home program, comprehensive care coordination and planning, initial plan). This code is used to report activities related to the initial assessment, care plan development, and comprehensive annual reassessments. Reimbursement is allowed for one billed unit per rolling year (365 days).

- S0281 (Medical home program, comprehensive care coordination and planning, maintenance of plan). This code is used to report activities related

to ongoing care coordination. Reimbursement is allowed for one billed unit per month.

HMOs must reimburse the health home provider at 100% of the Medicaid Max Fee schedule. HMOs are required to report the services noted above via the encounter data system. As these two services are reimbursed outside of the capitation payment, the associated encounters are excluded from the rate setting process.

ARCW is a Medicaid-enrolled provider in addition to serving as a health home. HMOs may choose to contract with them for additional medical care services including physician, dental, and behavioral health services. These additional services are not subject to the health home requirements or reimbursement policy.

Encounter Based Payment Fields – HIV/AIDS

The following file fields vary in use depending on the reason for the encounter based payment. Specific expected values for HIV/AIDS are below.

RSN-CDE: 0429
RSN-CDE-DESC: Managed Care HIV/AIDS
BASE-PAID-AMT: 0.00
ENH-PAID-AMT: The fee-for-service reimbursement amount
PAYABLE-AMT: The fee-for-service reimbursement amount
HMO-RETURN-REQ: N

An HMO-RETURN-REQ value of N (no) indicates that the encounter based payment return report is not required. MCOs void ICNs for which recoupment is required, for example because a member was retroactively dis-enrolled.

Encounter Based Payment Logic – HIV/AIDS

The following encounter based payment logic applies to HIV/AIDS:

- The MCO reports payment or shadow pricing at the detail to qualify for HIV/AIDS payment for Procedures S0280 and S0281.
- The HIV/AIDS rate is cut back to the amount billed.
- Other insurance is deducted from the HIV/AIDS rate.

Encounter Based Payment – Narcotic Treatment Services

Narcotic Treatment Services Introduction

Effective 1/1/2018 date of service (DOS), the department is paying MCOs outside of the capitation payment for member Narcotic Treatment Services (NTS) for 2018 DOS only. The table below defines NTS services covered by this policy.

Code	Brief Description	MHNTS Modifier	MHNTS PT/SP
H0001	AODA Assessment	HG	11/121 MH Substance Abuse/Licensed Psychotherapist with SAC 11/122 MH Substance Abuse/AODA Counselor 11/123 MH Substance Abuse/Certified Psychotherapist with SAC 52/532 Narcotic Treatment Service/Registered Alcohol and Drug Counselor (RADC)/NTS
H0003	AODA Screening	HG	52/160 Narcotic Treatment Service/Registered Nurse 52/161 Narcotic Treatment Service/Licensed Practical Nurse
H0020	Methadone Administration	HG	31/000 Physician 52/160 Narcotic Treatment Service/Registered Nurse 52/161 Narcotic Treatment Service/Licensed Practical Nurse
86580	Skin Test – Tuberculosis	HG	52/160 Narcotic Treatment Service/Registered Nurse 52/161 Narcotic Treatment Service/Licensed Practical Nurse
99001	HANDLING AND/OR CONVEYANCE OF SPECIMEN FOR TRANSFER FROM THE PATIENT IN OTHER THAN AN OFFICE TO A LABORATORY (DISTANCE MAY BE INDICATED)	HG	52/160 Narcotic Treatment Service/Registered Nurse 52/161 Narcotic Treatment Service/Licensed Practical Nurse

Encounter Based Payment Fields – Narcotic Treatment Services

The following file fields vary in use depending on the reason for the encounter based payment. Specific expected values for NTS are below.

RSN-CDE: 0432
RSN-CDE-DESC: Narcotic Treatment Services
BASE-PAID-AMT: 0.00
ENH-PAID-AMT: The fee-for-service reimbursement amount
PAYABLE-AMT: The fee-for-service reimbursement amount
HMO-RETURN-REQ: N

An HMO-RETURN-REQ value of N (no) indicates that the encounter based payment return report is not required. MCOs void ICNs for which recoupment is required, for example because a member was retroactively dis-enrolled.

Encounter Based Payment Logic – Narcotic Treatment Services

The following encounter based payment logic applies to NTS:

- The NTS payment is applied after all member-related cutbacks to pricing (third party liability, copay).
- The MCO reports payment or shadow pricing at the detail to qualify for NTS payment.
- NTS encounter details will be identified by Procedure Codes HCPCS H0001, H0003, H0020, 86580, 99001 – each with Modifier HG – under the Mental Health-Narcotic Treatment (MHNTS) contract.
- The logic only applies to 2018 DOS. Details with DOS ranges that include DOS outside of 2018 are priced or denied but not included in the encounter based payment report.
  Example 1: Detail DOS 12/30/2017-1/3/2018 – Entire detail is priced or denied but not included in the encounter based payment report.
  Example 2: Detail DOS 12/30/2018-1/3/2019 – Entire detail is priced or denied but not included in the encounter based payment report.
- In order to receive reimbursement via this report for services which occur around the start and end of 2018 MCOs will need to instruct providers to split the claim.

Appendix 1

Encounter Based Payment File Layout

Field/Column Heading	Description	Data Type	Length
HMO-ID	The Payee ID for the MCO	Number	8
BILL-PROV-ID	Billing Provider NPI used in the processing of the encounter	Number	15
BILL-PROV-TAXO	Taxonomy for the Billing Provider used in the processing of the encounter	Character	10
BILL-PROV-LST-NM	Billing Provider Last Name used in the processing of the encounter (Full name if business)	Character	60
BILL-PROV-FRST-NM	Billing Provider First Name used in the processing of the encounter	Character	35
BILL-PROV-TAX-ID	Billing Provider Tax ID submitted by the MCO on the 837	Character	9
BILL-PROV-ADDR-1	Billing Provider Physical street address line 1	Character	30
BILL-PROV-ADDR-2	Billing Provider Physical street address line 2	Character	30
BILL-PROV-CITY	Billing Provider City	Character	30
BILL-PROV-ST	Billing Provider State	Character	2
BILL-PROV-ZIP	Billing Provider Zip Code	Number	9
REND-PROV-ID	Rendering Provider ID used in the processing of the encounter	Number	15
REND-PROV-TAXO	Taxonomy for the Rendering Provider used in the processing of the encounter	Character	10
REND-PROV-LST-NM	Rendering Provider Last Name used in the processing of the encounter	Character	60
REND-PROV-FRST-NM	Rendering Provider First Name used in the processing of the encounter	Character	35
REND-PROV-ADDR-1	Rendering Provider Physical street address line 1	Character	30
REND-PROV-ADDR-2	Rendering Provider Physical street address line 2	Character	30
REND-PROV-CITY	Rendering Provider City	Character	30
REND-PROV-ST	Rendering Provider State	Character	2
REND-PROV-ZIP	Rendering Provider Zip Code	Character	9
RSN-CDE	Reason code for the financial transaction being applied	Character	4
RSN-CDE-DESC	Reason code description for the financial transaction applied to the encounter	Character	50
ICN	Internal claim identifier value for the encounter	Number	13
DTL-LN-NUM	Detail Line number for the encounter	Number	4
MBR-ID	The Member ID for the impacted encounter	Character	12
MBR-DOB	The date of birth for the member	Number	8
MBR-CNTY	County of residence at DOS for encounter	VarChar2	10
MBR-REGION	Rate Region at DOS for encounter	Character	50
PCN	Provider control number for the submitted encounter	VarChar2	38
PROC-CDE	Procedure code for the encounter detail	Character	6

PROC-CDE-DESC	Description for the procedure code on the encounter detail	Character	40
TOOTH-NUM	The number identifying the tooth for the service on the given encounter detail	Character	2
MOD-1	First Modifier code submitted on the given encounter detail	Character	2
MOD-2	Second Modifier code received on the given encounter detail	Character	2
REV-CDE	Revenue code on encounter detail	Number	4
REV-CDE-DESC	Revenue code description	VarChar2	200
DRG-CDE	DRG Code assigned to encounter	Character	4
EAPG-CDE	EAPG Code assigned to the encounter	Character	5
FDOS	The First Date of Service on the encounter detail	Number	8
ALLOW-UNIT	The number of allowed units for the given detail	Number	15
PAID-DTE	The date the encounter financial transaction was made	Number	8
RA-NUM	Remittance Advice # pertaining to this payment	Number	9
AR-NUM	A/R number applicable to this encounter (only populates on recoupments)	Character	13
TXN-NUM	Transaction number applicable to this encounter (only populates on payments)	Character	20
ADJ-ICN	The ICN for the mother encounter that has been adjusted (only populates on an adjusted encounter)	Number	13
HMO-PAID-AMT	The amount the MCO paid for the service	Number	10
BASE-PAID-AMT	The base fee schedule payment amount for the encounter built into the capitation rate	Number	10
ENH-PAID-AMT	Value added payment amount	Number	10
PAYABLE-AMT	The amount to be paid out for the given encounter detail, value added payment amount less the based payment amount (ENH-PAID-AMT – BASE-PAID-AMT)	Number	10
HMO-RETURN-REQ	Indication based on reason code whether the MCO needs to report back their value added payment information.	Character	1

Appendix 2

Encounter Based Payment Return File Layout

Field	Description	Data Type	Length
ICN	Claim Identifier Value	Number	13
PCN	Provider Control Number	Character	38
DTL NUM	Detail Line Number	Number	4
REASON CODE	Financial Reason Code for payment	Character	4
DISTRIBUTED INDICATOR	Fields values are Y/N. A "Y" should be the default value as it indicates that the Department should not recoup the payment. A "N" value will cause the original payment to be automatically recouped as the MCO was unable to make payment to the provider	Character	1
AMOUNT DISTRIBUTED	Value added payment distributed to the provider	Number	10