District of Columbia
Department of Health
Medical Assistance Administration
Medicaid Managed Care Organizations

Managed Care Organization (MCO)
Instruction Manual for
Encounter Data Submission

Prepared for:
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Medical Assistance Administration, Division of Managed Care
Washington, DC

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Instruction Manual for Encounter Data Submission

Documentation change control is maintained in this Manual through the use of the Change Control Table shown below. All changes made to this Manual after the creation date are noted along with the author, date, and reason for the change.

Change Control Table

Author of Change	Sections Changed	Description	Reason	Date
Sharon Jackson	Appendix A	Definitions	Order of definitions	July 28, 2006

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Overview

Introduction

The District of Columbia (District) Medical Assistance Administration (MAA) requires each health plan report all encounters that each participating health plan's providers have with the Medicaid Managed Care Program (MMCP). Encounters include all services delivered to enrolled beneficiaries, if the services are provided through a capitation or fee-for-service (FFS) arrangement. Historically, this reporting was conducted using proprietary electronic formats designed to accommodate data found in Uniform Billing-92 (UB-92) and Health Care Financing Administration-1500 (HCFA-1500) claim forms. The Health Insurance Portability and Accountability Act (HIPAA) legislation mandates that health care claims and related transactions be processed using standard electronic data interchange (EDI) format and content for covered entities. MAA has chosen to adopt these standards for managed care organization (MCO) encounter data reporting.

HIPAA Background

In August 1996, the United States Congress adopted the Health Insurance Portability and Accountability Act. The Act, known as HIPAA, includes administrative simplification components. The intent of the administrative simplification provisions of HIPAA is to improve the efficiency and effectiveness of health care systems by establishing standards for the electronic exchange of certain administrative and financial transactions and to protect the security and privacy of transmitted health information.

The regulation pertaining to transaction standards and code sets was adopted in August 2000. This regulation mandates the use of EDI standard transactions for many of the more common communications used in health care administration, as well as the use of standard code sets. The transaction standards and code sets regulation had an effective date of October 16, 2002. Subsequent legislation allowed the effective date to be extended to provide more time to covered entities to be fully compliant. Entities that

requested extensions to the effective date for transactions and code sets had until October 16, 2003 to implement the regulation.

There are three HIPAA-compliant 837 transactions: institutional, professional, and dental services. The transactions MCOs will use depend upon the type of service being reported. MCOs will use the 837 transaction formats to report their encounters. The table below shows some examples of specific types of encounters and the appropriate transaction MCOs should use for reporting:

Type of Service	837 Transaction
Acute Care Hospital	Institutional
Ambulance	Professional
Chiropractor	Professional
Dental	Dental
Durable Medical Equipment (DME)	Professional
Home Health	Professional
Hospice Services	Institutional
Long Term Care	Institutional
Physician	Professional

Prescription Drug Records: Still pending.

Encounter Definition

Encounters are records of medically-related services rendered by an MCO provider to a MAA beneficiary enrolled with the capitated MCO on the date of service. It includes all services for which the MCO has any financial liability to a provider. An encounter is comprised of the procedures(s) or service(s) rendered during the contact. Encounters include services rendered as FFS, as well as services rendered under a capitated vendor arrangement. Encounters for all incurred services in the MAA managed care benefit package must be reported. Referrals to services that are covered by another payer should not be reported. Encounter services include, but are not limited to:

- hospital services
- physician visits
- nursing visits
- surgical services
- anesthesia services
- laboratory tests
- radiology services
- DME
- dialysis center services
- nursing home services
- long-term care services

- physical therapy services
- EPSDT services
- case management services
- home health services
- pharmacy services
- dental services

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contractual Requirements

Section C.12.3.2 of the MCO contract requires Contractors to collect and submit service-specific encounter data in the appropriate HCFA-1500 or UB-92 format or an alternate format approved by MAA. The data is to be submitted electronically within seventy-five (75) days of the end of the month in which the service occurred, or as needed. The data shall include all services reimbursed by the MCO.

Rate Setting

The BBA requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the contract. In addition, CMS requires that rates be based upon at least one year of recent data, that is not more than five years old, in order to be accepted for use for payment. In order to achieve compliance by contract year 2005, it was necessary for MAA to begin collecting encounter data in 2004 from the Medicaid contracted, risk-sharing MCOs that provide services to the District Medicaid beneficiaries.

Quality Management and Improvement

MAA's managed care plan is a Medicaid waiver program partially funded by CMS. Encounter data is analyzed and used by CMS and MAA to evaluate program effectiveness and monitor quality of care, utilization levels and patterns, access to care, and to evaluate MCO performance. The utilization data from encounter records provides MAA with performance data and indicators. MAA will use this information to evaluate the performance of each contracted MCO and to audit the validity and accuracy of the reported measures per contract.

MCOs are required to generate and track performance measures, such as early identification of pregnancy and quality measures, including eye exams, routine diabetic testing, use of beta-blockers, and early and periodic screening, diagnosis, and treatment (EPSDT) or HealthCheck screenings. MAA will use the encounter data to validate the accuracy of MCO reporting to support continuous quality improvement.

Continuous quality improvement focuses on measuring and improving the quality of data available to MAA. Data from MCOs will continue to undergo data quality checks beyond the minimum criteria used in the edit process. The results of both the edits and ongoing data quality monitoring are combined to develop plan-specific data quality improvement plans (DQIPs).

Continuous Quality Improvement Plan for Oversight and Assessment of Medicaid Managed Care

According to the Balanced Budget Act (BBA) of 1997, a written strategy plan is required to serve as the guiding principles for assessing the quality, effectiveness, and efficiency of serves rendered to beneficiaries. The goal of the strategy plan is to purchase the best value health care and services for MAA beneficiaries, to improve access to service for underserved and vulnerable beneficiary populations, and to protect them from substandard care. The objectives of the plan are to assess, monitor, and measure the improvement in health care and behavioral health services provided directly or through referrals to Medicaid managed care beneficiaries, and to ensure the accuracy in claim payments for services rendered.

Medium for Collection

Under the current process for reporting encounters, encounters are accepted electronically into the ACS EDI Gateway, Inc. (ACS) Data Center in Tallahassee, Florida, where they are processed through various electronic systems for payment. As a gateway service, ACS provides connectivity to various health care plans and states where ACS is the fiscal agent. The current proprietary electronic formats are designed to accommodate data found in UB-92 and HCFA-1500 claim forms.

Effective October 1, 2003, on behalf of MAA, ACS will accept electronic encounters submitted by MCOs in an ANSI ASC X12N 837 Payer-to-Payer format. MCOs should follow the ACS ANSI X12N 837 Healthcare Claim Institutional, Professional, and Dental District MAA Companion Guides and MAA Supplemental Companion Guide instructions for submitting claims to ACS. ACS will notify the MCOs if any substituted electronic encounter submission will be required.

Implementation Date

ACS began accepting encounters in the 837 COB formats effective October 1, 2003. MCOs prepared to submit all claims incurred on or after that date in the required 837 Payer-to-Payer format.

MAA Responsibilities

MAA is responsible for administering the District's MMCP. Encounter data are an instrumental tool in that administrative effort. Administration includes data analysis, production of feedback and comparative reports to MCOs, data confidentiality, and the

contents of this Encounter Reporting Manual (Manual). Inquiries about the Manual may be made to:

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MAA is responsible for the oversight of the contract and activities of contractors and comparative analysis of Medicaid managed care encounter versus FFS claims data.

MAA encounter responsibilities include production and dissemination of the Manual, the initiation and ongoing discussion of data quality improvement with each MCO, and MCO training. MAA will update the Manual on a periodic basis. Revisions to the Manual are noted in each subsequent update.

ACS Responsibilities

ACS is under contract with the District to provide Medicaid Management Information System (MMIS) services, including the acceptance of electronic encounter reporting through ACS from the MCOs.

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. If the data fails payer-specific edits, the 824 Application Advice is returned to the submitter.

After encounter adjudication, an ANSI ASC X12N 835 Remittance Advice is delivered to the EDI Data Delivery (IDEX) System. ACS will also provide MCOs with MMIS encounter adjudication edit reports on monthly submissions through a web portal.

The ACS EDI Support Unit is available to help resolve transmission and production issues.

MCO Responsibilities

It is the MCO's responsibility to ensure accurate and complete encounter reporting from their providers.

MCOs must evaluate the adequacy of, and revise if necessary, the data collection instruments and processes being used by their providers. MCOs are responsible for ensuring that the appropriate Medicaid (MAA) or ACS-provided Proxy Identification Numbers are on each encounter.

Section C.12.3.2 of the MCO contract requires Contractors to collect and submit service-specific encounter data in the appropriate HCFA-1500 or UB-92 format or an alternate format approved by MAA. The data is to be submitted electronically within seventy-five (75) days of the end of the month in which the service occurred, or as needed. The data shall include all services reimbursed by the MCO. Adjustments to previous records that are deemed reparable denials by ACS are submitted in the next monthly cycle.

MCOs are expected to investigate the findings of DQIPs and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, MCOs must incorporate action steps into a Quality Strategy Outcomes Plan (QSOP). Any issues that are not fully addressed on a timely basis may be escalated into a corrective action plan (CAP). The CAP will include a listing of issues, responsible parties, and projected resolution dates.

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Companion Guides

Introduction

The HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats. Further, HIPAA has defined how each of these transactions is to be implemented. Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs). The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

The 837 formats to be used for MAA are the 837 Institutional, 837 Professional, and 837 Dental Provider-to-Payer-to-Payer Coordination of Benefits (COB) Model, as defined in the HIPAA IGs.

This Manual will not provide detailed instructions on how to map encounters from the health plans' systems to the 837 transactions. The 837 IGs contain most of the information needed by the MCOs to complete this mapping.

Health plans should create their 837 transactions for MAA using the HIPAA IG for Version 4010 of the ASC X12 837 transactions published in May 2000 with the accompanying Addenda from October 2002 (Professional 004010X098A1, Institutional 004010X096A1, and Dental 004010X097A1). These guides are available from the Washington Publishing Company.

Health plan Institutional, Professional, and Dental encounters are reported to MAA using the Provider-to-Payer-to-Payer COB Model of the 837 transaction set as defined in the corresponding IG.

For health plans that opt to prepare their own outbound EDI files (as opposed to using a clearinghouse), the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Plan (SNIP) website may prove helpful. The website at

http://www.wedi.org/snip/ is an excellent source for information on implementing transaction sets. The site contains information on several workgroups and white papers on various topics.

ACS Companion Guide

ACS provides EDI Gateway Services to MAA. The ACS State Health Care Clearinghouse (SHCH) validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. If the data fails payer-specific edits, the 824 Application Advice is returned to the submitter. The ACS Companion Guides can be found at http://www.acs-gcro.com. Follow the path to Medicaid Accounts, District of Columbia and select Companion Guides from the left hand menu.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional, and Dental) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/Insurance_40.asp. This guide outlines the procedures necessary for engaging in EDI with ACS and specifies data clarification, where applicable.

<<Place holder for the Pharmacy Submission information>>

MAA Supplemental Instructions

MAA requires MCOs to submit the Provider-to-Payer-to-Payer COB Model of the 837. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information) and 2430 (Service Line Adjudication Information). The 2330B (Other Payer information) is a required loop in the 837 COB format with the MCO as the other payer.

The reporting of financial data elements is required for encounter submissions effective October 1, 2003. Health plans should report adjudication information at the service level.

Financial Fields

The financial fields that MAA requests the MCOs to report include:

- Submitted Line Item Charge Amount,
- Approved (Allowed) Amount,
- Paid Amount, and
- Adjustment Amount.

Submitted Line Item Charge Amount — MCOs should report the provider's charge or billed amount. The value may be "000" if the MCO contract with the provider is

sub-capitated and the MCO permits zero as a charged amount. A value other than “000” is required when the contract arrangement is on a FFS basis. If the submitted charge is billed as “000”, the MMIS will calculate the payment amount as zero since MAA pays the lesser of the submitted charge or the calculated fee amount.

Approved (Allowed) Amount — MCOs should report their fee schedule amount or maximum allowed amount. If the MCO does not cover the specific service reported, the Approved Amount may be “000”. The MMIS will not currently store the approved amount in the claim record.

Paid Amount — If the MCO paid the provider for the service, the Paid Amount should reflect the amount paid. If the service was not covered by the health plan or was covered under a capitation arrangement, “000” is the appropriate Paid Amount. This amount is stored in the claim as a Third Party Liability (TPL) amount.

Adjustment Amount — If the Paid Amount reflects any adjustments to the Submitted Line Item Charge Amount, the adjustment amounts must be reported. Any time the charge amount does not equal the paid amount, the MCO is required to report both the Adjustment Amount and the adjustment reason code. The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

Professional Identifiers

MCOs are required to submit the provider’s MAA identifier, if the provider is a contracted MAA provider. If the provider is not a contracted MAA provider, MCOs must follow the ACS instructions to assign a “pseudo ID”. The pseudo ID are based on provider type and/or specialty. Failure to populate the rendering provider’s Medicaid ID or pseudo ID will result in an encounter rejection by EDI at the clearinghouse. These encounters are returned to the MCO on an 824 transaction. Failure to submit a correct MAA identifier or pseudo ID will result in an encounter denial. All encounters denied for reason of invalid ID are returned to MCOs for correction.

Additional information

Certain information may be required that is not routinely present on the UB-92 or HCFA-1500. In these circumstances, MCOs must obtain valid medical records to supplement the UB-92 or use logic from the paper claim to derive the required additional information.

Birth Weight

Birth weight is required on encounters for delivery services to report newborn’s birth weight when the value code is “54”. It may be necessary for the MCOs to crosswalk the diagnosis code from deliveries to populate the patient information for the birth weight. Birth weight is reported on the 837I transaction in Loop 2000B.

The following are diagnosis codes to birth weight cross-walk:

Diagnosis Code	Description	837I Loop 2000B
V21.30	Low birth weight status, unspecified	1,000
V21.31	Low birth weight status, less than 500 grams	250
V21.32	Low birth weight status, 500-999 grams	750
V21.33	Low birth weight status, 1,000-1,499 grams	1,250
V21.34	Low birth weight status, 1,500-1,999 grams	1,750
V21.35	Low birth weight status, 2,000-2,500 grams	2,250
764.x0 — 779.x0	Fifth digit classification — unspecified weight	1,000
764.x1 — 779.x1	Fifth digit classification — less than 500 grams	250
764.x2 — 779.x2	Fifth digit classification — 500-749 grams	675
764.x3 — 779.x3	Fifth digit classification — 750-999 grams	825
764.x4 — 779.x4	Fifth digit classification — 1,000-1,249 grams	1,075
764.x5 — 779.x5	Fifth digit classification — 1,250-1,499 grams	1,375
764.x6 — 779.x6	Fifth digit classification — 1,500-1,749 grams	1,625
764.x7 — 779.x7	Fifth digit classification — 1,750-1,999 grams	1,825
764.x8 — 779.x8	Fifth digit classification —2,000-2,499 grams	2,225
764.x9 — 779.x9	Fifth digit classification —2,500 grams and over	2,500

Newborn ID Usage

MCOs should submit baby's facility bill for the well child at the time of delivery using the mom's Medicaid ID. The baby's Medicaid ID is to be used on babies with extended stays (sick babies) past the mother's stay and on all aftercare and professional bills. MCOs are to hold the encounter until the newborn Medicaid ID can be obtained and submitted with the encounter.

Claim Type

The following provider types use 837D:

Provider Type	Description
22	DENTIST
23	DENTAL CLINIC

The following provider types use 837I:

Provider Type	Description
01	GENERAL HOSPITAL
03	PSYCHIATRIC HOSPITAL PUBLIC
05	AMBULATORY SURGICAL CENTER
07	NURSING FACILITY
08	ICF/MR
09	PSYCHIATRIC HOSPITAL PRIVATE
10	HOSPICE
14	LTAC HOSPITAL
19	EMERGENCY ACCESS HOSPITAL
29	HEMODIALYSIS CENTER FREESTAND

The following provider types use 837P:

Provider Type	Description
01	GENERAL HOSPITAL
02	REHABILITATION CENTER
03	PSYCHIATRIC HOSPITAL PUBLIC
06	RESIDENTIAL TREATMENT CENTERS
07	NURSING FACILITY
09	PSYCHIATRIC HOSPITAL PRIVATE
10	HOSPICE
11	DC SCHOOLS
13	HCBS WAIVER
14	LTAC HOSPITAL
15	PHYSICIAN MD SERVICES
16	PHYSICIAN DO SERVICES
17	PODIATRIST
18	NURSE PRACTITIONER
19	EMERGENCY ACCESS HOSPITAL

Provider Type	Description
20	CASE MANAGER
24	DHS CLINICS
25	AMBULANCE TRANSPORTATION
26	SCREENING CLINICS
27	OTHER MEDICAL TRANSPORTATION
28	INDEPENDENT XRAY
29	HEMODIALYSIS CENTER FREESTAND
30	INDEPENDENT LAB
31	RADIATION THERAPY CENTER
32	DAY TREATMENT
36	ADULT DAY CARE FACILITY
37	AUDIOLOGIST
38	HEARING AID DISPENSER
39	OPTOMETRIST
40	OPTICIAN
41	FAMILY PLANNING CLINIC
42	HOME HEALTH AGENCY
43	SPEECH/HEARING CLINIC
44	FEDERAL QUAL HEALTH CENTER
46	ALCOHOL/SUBSTANCE ABUSE CLINIC
47	MENTAL HEALTH CLINIC
48	DME PROVIDER
50	BIRTHING CENTER
51	COMMUNITY RESIDENTIAL FACILITY
52	PRIVATE CLINIC

** Note that most of the provider types that bill primarily with an 837I may also bill some services with an 837P.

Date Fields

For 837 required date fields that are not applicable to paper claims, MCOs are to populate the field with “19640101”.

Other Fields

For 837 required fields other than financial or date not applicable to paper claims, MCOs are to populate the field with “NA”.

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Denied Encounter Correction File Specifications

Introduction

Effective September 29, 2003, during MMIS encounter processing, data quality edits were applied which may result in a service line exception. The service line is stored in the MMIS, along with the service lines that passed all edits, but with a price of $0.00. Service lines that were priced at $0.00 will not be included in the rate setting. In order for the most complete data for rate setting, the MCO is to repair as many of the exceptions as possible.

Reparable Exceptions

The table below represents the exceptions that must be corrected by the MCOs. For a complete list of exceptions, see Appendix E of this Manual.

EXCEPTION CODE	EXCEPTION DESCRIPTION
112	FROM/THRU SPANS MONTHS
113	1ST DOS VS ADMIT DATE CONFLICT
114	INVALID DISCHARGE HOUR
115	INVALID DISCHARGE DATE
116	INVALID 1ST PROCEDURE CODE MODIFIER
117	INVALID 2ND, 3RD, 4TH PROCEDURE CODE MODIFIER
118	MISSING ANESTHESIA TIME
119	INVALID/MISSING ADMISSION TYPE
120	INVALID BILLING PROVIDER NUMBER
121	INVALID/MISSING PATIENT STATUS
122	INVALID PROVIDER NUMBER
124	MISSING DATE OF SERVICE

EXCEPTION CODE	EXCEPTION DESCRIPTION
125	INVALID BILLING PROVIDER CHECK DIGIT
126	1ST DOS GREAT THAN LAST DOS
129	MISSING BENEFICIARY NUMBER
130	INVALID/MISSING ADMIT HOUR
131	INVALID/MISSING ADMIT SOURCE
132	AMOUNT CHARGED MISSING
133	INPATIENT UNIT OF SERVICE ZERO
134	DUPLICATE MOUTH QUADRANT
135	BILLING PROVIDER NUMBER ZEROS
136	PROCEDURE INCOMPAT WITH DIAGNOSIS
138	INVALID TOB (FLD 4) UB-92
144	SERVICE DATE AFTER DATE RECEIVED
148	REVENUE CODE MISSING ON UB-92
157	INVALID TOOTH SURFACE
158	INVALID TOOTH NUMBER
161	INVALID TOOTH CHARACTER
162	TOOTH NUMBER & CHARACTER N/A
163	MISSING DIAGNOSIS CODE
164	INVALID MOUTH QUADRANT
167	INVALID/MISSING ADMIT DATE
170	MISSING/INVALID PLACE OF SERVICE
171	PROCEDURE CODE NOT VALID
172	INVALID/MISSING PROCEDURE CODE
173	INVALID LINE ITEM DATE-HOSPITAL
174	NEGATIVE LENGTH OF STAY
175	SURGERY AFTER BILLING DATE
183	REV 36X & 49X REQUIRE CPT SURGERY
184	RAD REV REQUIRES PROCEDURE
186	DOB AFTER FIRST DOS
188	1ST SURGERY DATE/STAY CONFLICT
189	2ND SURGERY DATE/STAY CONFLICT
190	3RD SURGERY DATE/STAY CONFLICT
191	4TH SURGERY DATE/STAY CONFLICT
192	5TH SURGERY DATE/STAY CONFLICT
193	6TH SURGERY DATE/STAY CONFLICT
196	1ST SURGICAL PROCEDURE MISSING

EXCEPTION CODE	EXCEPTION DESCRIPTION
197	INVALID 1ST SURGICAL PROCEDURE DATE
198	INVALID 2ND SURGICAL PROCEDURE DATE
199	INVALID 3RD SURGICAL PROCEDURE DATE
200	INVALID 4TH SURGICAL PROCEDURE DATE
202	INVALID 5TH SURGICAL PROCEDURE DATE
204	INVALID 6TH SURGICAL PROCEDURE DATE
205	PROCEDURE VALID FOR PERM TEETH ONLY
206	MISSING BIRTH WEIGHT
213	DUPLICATE TOOTH NUMBER OR SURFACE
244	BENEFICIARY DEATH BEFORE LAST DOS
250	BENEFICIARY NOT ON FILE
251	BENEFICIARY NOT ON FILE-CLAIM OVER 30 DAYS
300	BILLING PROVIDER NOT ON FILE
301	PROVIDER INELIGIBLE FOR CLAIM TYPE
306	MISSING TOOTH #/CHARACTER
307	MISSING TOOTH SURFACE
308	MOUTH QUADRANT MISSING
323	DIAGNOSIS/AGE CONFLICT
324	DIAGNOSIS/SEX CONFLICT
344	DIAGNOSIS NOT FOUND ON THE PDD FILE
347	REVENUE CODE NOT ON PDD FILE
365	PROCEDURE/PLACE OF SERVICE CONFLICT
367	PROCEDURE/TREAT PROVIDER TYPE CONFLICT
368	CLAIM TYPE FOR PROCEDURE INVALID
405	SURGERY PROCEDURE REQUIRES REVENUE CODE
410	TREATING PROVIDER MISSING
412	TREAT PROVIDER NUMBER NOT FOUND
420	INDEPENDENT LAB INVALID PROCEDURE MODIFIER
422	TREAT PROVIDER INELIGIBLE FOR DOS
424	BILL PROVIDER INELIGIBLE FOR SERVICE DATES
430	PROCEDURE CODE NOT ON PDD FILE
434	PROCEDURE CODE/AGE CONFLICT (applicable to medical claims)
435	PROCEDURE CODE/SEX CONFLICT
444	1ST DIAGNOSIS CODE NOT FOUND
445	1ST DIAGNOSIS CODE NOT COVERED
448	1ST DIAGNOSIS/AGE CONFLICT

EXCEPTION CODE	EXCEPTION DESCRIPTION
449	1ST DIAGNOSIS/SEX CONFLICT
452	2ND DIAGNOSIS CODE NOT FOUND
453	2ND DIAGNOSIS CODE NOT COVERED
456	2ND DIAGNOSIS/AGE CONFLICT
457	2ND DIAGNOSIS/SEX CONFLICT
460	3RD DIAGNOSIS CODE NOT FOUND
461	3RD DIAGNOSIS CODE NOT COVERED
464	3RD DIAGNOSIS/AGE CONFLICT
465	3RD DIAGNOSIS/SEX CONFLICT
468	4TH DIAGNOSIS CODE NOT FOUND
469	4TH DIAGNOSIS CODE NOT COVERED
472	4TH DIAGNOSIS/AGE CONFLICT
473	4TH DIAGNOSIS/SEX CONFLICT
476	5TH DIAGNOSIS CODE NOT FOUND
477	5TH DIAGNOSIS CODE NOT COVERED
480	5TH DIAGNOSIS/AGE CONFLICT
481	5TH DIAGNOSIS/SEX CONFLICT
484	6TH DIAGNOSIS CODE NOT FOUND
485	6TH DIAGNOSIS CODE NOT COVERED
488	6TH DIAGNOSIS/AGE CONFLICT
489	6TH DIAGNOSIS/SEX CONFLICT
492	7TH DIAGNOSIS CODE NOT FOUND
493	7TH DIAGNOSIS CODE NOT COVERED
496	7TH DIAGNOSIS/AGE CONFLICT
497	7TH DIAGNOSIS/SEX CONFLICT
521	8TH DIAGNOSIS NOT FOUND
522	8TH DIAGNOSIS CODE NOT COVERED
525	8TH DIAGNOSIS/AGE CONFLICT
526	8TH DIAGNOSIS/SEX CONFLICT
529	9TH DIAGNOSIS CODE NOT FOUND
530	9TH DIAGNOSIS CODE NOT COVERED
533	9TH DIAGNOSIS/AGE CONFLICT
534	9TH DIAGNOSIS/SEX CONFLICT
537	1ST SURGERY PROCEDURE NOT FOUND
538	1ST SURGERY PROCEDURE NOT COVERED
541	1ST SURGERY PROCEDURE/AGE CONFLICT

EXCEPTION CODE	EXCEPTION DESCRIPTION
542	1ST SURGERY PROCEDURE/SEX CONFLICT
545	2ND SURGERY PROCEDURE NOT FOUND
546	2ND SURGERY PROCEDURE NOT COVERED
549	2ND SURGERY PROCEDURE/AGE CONFLICT
550	2ND SURGERY PROCEDURE/SEX CONFLICT
552	3RD SURGERY PROCEDURE NOT FOUND
553	3RD SURGERY PROCEDURE NOT COVERED
556	3RD SURGERY PROCEDURE/AGE CONFLICT
557	3RD SURGERY PROCEDURE/SEX CONFLICT
559	4TH SURGERY PROCEDURE NOT FOUND
560	4TH SURGERY PROCEDURE NOT COVERED
563	4TH SURGERY PROCEDURE/AGE CONFLICT
564	4TH SURGERY PROCEDURE/SEX CONFLICT
566	5TH SURGERY PROCEDURE NOT FOUND
567	5TH SURGERY PROCEDURE NOT COVERED
570	5TH SURGERY PROCEDURE/AGE CONFLICT
571	5TH SURGERY PROCEDURE/SEX CONFLICT
573	6TH SURGERY PROCEDURE CODE NOT FOUND
574	6TH SURGERY PROCEDURE CODE NOT COVERED
577	6TH SURGERY PROCEDURE/AGE CONFLICT
578	6TH PROCEDURE/SEX CONFLICT
583	MULTIPLE ANESTHESIA
599	LINE NUMBERS NOT SEQUENTIAL
840	ADJUSTMENT IS IN PROCEDURES
841	TCN TO CREDIT OR ADJ IS BUSY
842	NO MATCH ON BENEFICIARY ID
843	NO MATCH ON PROVIDER NUMBER
850	NO PAID CLAIM FOR ADJUSTMENT/CREDIT
894	TOO MANY ADJUSTMENTS
899	TOO MANY EXCEPTIONS POSTED TO CLAIM

Encounter Correction Process

ACS will send the reports to the MCOs the day after they are produced by the MMIS adjudication cycle via the web. The MCOs are required to submit corrections at the next submission cycle.

Resubmissions

MCOs are required to correct encounters before resubmission. There are two options available for resubmission of the denied exception:

1. Make the correction to the service line(s) to which a reparable exception was applied and resend the entire original encounter with the service line correction as an adjustment with a void for the original Transaction Control Number (TCN). See Section 7 of this Manual for the service line correction process.

2. The second option is for the MCO to make the exception correction by establishing a new original encounter for only the service line on which a reparable exception occurred.

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Transaction Testing and Certification

Introduction

The intake of encounter data from each of the contracted MCOs is treated as HIPAA compliant transactions by Medicaid and ACS. As such, MCOs are required to undergo Trading Partner testing with ACS prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, MCOs are requested to send real transmission data. ACS does not define the number of encounters in the transmission; however, MAA requires a minimum of twenty-five (25) encounters for each claim type. Encounters are to include a representative number of provider types.

If a MCO rendering contracted provider has a valid Medicaid Provider Number (MPN), the MPN must be submitted in loops 2310B and 2420A of the 837. If the provider does not have a valid MPN, the MCO must assign one of the ACS provider numbers, as outlined in Appendix F of this Manual.

MCOs are responsible for assigning numbers based on provider types. Prior to testing, MCOs must supply documentation from their systems confirming the matching of provider type and ACS provider number.

Test Process

The ACS Companion Guides and enrollment forms can be found at http://www.acs-gcro.com. Follow the path to Medicaid, District of Columbia and select the appropriate item from the left hand menu. After completing and returning the enrollment package to ACS, MCOs are assigned a Trading Partner Logon Name and Logon User ID. Trading Partners will contact ACS to schedule a testing schedule and complete their EDIFECS enrollment.

Trading Partners will have access to the EDIFECS website to submit X12 test files for analysis. EDIFECS will analyze each test file based on the seven (7) levels of testing defined by WEDI SNIP. Testing Partners will correct any errors prior to testing with ACS. EDIFECS also provides HIPAADesk, a free on-line testing application available to the District. Please refer to the ACS Companion Guides to obtain instructions for obtaining a free copy of HIPAADesk.

When submitting test files, MCOs will insert a "T" in data element 15 of the ISA segment of the envelope. At the SHCH, ACS validates submission of ANSI X12 format(s). The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid Trading Partner relationship. If the file contains syntactical error(s), the segments and elements where the errors occurred are reported in a 997 Functional Acknowledgement. If the data fails payer-specific edits, an 824 Application Advice is returned to the submitter.

Payer-specific edits can be obtained from the ACS Companion Guides. Supplemental instructions are included in Section 2 of this Manual. The ACS Companion Guides can be found at http://www.acs-gcro.com. The ACS Client Integration Testing Support Unit can be reached at 1 850 558 1630.

A test plan with step-by-step account of the ACS, Inc. plan for testing the ASC X12N 837 COB and 835 electronic transaction sets for use in submitting encounter data for storage in the MMIS claims history file. The plan consists of three (3) tiers of testing, which are outlined in detail in Appendix G.

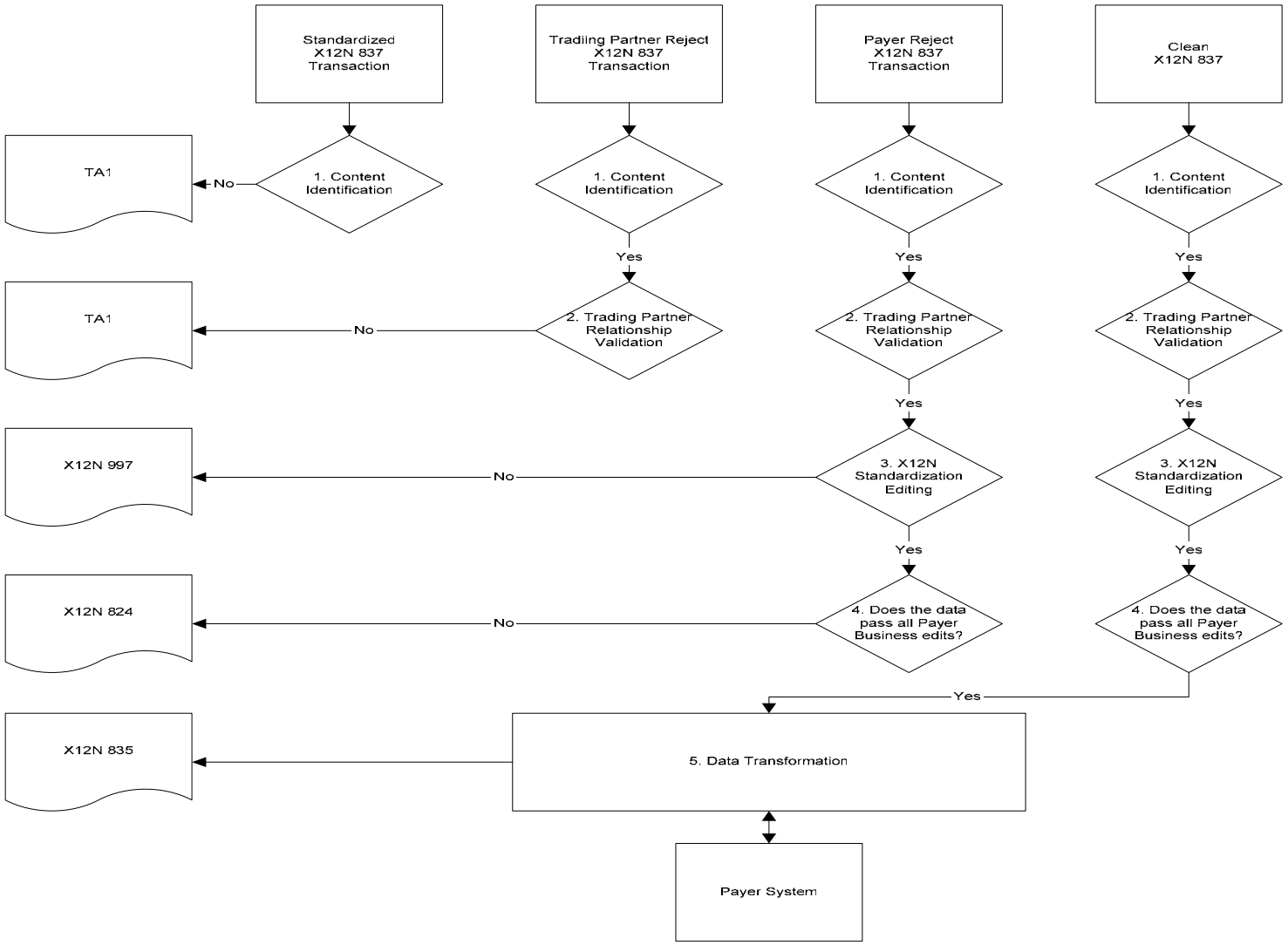
Timing

MCOs may initiate testing at any time. ACS Business Support Analysts are ready to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please reference the ACS Companion Guides for specific instructions.

Editing and Validation Flow Diagram

The following process flow chart depicts an incoming ANSW ASC X12N 837 transaction validation for syntax at the ACS SHCH.

Editing and Validation Flow:



Data Certification[1]

The Balanced Budget Act of 1997 (BBA) requires that when State payments to an MCO are based on data that is submitted by the MCO, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. Encounter files submitted by the MCOs are used to create payments and/or capitated rates are certified by a completed, signed Health Plan Data Certification (HPDC) form. A completed, signed form is required to accompany each encounter submission the data must be certified by one of the following individuals:

(1) The MCO's Chief Executive Officer,
(2) The MCO's Chief Financial Officer, or
(3) An individual who has delegated authority to sign for, and who reports directly to the MCO's Chief Executive Officer or Chief Financial Officer.

Data Certification for All Other Required Data

All other data or information submitted by the MCOs and used to create payments and/or capitated rates are certified by a completed, signed Health Plan Data Certification (HPDC) form. A completed, signed form is required to accompany each document submission in order to provide concurrent attestation.

[1] CFR 42 § 438.604 - Data that must be certified; CFR § 438.606 - Source, content, and timing of certification.

5

Data Management and Error Correction Process

Introduction

Encounter data is submitted through the ACS EDI Gateway. The ACS EDI Gateway provides an interactive menu-driven bulletin board system (BBS) for file uploading. Confirmation of the status of the transfer is also obtained through the BBS. Various alternative modes for data receipt may be made available, but may involve connectivity issues and additional expenses. Once received, 837 transactions are subject to initial edits. Further edits are applied during MMIS encounter processing.

Rejection Criteria

Incoming 837s may be rejected either at the SHCH or during the MMIS encounter processing. At SHCH, there are four levels where edits (data validation processes) are present. Rejection of an entire batch or a single encounter is designated by the edit level in which the error occurs. Line level errors may occur at the MMIS. MAA will require MCOs to correct certain MMIS line level errors.

Entire File

Each transaction contains four levels where edit (data validation) processes are present. Rejection of an entire batch is designated by the edit level in which the error occurs. Interchange Level Errors will result in the rejection of an entire batch and the generation of a TA1 Rejection Report.

The TA1 is an ANSI ASC X12N Interchange Acknowledgement segment that is used to report receipt of individual envelopes. An interchange envelope contains the sender, receiver, and data type information for the header. If the syntactical analysis of the interchange header and trailer is invalid, the interchange will reject and a TA1 will be forwarded to the ACS Call Center. In this scenario, the entire transaction is rejected at the header level. MCOs are notified of such errors by ACS Business Support Analysts.

Once the transaction has passed interchange edits, it should be subject to transaction set syntax errors. If the error occurs at the ST or SE level segments, the entire transaction is rejected. These edits are reported on the ANSI ASC X12N 997.

Claim

Transactions with errors at the ST or SE level segments are rejected in their entirety. However, if the functional group consists of additional transactions without errors, these transactions are processed. The 997 transaction contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or elements(s) where the error(s) occurred are reported.

Once the transaction has passed through syntactical edits, the transaction is edited according to implementation guide rule sets and payer-specific requirements. Any errors that occur at this level will result in the data content within that encounter being rejected. The ANSI ASC X12N 824 may be used to report those errors.

Service Line

Data that passes ACS edits will proceed to the data transformation step for processing. In this step, certain data elements are converted into a format that is acceptable for claims processing. During processing, the MMIS will apply standard edits to the encounters. Depending upon the level of edit, an individual encounter may reject at the header or at a single detailed line.

A full listing of encounter edits is contained in Appendix E. After processing, an ANSI ASC X12N 835 Remittance Advice is returned to the sender.

Error Correction Process

MCOs are required to correct and resubmit any transactions or encounters that are rejected in their entirety. For service line rejections, MCOs are required to correct and resubmit errors that are known to be “reparable”. A list of reparable denials is contained in Section 3 of this Manual.

Entire File

MCOs will receive either a TA1 or X12N 997 error report. MCOs are required to work with ACS Business Support Analysts to determine the cause of the error.

Claim

MCOs will receive either an X12N 824 for claim level rejections. MCOs are responsible for adherence to the implementation guide, code sets, and looping structures for the transaction. MCOs will also be responsible for adhering to the MAA payer-specific data rules, as defined in Chapter 5 of the ACS Companion Guide and Section 2 of this Manual.

Service Line

MCOs will receive an X12N 835 for transaction claims that have processed through the MMIS. If the service line fails MMIS encounter edits, an adjustment reason code, adjustment amount, and adjustment quantity are returned in the CAS segment of loop 2110.

This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

Each adjustment reason is associated with a particular MMIS exception. MCOs are presented with an exception report to assist them in identifying reparable errors. Reparable errors resulting in service line denials will not be included in data for rate setting purposes. MCOs are responsible for correcting and resubmitting service line denials. All corrected service lines are included in data for rate setting.

Outstanding Issues

After implementing the data management and error correction process and any processing error(s) remaining unresolved, the MCO may present the outstanding issue(s) to ACS, Mercer, and MAA for clarification or resolution. These parties will review the issue(s) and transmit to the appropriate entity for resolution, and respond to the MCO with their findings. If the outcome is not agreeable to the MCO, the MCO can re-submit the outstanding issue(s) to ACS, Mercer, and MAA for reconsideration. The final outcome determined by these entities will prevail.

Grievances

An MCO may believe that a rejected encounter is the result of an "ACS error." ACS error is defined as a rejected encounter that (1) ACS acknowledges to be the result of its own error, and (2) requires a change to the system programming, an update to MMIS reference tables, or further research by ACS, and therefore requires ACS resolution to process the rejection.

An MCO must notify MAA in writing within a 30-calendar day timeframe if it believes that the resolution of a rejected encounter rests on ACS rather than the MCO. ACS will respond in writing within 30 days of receipt of such notification. MAA encourages MCOs to provide written notice as soon as possible. The ACS response will identify the status of each rejected encounter problem or issue in question.

For ease in filing written requests, MCOs may use the Exception Reports provided by ACS. The MCO should highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

ACS will review the MCO's notification and may ask the MCO to research the issue and provide additional substantiating documentation, or ACS may disagree with the MCO's claim of ACS error. If a rejected encounter being researched by ACS is later determined to not be caused by ACS error, the MCO will be required to make corrections to the encounter, if appropriate, and resubmit during the next billing cycle.

MCOs have the right to file a grievance regarding rejected encounters. Grievances must be filed in a timely manner.

6

Continuous Quality Improvement

Introduction

In accordance with the Balance Budget Act of 1997, MAA developed a quality strategy plan that serves as the guiding principles for the establishment of quality improvement efforts for the MCOs. Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from MCOs will continue to undergo data quality checks beyond the minimum criteria used in the MMIS edit process. The result of edits and data quality improvement monitoring are combined to develop plan-specific DQIPs. Interim monitoring and follow-up on identified quality problem areas is an integral component of MAA's encounter process.

The DQIP is designed to provide MAA and the MCO with a comprehensive list of data quality issues present in the data for a given period at the time of the report. MAA will meet with MCOs every three (3) months, or as needed. The DQIPs are sent to MCOs in advance of the meeting.

At the site visit, the MCO is expected to have investigated the findings of DQIPs and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, MCOs must incorporate action steps into a corrective action plan (CAP). The CAP should include a listing of issues, responsible parties, and projected resolution dates.

Minimum Standards

There are two components to encounter data quality assessment: ACS Reparable Denial and Pay-and-Report Edits and Data Volume Assessment.

ACS Reparable Denial and Pay-and-Report Edits

Pay-and-Report Edit summaries are provided to MAA and MCOs at the end of each

encounter reporting cycle. These are edits for items priced through the MMIS, but reported to MAA as questionable. Examples include non-covered items of surgery on the same day as an office visit and high usage of procedure codes ending in 99.

Data Volume Assessment

Data Volume Assessment refers to the evaluation of whether key services meet expected rates of provision, as demonstrated in the data. This is important to decide whether plans are submitting data and, ultimately, whether the actual level of services are adequate to meet contractual requirements, justify capitation rates, and provide appropriate access to care for the enrolled population. A core audit function includes determining whether MAA has all of the encounter data generated for a specific period.

To perform Data Volume Assessment, MAA will construct several rate-based measures representing each of the core health care service types represented in the data. These include:

- Hospital Admissions/1,000,
- Hospital Days/1,000,
- Average Length of Stay,
- Average Physician Encounters/Beneficiary/Year,
- Average Ambulatory Visits/Beneficiary/Year, and
- Prescriptions Dispensed/Beneficiary/Month.

MAA will construct discharges and visits from the data to approximate the units of analysis in the selected benchmarks and constructed rates based on 1,000/beneficiary months or beneficiary years. MAA will compare MCO rates to industry commercial, Medicare, and Medicaid benchmarks.

7

Void/Cancel and Replacement

Introduction

In the case of adjustments, MCOs are required to submit a void and replacement of the entire claim identified by the TCN. The MMIS will not process line level corrections. Detailed, payer-specific instructions are provided in the ACS Companion Guides found at www.acs-gcro.com. Follow the path to Medicaid, District of Columbia and select Companion Guides. Below are the most recently published instructions for encounter void and replacement.

Void/Cancel and Replacement Instructions

Loop	Segment	Data Element	Comments
2300	CLM05-3	1325	Claim Frequency Type Code To correct or void a previously submitted claim, "**X**" for Encounter Void/Cancel of Prior Claim. See also 2300/REF02.
2300	REF01	128	Reference Identification Qualifier To cancel or adjust a previously submitted claim, submit "**F8**" to identify the Original Reference Number.
2300	REF02	127	Original Reference Number To cancel or adjust a previously submitted claim, please submit the **17-digit TCN** assigned by the adjudication system and printed on the remittance advice, for the previously submitted claim that is being replaced or voided by this claim.

Appendix A

Definitions

Term	Definition
Automated Client Eligibility Determination System (ACEDS)	The information system maintained by the District to document Medicaid claims payment and service provisions.
ACS EDI Gateway, Inc. (ACS)	ACS is under contract with the District to provide MMIS services, including the acceptance of electronic encounter reporting through the ACS EDI Gateway from the MCOs.
Adjudicated Encounter File	An encounter file produced by an MCO, which includes all encounter records adjudicated during the current encounter cycle. Adjudicated claims are claims that have been processed to payment or denial.
Beneficiary	A person eligible to receive medical and/or behavioral health services.
Beneficiary Month	One enrollee who is enrolled in the MMCP for one month.
Capitation Rate	The monthly rate per enrollee, fixed annually in advance, paid by MAA to a contracted managed care plan for managing the services described in the contracted Evidence of Coverage, whether or not the enrollee receives services during the period covered by the rate.
Care Management System	In this document, refers to an organized system for managing the medical and/or mental health and alcohol and drug abuse care of enrollees with complex care needs, including a primary care physician's (PCP) responsibility for providing and managing primary care, an EPSDT tracking system, a utilization management system with special procedures for high cost/high-risk cases, and care coordination.
Child and Adolescent Supplemental Security Income Program (CASSIP)	Child and Adolescent Supplemental Security Income (SSI) or SSI-related Plans.

Term	Definition
Centers for Medicare and Medicaid Services (CMS)	The CMS is an organization within the Department of Health and Human Services (DHHS), which has oversight responsibilities for the MAA program, including encounter reporting.
Child	In this document, refers to children and adolescents ages 0 through 21, eligible for Medicaid and/or enrolled in a MMCP.
Children's Health Insurance Program (CHIP)	Passed as part of the BBA, the CHIP provides health insurance for children who come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance.
Children with Special Health Care Needs	Those children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by children generally. This definition includes children on SSI or who are SSI-related eligibles.
Claim	A bill from a provider of a medical service or product that is assigned a unique identifier (i.e., claim reference number). A claim does not include an encounter form for which no payment is made or only a nominal payment is made.
Clean Claim	Claim submitted on an approved claim form, and containing complete and accurate information for all data fields required by the Contractor and MAA for final adjudication of the claim. If information that is not included on the claim form is necessary for adjudication of a claim, then such additional information shall be submitted as required in order for the claim to be considered "clean".
Complaints	An issue an enrollee or provider presents to the MCO, either in written or oral form, which is subject to resolution by the Contractor, their designee, and/or MAA.
Contractor	A MCO participating in the District's MMCP authorized, under DC Code Sec. 1-359(d).
Covered Services	Health care services that the Contractor shall provide to enrollees, including all services required by this contract and state and federal law, and all additional services described by the Contractor in its response to the Request for Proposal (RFP) for this contract.
Continuous Quality Improvement (CQI)	Methods to identify opportunities for improving organizational performance: identify causes of poor performance, design and test interventions, and implement demonstrably successful interventions system-wide.
Corrective Action Plan (CAP)	As data issues are discussed, MCOs must incorporate action steps into a CAP. The CAP should include a listing of issues, responsible parties, and projected resolution dates.
Covered Services	Health care services provided to enrollees, which includes all services required under contract, state, and federal law, and all additional services described by the MCO in response to the RFP for the contract.

Term	Definition
Data Quality Improvement Plan (DQIP)	The result of edits and data quality improvement monitoring that is combined to develop plan-specific data quality improvement plans.
Denial of Services	Any determination made by the Contractor in response to a provider's request for approval to provide MAA-covered services of a specific duration and scope which: disapproves the request completely; approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; or disapproves provision of the requested service(s), but approves provision of an alternative service(s). An approval of a requested service which includes a requirement for a concurrent review by the Contractor during the authorized period does not constitute a denial.
Denied Claim	An adjudicated claim that does not result in a payment obligation to a provider.
Denied Encounter Correction File	An encounter file submitted by an MCO to ACS containing encounter records that had previously been submitted and had failed the edits and audits process.
Denied Encounter File	An encounter 835 file produced by ACS for MCOs containing encounter records that have failed ACS MMIS edits and audits process and have been denied.
Denial Reports	Monthly reports generated by ACS summarizing the encounter denials.
Denied Service Line	A claim line accepted into the MMIS that does not pass MMIS edits. The claim line is priced at $0.00.
Disenrollment	Action taken by the MAA to remove a beneficiary’s name from the monthly Enrollment Report following the MAA’s receipt of a determination that the beneficiary is no longer eligible for enrollment.
District	Refers to the Government of the District of Columbia.
Diagnostic and Statistical Manual of Mental Disorders, Forth Edition (DSM-IV)	The DMS-IV is the American Psychiatric Association’s official classification of mental, alcohol, and drug abuse disorders.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The pediatric component of the Medicaid program created and implemented by federal statute and regulations. This program establishes standards of care for children and adolescents under age 21, calling for regular screening and for the services needed to prevent, diagnose, correct, or ameliorate a physical or mental illness, including alcohol and drug abuse, or condition identified through screening. Medicaid services for children are required as a matter of law to meet these standards, which may require that services outside traditional Medicaid benefits be provided, when needed, to treat such conditions.
Eligibility Period	A period of time during which a consumer is eligible to receive MAA benefits. An eligibility period is indicated by the eligibility start and end date.

Term	Definition
Eligibility Verification System (EVS)	The information system maintained by the District Income Maintenance Administration that allows providers to verify eligibility status of Medicaid beneficiaries.
Encounter	An encounter is defined as any health care service provided to a beneficiary, whether reimbursed through FFS or another method of compensation, which shall result in the creation of an encounter record to MAA. The information provided on these records represents the encounter provided by the MCO.
Encounter Data	An encounter is defined as any health care service provided to a beneficiary. Encounters, whether reimbursed through capitation, FFS, or another method of compensation, shall result in the creation and submission of an encounter record to the MAA. The information provided on these records represents the encounter data provided by the Contractor.
Encounter Edits and Audits	ACS system processing checks that evaluate submitted encounter data for syntax, format, data quality problems, and duplicate records.
Encounter Reporting Formats	Reference guides for MCOs required to submit encounter data to ACS in standard claims formats. The type of claim formats used to submit encounter records. The required formats are as follows: ▪ 837 Dental (837D); ▪ 837 Professional (837P); ▪ 837 Institutional (837I); and ▪ NCPDP 5.1 Retail Pharmacy.
Encounter Submission	The monthly processing of encounter data performed by ACS, which includes receipt of new and correction encounter files, encounter processing, and distribution of Adjudicated and Denied Correction 835 files to MCOs.
Encounter Submission Requirements	Encounter submission requirements, as stated in Section C.12.3.2 of the contract. “The Contractor shall collect and submit service-specific encounter data in a HCFA-1500 or UB-92 format or an alternative format, if approved by MAA. The data shall be submitted electronically within 75 days of the end of the month in which the service occurs, or as needed. The data shall include all services reimbursed by the MCO”.
Enrollee	A person eligible for the District’s Medicaid program who is enrolled in a MMCP contracted health plan or CASSIP.
Enrollment	The process by which a beneficiary’s entitlement to receive services from a Contractor are initiated.
Enrollment Broker	The Contractor that provides assistance to Medicaid eligibles in the selection of a health plan. The same Contractor will offer a 24-hour helpline to answer Medicaid beneficiaries’ questions about participating in their health plans.

Term	Definition
External Quality Review (EQR)	A requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with MCOs, including the evaluation of quality outcomes, timeliness, and access to services.
Fee-For-Service (FFS)	Payment to providers on a per-service basis for health care services.
Fraud	An intentional deception, misrepresentation, or concealment of the facts made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or another person. It includes any act that constitutes fraud under applicable federal or state law.
Generally Accepted Accounting Principles (GAAP)	A technical term in financial accounting. It encompasses the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time. This includes not only broad guidelines of general application, but also detailed practices and procedures.
Health Maintenance Organization (HMO)	A District-licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled beneficiaries for a fixed, prepaid fee.
HIPAA	Health Insurance Portability and Accountability Act of 1996.
HIPAA Transaction	Transaction standards mandate that health care claims and related transactions be processed using standard “EDI” format and content with an effective date of October 16, 2003. The ANSI ASC X12N HIPAA standard transactions for electronic data interchange are: ▪ 837 (I, P, and D) health claims (or equivalent encounter information); ▪ 834 health plan enrollment and disenrollment; ▪ 270/271 health plan eligibility; ▪ 835 health care payment and remittance advice; ▪ 820 health plan premium payments; and ▪ 276/277 referral certification and authorization.
Involuntary Disenrollment	The termination of membership of an enrollee under conditions permitted in this agreement.
Managed Care Organization (MCO)	MCO is the term used to represent those plans participating in the 1915(b) MMCP, as well as the CASSIP program.
Managed Care Eligibles	District residents who have been determined eligible for Medicaid in an eligibility category that requires them to participate in a MMCP by enrolling in a health plan.
Medicaid Management Information System (MMIS)	Computerized or other system for collection, analysis, and reporting of information needed to support management activities.

Term	Definition
Medicaid	A program established by Title XIX of the Social Security Act which provides payment of medical expenses for eligible persons who meet income and/or other criteria.
Medicaid Managed Care Program (MMCP)	A program for the provision and management of specified Medicaid services through contracted HMOs. MMCP was established pursuant to the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1992 (DC Law 9-247, DC Code Section 1-359), as amended.
Medical Assistance Administration (MAA)	The administration within the District Department of Health responsible for administering all Medicaid services under Title XIX (Medicaid) for eligible beneficiaries, including the MMCP and oversight of its managed care contractors.
Network	Means all contracted or employed providers in the health plans that are providing covered services to beneficiaries.
Network Provider	Health and mental health services provider who is an individual or organization selected and under contract with a specific contractor.
Original Transaction Control Number (TCN)	The TCN of the originally submitted claim. The original TCN must be submitted on claims with claim frequency type code value 7 or 8 (replacement or prior claim or void/cancel of a prior claim).
Out-of-Network Provider	A health, mental health, alcohol or drug abuse individual or organization that does not have a written provider agreement with a Contractor and therefore, not included or identified as being in the Contractor's network.
Primary Care Physician (PCP)	A board-certified or board-eligible physician who has a contract with a managed care plan to provide necessary well care, diagnostic, and primary care services, and to manage covered benefits for enrollees in his or her caseload. A physician with a specialty of pediatrics, obstetrics/gynecology, internal medicine, family medicine, or any other specialty the Contractor designates from time to time may serve as a PCP.
Prior Authorization	A determination made by a Contractor to approve or deny a provider's or enrollee's request to provide a service or course of treatment of a specific duration and scope to an enrollee prior to the provision of the service. (See also "Service Authorization".)
Provider	An individual or organization that delivers medical, dental, rehabilitation, or mental health services.
Provider File	A monthly file produced by MAA for MCOs with information regarding all MAA registered providers.
Pseudo ID	A provider type-specific provider ID created by ACS for assignment to providers who do not have an MAA provider ID.
Quality Improvement	Methods to identify opportunities for improving organizational performance: identify causes of poor performance, design and test interventions, and implement demonstrably successful interventions system-wide.
Reference File	A monthly file produced by MAA for MCOs with information regarding service coverage and FFS payment rates.

Term	Definition
Reparable Denials	Denials that are to be corrected and resubmitted to ACS.
Section 1915(b) Waiver	A statutory provision of Medicaid that allows a state to partially limit the freedom of choice by consumers of Medicaid-eligible services or that waives the requirements under Title XIX, the Medicaid Act, for state wideness of a plan or comparability of benefits.
Start Date	The first date that consumers are eligible for medical services under the operational contract, and on which the Contractors are operationally responsible and financially liable for providing medically necessary services to consumers.
Supplemental Security Income (SSI)	A Medicaid category of assistance for blind or disabled individuals who are eligible for federal SSI benefits and Medicaid.
SSI-Related	A Medicaid category, which includes, but is not limited to, the same requirements as the corresponding category of SSI. Persons who receive Medicaid in SSI-Related categories may include, but are not limited to, aged, blind, or disabled, and people determined to be medically needy.
Temporary Assistance for Needy Families (TANF)	Federally funded program that assists single-parent families with children who meet the categorical requirements for aid. TANF eligibles also qualify for Medicaid coverage.
TANF-related Individuals	Persons who qualify for Medicaid and whose family incomes do not exceed 200 percent of federal poverty level (FPL). TANF-related eligibility is determined by the District's State Medicaid Plan or federal law (including medically needy and transitional Medicaid).
Third Party Liability (TPL)	Insurance policy or other form of coverage with responsibility to pay for certain health services for a Medicaid-eligible, in addition to Medicaid. Includes commercial health insurance, worker's compensation, casualty, torts, and estates. These sources shall be used to offset the costs of Medicaid services.
Title XVIII (Medicare)	A federally-financed health insurance program administered by the CMS, covering almost all Americans 65 years old and older and certain individuals under 65 who are disabled or have chronic kidney disease. The program provides protection with an acute care focus under two parts: (1) Part A covers inpatient hospital services, post-hospital care in skilled nursing facilities, and care in patients' homes, and (2) Part B covers primarily physician and other outpatient services.
Transportation Services	Mode of transportation that can suitably meet enrollee's medical needs. Acceptable forms of providing transportation include, but are not limited to, provision of bus, subway, or taxi vouchers; wheel chair vans, and ambulances.
Trading Partner ID	A 6-digit ID number assigned by ACS for each submitter of encounter data. A Transmission Submitter may be an MCO or a vendor under contract to an MCO.

Term	Definition
Transaction Control Number (TCN)	A unique 17-digit number assigned to each encounter record by ASC for tracking purposes. The first five numbers of the TCN contains the Julian Date, which reflects the date of receipt of the encounter file that contained the encounter record.

Appendix B

Frequently Asked Questions (FAQs)

What is HIPAA and how does it pertain to MCOs?

The Administrative Simplification provisions of HIPAA, Title II, include requirements that national standards be established for electronic health care transactions. These standards are being adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of EDI in health care. MAA has chosen to adopt these standards for MCO encounter data reporting.

What is ACS and what is their role with MCOs?

ACS provides functions and services to receive and send ANSI ASC X12N transactions on behalf of their clients, including the MAA.

We understand that ACS will no longer accept electronic proprietary claims formats from MCOs. What claim format is required and when will it go into effect?

ACS will not accept proprietary claims formats after October 1, 2003. After that time, all claims with dates of service on or after October 1, 2003, are submitted via an 837 Payer-to-Payer COB transaction.

Is there more than one 837 format? Which should I use?

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services. The transactions MCOs will use will depend upon the type of service being reported. Further instructions can be found in Section 2 of this Manual.

Whom do I contact if I have a question regarding the EDI Information Sheet or need technical assistance concerning electronic claim submission?

You may contact the ACS EDI Support Unit Monday through Friday, from 8:00 a.m. to 5:00 p.m. EST, at 1 866 775 8563.

I am preparing for testing with ACS. Whom do I contact for more information?

For answers to questions regarding specifications and testing, please contact our EDI Business Support Analysts at 1 850 201 1171.

Will MAA provide us with a paper or electronic remittance advice?

ACS will provide MCOs with an electronic 835 Health Care Claim Payment/Advice.

Where can I find HIPAA code lists, including the Claim Adjustment Reason Codes and Remittance Remark Codes, which appear in the 835 Health Care Claim?

The Claim Adjustment Reason Codes provide the “explanation” for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 835.

The Remittance Remark Codes are used in the 835 to relay informational messages that cannot be expressed with a Claim Adjustment Reason Code. These codes are all nationally mandated codes that must be used by payers in conjunction with the 835.

Payers may no longer use the proprietary codes that they used prior to HIPAA, even if the proprietary codes give better details about how a claim was adjudicated.

HIPAA code lists can be found on the Washington Publishing Company’s website at http://www.wpc-edi.com/codes/.

We understand that MAA will not require the taxonomy code to process the 837 COB. Is this correct?

Yes, that is correct. MAA does not require the taxonomy code to process a claim. However, the taxonomy code is a "Situational" data element in some of the X12 Implementation Guides. Submitters must send all "Required" data elements or the claim is considered non-compliant. Payers are prohibited from accepting non-compliant claims.

Does MAA require provider type information to process a claim? If so, how do we communicate that information?

Yes, MAA does require provider type to process a claim. ACS retains the provider type for each Medicaid provider in the provider file.

If an MCO rendering contracted provider has a valid Medicaid Provider Number, the Medicaid Provider Number must be submitted in loops 2310B and 2410A of the 837. If the provider does not have a valid Medicaid Provider Number, the MCO must assign one of the ACS provider numbers listed in Appendix F.

MCOs are responsible for assigning numbers based on the provider types. The MMIS will deny encounters with invalid provider type/procedure code combinations. MCOs are responsible for correcting and resubmitting encounters denied for reason of inappropriate provider number assignment.

Does ACS have any payer-specific instructions for 837 COB transactions?

Yes, the ACS Companion Guides contain a number of payer-specific instructions for 837 transactions. The ACS Companion Guides can be found at www.acs-gcro.com. Once on the ACS website, select Medicaid, District of Columbia and choose Companion Guides. There are separate companion guides for each of the 837 transactions.

What is a Trading Partner ID?

The Trading Partner ID is a 6-digit ID number assigned by ACS for each submitter of encounter data. You are assigned this ID prior to testing.

Why must MCOs submit encounter data?

The reasons why MCOs are required to submit encounter data are as follows:

1. Contractual Requirements: Section C.12.3.2 of the MCO contract requires Contractors to collect and submit service-specific encounter data in a format approved by MAA. The data is to be submitted electronically within 75 days of the end of the month in which the service occurred, or as needed. The data shall include all services reimbursed by the MCO.

2. Rate Setting: The BBA requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the contract. In addition, CMS requires that rates be based upon at least one year of recent data, that is not more than five years old, in order to be accepted for use for payment. In order to achieve compliance by contract year 2005, it should be necessary for MAA to begin collecting encounter data from the Medicaid contracted, risk-sharing MCOs that provide services to the District Medicaid beneficiaries.

3. Utilization Review and Clinical Quality Improvement: MAA's managed care plan is a Medicaid waiver program partially funded by CMS. Encounter data are analyzed and used by CMS and MAA to evaluate program effectiveness and monitor quality of care, utilization levels and patterns, access to care, and to evaluate MCO performance. The utilization data from encounter records provides MAA with performance data and indicators. MAA will use this information to evaluate the performance of each contracted MCO and to audit the validity and accuracy of the reported measures per contract.

Appendix C

Code Sets and Local Code Cross-Walks

The use of standard code sets will improve the effectiveness and efficiency of Medicaid, Federal, and other private health programs through system administration simplification and efficient electronic transmission of certain health information. *Code set* means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A *code set* includes the codes and the descriptors of the codes.

When conducting 837 transactions, MAA requires MCOs to adhere to HIPAA standards governing Medical data code sets. Specifically, MCOs must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. MCOs are also required to use the non-medical data code sets, as described in the IGs that are valid at the time the transaction is initiated.

For service dates beginning October 1, 2003, MAA required MCOs to adopt the following standards for Medical code sets:

A. International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:

   - diseases;
   - injuries;
   - impairments;
   - other health problems and their manifestations; and
   - causes of injury, disease, impairment, or other health problems.

B. ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals:

- prevention,
- diagnosis,
- treatment, and
- management.

C. National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:

   - drugs and
   - biologics.

D. Current Dental Terminology (CDT) Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA) for dental services.

E. The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by DHHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. These services include, but are not limited to, the following:

   - physician services,
   - physical and occupational therapy services,
   - radiological procedures,
   - clinical laboratory tests,
   - other medical diagnostic procedures,
   - hearing and vision services, and
   - transportation services, including ambulance.

F. The HCPCS, as maintained and distributed by DHHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

   - medical supplies,
   - orthotic and prosthetic devices, and
   - durable medical equipment.

MAA has historically used HCPCS Level III “local” procedure codes for their own purposes. For service dates beginning October 1, 2003, the MAA will not process claims containing local codes. MCO providers who are currently submitting claims using MAA local codes must adhere to the new code standards. MCOs are responsible for communicating these standards with their contracted providers.

Appendix D

System Generated Reports

The over arching purpose of this set of reports is to enhance the quality of the encounter data by providing MAA and the submitting MCO with a basic accuracy and completeness assessment of each claim after each encounter cycle in order that preliminary corrections and repairs can be conducted and the encounter resubmitted to ACS. These reports will take advantage of the existing MMIS reporting capacity for claims data. However, the reports are altered, as necessary, to enhance their usefulness in depicting encounter data errors.

Encounter data is submitted through the ACS EDI Gateway and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in summary and reparable exceptions reports and a summary report of the encounter data submitted. These exceptions edits are listed in Appendix E of this Manual. Those exception edits that assess encounters to be reparable for correction and resubmission by the MCO are found in Section 6 of this Manual.

The following reports are generated by the MMIS system and have been selected specifically to provide each MCO with useful information that, when compared with the ASC X12N 835 Remittance Advice for the specific encounter, will provide a complete explanation for the exception. A second set of reports that focus more closely on the overall quality of the data will also be created from the encounter data. These reports and the process for Data Quality Assessment are discussed in Section 7 of this Manual. These quality reports will also depict accuracy and completeness at a volume and utilization level. Please refer to these reports, as outlined in Section 7.

ASC X12N 835

As discussed above, and in Section 6, MCOs will receive an X12N 835 for transaction encounter claim data that have been processed through the MMIS. Adjustment reason code, adjustment amount, and adjustment quantity are returned via the CAS segment of loop 2110 if the service line fails MMIS encounter errors. CAS segments are also created

for cutbacks to the submitted charge for fee schedule reductions, etc. All encounter data denials, including those that are reparable, are represented in the X12N 835. TCNs are assigned by claim and can be located in the X12N 835 specific to the encounter. Please refer to Section 6 for more information regarding X12N 835 transaction reporting.

Encounter Claims Summary — ACS Report DCMC0710-R001

This report will serve as the high-level error report for the MCOs as a summarization of the errors incurred. The format, as depicted below, is by claim type. This report will produce the overall claim count with the disposition of MMIS paid or denied status occurrence and overall percentage. The number and percent to be denied represent all denials, reparable or not.

DCMC0710-R001 DISTRICT OF COLUMBIA MEDICAL ASSISTANCE ADMINISTRATION PAGE 1
AS OF *MM/DD/YY* MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE *MM/DD/YY*
ENCOUNTER CLAIMS SUMMARY REPORT
MCO NAME HERE.

CLAIM TYPE	CLAIM DESC	CLAIM COUNT	# TO BE PAID	% TO BE PAID	# TO BE DENIED	% TO BE DENIED	# TO PAY-BUT-RPT	% TO PAY-BUT-RPT
D	DENTAL	317	206	64	111	35	0	0
I	INPATIENT	83	80	96	3	3	0	0
M	PRACTITIONER	1,109	951	85	99	8	59	5
O	OUTPATIENT	1,032	0	0	1,032	100	0	0
		2,541	1,237	0	1,245	0	59	0

Encounter Exception Disposition Summary — ACS Report DCMC0712-R001

This report will serve as the high-level edit report for the MCOs as a summarization of the exceptions incurred. The format, as depicted below, is by claim type. This report will produce the overall exception disposition, exception code, and the number of exceptions from the submission.

DCMC0712-R001 DISTRICT OF COLUMBIA MEDICAL ASSISTANCE ADMINISTRATION PAGE 1
AS OF *MM/DD/YY* MEDICAID MANAGEMENT INFORMATION SYSTEM DATE *MM/DD/YY*
ENCOUNTER EXCEPTION DISPOSITION SUMMARY
MCO NAME HERE

EXCEPTION DISPOSITION	CLAIM TYPE	CLAIM DESC	EXCP CODE	SHORT DESCRIPTION	NUM OF EXCEP
DENY	D	DENTAL	101	EXACT DUPLICATE CLAIM	133
DENY	D	DENTAL	205	PROC VALID FOR PERM TEETH ONLY	54
DENY	D	DENTAL	252	RECIP ID/NAME MISMATCH	7
DENY	D	DENTAL	271	RECIP INELIG FOR SVCS DATE(S)	7
DENY	D			687	
DENY	M	PRACTITIONER	252	RECIP ID/NAME MISMATCH	19
DENY	M	PRACTITIONER	302	INELIGIBLE PROVIDER COS	4
DENY	M	PRACTITIONER	365	PROC/PLACE OF SVC CONFLICT	3
DENY	M	PRACTITIONER	434	PROC CODE/AGE CONFLICT	18
	M			44	
PAY/REPORT	M	PRACTITIONER	366	PROC CODE/SPECIALTY CONFLICT	71
PAY/REPORT	M	PRACTITIONER	440	PROC REQ MED REV FOR SVC DATE	11
	M			82	
PAY	D	DENTAL	218	SERVICE COVERED BY HMO	1,295
PAY	D	DENTAL	352	BILLED AMT DEVIA FROM NORM-LO	34
PAY	D	DENTAL	423	TREAT PROV NOT MEM OF GROUP	317
PAY	D	DENTAL	436	PROC/REVENUE REQUIRE PR AUTH	4
	D			1,650	
PAY	M	PRACTITIONER	104	MULTI SURG REQ REVIEW.	12
PAY	M	PRACTITIONER	203	REF. PROV UPIN IS REQ - PT	286
PAY	M	PRACTITIONER	265	TPL ON RECIP FILE NOT ON CLAIM	40
PAY	M	PRACTITIONER	423	TREAT PROV NOT MEM OF GROUP	1,899
	M			2,237	
TOTAL NUMBER OF EXCEPTIONS				4,700	

Reparable Exceptions and Pay-but-Report Detail — ACS Report DCMC0714-R001

This report lists encounters that are denied or have a pay-but-report edits within the MMIS for encounter data contained in each submission cycle. Some of the denied edits are reparable. Refer to Section 4 of the Manual for a listing of reparable edits. It is a detailed listing by line item of the edits applied to the encounter data.

DCMC0714-R001 DISTRICT OF COLUMBIA MEDICAL ASSISTANCE ADMINISTRATION PAGE 1
AS OF *MM/DD/YY* MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE *MM/DD/YY*
REPARABLE EXCEPTIONS AND PAY-BUT-REPORT DETAIL
MCO NAME HERE.

CLAIM STATUS	CLM TYP	TRANSACTION CONTROL NUMBER	HEADER/ LINE CD	RECIP ID	PROVIDER NUMBER	DATES OF SERVICE FIRST	DATES OF SERVICE LAST	MCO PAID AMOUNT	BILLED CHARGE	EXCEPTIONS
PATIENT ACCOUNT NUMBER: *MCOICN53*										
DENIED	M	60424300865000027	00	70099993	024700300	10/06/03	10/14/03	.00	108.00	427
			01	70099993	024700300	10/06/03	10/14/03	.00	54.00	128 218 423 364 101 859
			02	70099993	024700300	10/06/03	10/14/03	.00	54.00	128 163 218 423 364 859

NUMBER OF HEADER/LINE : 3

Appendix E

Encounter Edits

In order for data to be useful, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All encounter data submitted to the MMIS are subject to edits.

Encounter data edits can have one of the following results:

1. the data passes all edits and is accepted into the MMIS and priced, per MAA guidelines;
2. the data contains a minor exception(s) — an information report is generated and the data is accepted into the MMIS and priced at $0.00; or
3. the data contains a fatal error that results in its rejection.

For encounters containing a minor exception(s), ACS will report exceptions from the edit process to the MCOs. Encounters may generate one or more of the following exceptions. Please see Section 6 of this Manual for the exceptions that are reparable for correction and resubmission by the MCO.

EXCEPTION CODE	EXCEPTION DESCRIPTION
089	PROCEDURE CODE CONTRAINDICATION
101	EXACT DUPLICATE CLAIM
108	SURGERY SAME DOS AS PAID NONSURGERY
109	COVERED BY SURGERY FOLLOW UP
110	NONSURGERY CLAIM AND SURGERY PAID
111	VISIT AND SURGERY SAME DAY
112	FROM/THRU SPANS MONTHS
113	1ST DOS VS ADMIT DATE CONFLICT

EXCEPTION CODE	EXCEPTION DESCRIPTION
114	INVALID DISCHARGE HOUR
115	INVALID DISCHARGE DATE
116	INVALID1ST PROCEDURE CODE MODIFIER
117	INVALID 2ND, 3RD, 4TH PROCEDURE CODE MODIFIER
118	MISSING ANESTHESIA TIME
119	INVALID/MISSING ADMISSION TYPE
120	INVALID BILLING PROVIDER NUMBER
121	INVALID/MISSING PATIENT STATUS
122	INVALID PROVIDER NUMBER
124	MISSING DATE OF SERVICE
125	INVALID BILLING PROVIDER CHECK DIGIT
126	1ST DOS GREAT THAN LAST DOS
129	MISSING BENEFICIARY NUMBER
130	INVALID/MISSING ADMIT HOUR
131	INVALID/MISSING ADMIT SOURCE
132	AMOUNT CHARGED MISSING
133	INPATIENT UNIT OF SERVICE ZERO
134	DUPLICATE MOUTH QUADRANT
135	BILLING PROVIDER NUMBER ZEROS
136	PROCEDURE INCOMPAT WITH DIAGNOSIS
138	INVALID TOB (FLD 4)-UB92
144	SERVICE DATE AFTER DATE RECEIVED
148	REVENUE CODE MISSING ON UB-92
156	MULTIPLE OUTPATIENT VISITS
157	INVALID TOOTH SURFACE
158	INVALID TOOTH NUMBER
161	INVALID TOOTH CHARACTER
162	TOOTH NUMBER & CHARACTER N/A
163	MISSING DIAGNOSIS CODE
164	INVALID MOUTH QUADRANT
167	INVALID/MISSING ADM DATE
170	MISSING/INVALID PLACE OF SERV
171	PROCEDURE CODE NOT VALID
172	INVALID PROCEDURE CODE
173	INVALID LINE ITEM DATE-HOSPITAL
174	NEGATIVE LENGTH OF STAY

EXCEPTION CODE	EXCEPTION DESCRIPTION
175	SURGERY AFTER BILLING DATE
183	REV 36X & 49X REQ CPT SURG
184	RADIOLOGY REVENUE REQUIRES PROCEDURE
186	DOB AFTER FIRST DOS
188	1ST SURGERY DATE/STAY CONFLICT
189	2ND SURGERY DATE/STAY CONFLICT
190	3RD SURGERY DATE/STAY CONFLICT
191	4TH SURGERY DATE/STAY CONFLICT
192	5TH SURGERY DATE/STAY CONFLICT
193	6TH SURGERY DATE/STAY CONFLICT
196	1ST SURGICAL PROCEDURE MISSING
197	INVALID 1ST SURGICAL PROCEDURE DATE
198	INVALID 2ND SURGICAL PROCEDURE DATE
199	INVALID 3RD SURGICAL PROCEDURE DATE
200	INVALID 4TH SURGICAL PROCEDURE DATE
202	INVALID 5TH SURGICAL PROCEDURE DATE
204	INVALID 6TH SURGICAL PROCEDURE DATE
205	PROCEDURE VALID FOR PERM TEETH ONLY
206	MISSING BIRTH WEIGHT
208	NURSING HOME INVALID CALC DAYS VS BILL
213	DUPLICATE TOOTH NUMBER OR SURFACE
217	UNABLE TO PRICE MODIFIER
222	UNGROUPABLE DRG
225	NO DRG HOSPITAL RATE
226	NO DRG RECORD
227	NO INTERIM BILLING FOR DRG
229	INVALID TAXONOMY
236	MEDICARE ELIGIBLE/NOT CROSS-OVER
244	BENEFICIARY DEATH BEFORE LAST DOS
250	BENEFICIARY NOT ON FILE
251	BENEFICIARY NOT ON FILE-CLAIM OVER 30 DAYS
252	BENEFICIARY ID/NAME MISMATCH
270	BENEFICIARY INELIGIBLE FOR DOS, CLM >30 DAY
271	BENEFICIARY INELIG FOR SERVICES DATE(S)
272	CLAIM DATES OLDER THAN 7 YRS
277	INPT PSYCH-BENEFICIARY OVER 22

EXCEPTION CODE	EXCEPTION DESCRIPTION
278	CHIP BENEFICIARY OVER AGE 19
300	BILLING PROVIDER NOT ON FILE
301	PROVIDER INELIG FOR CLAIM TYPE
302	INELIGIBLE PROVIDER COS
305	INPATIENT RESPITE CARE > 5 UNIT
306	MISSING TOOTH #/CHARACTER
307	MISSING TOOTH SURFACE
308	MOUTH QUADRANT MISSING
313	UNABLE TO DETERMINE CATEGORY OF SERVICE
322	PROCEDURE NOT COVERED ON WEEKEND
323	DIAGNOSIS/AGE CONFLICT
324	DIAGNOSIS/SEX CONFLICT
344	DIAGNOSIS NOT FOUND ON THE PDD FILE
345	INVALID DIAGNOSIS CODE
347	REVENUE CODE NOT ON PDD FILE
361	ONLY ONE 50 MODIFIER ALLOWED
362	1ST PROCEDURE CODE MODIFIER CONFLICT
363	2ND PROCEDURE CODE MODIFIER CONFLICT
365	PROCEDURE/PLACE OF SERVICE CONFLICT
367	PROCEDURE/TREAT PROVIDER TYPE CONFLICT
368	CLAIM TYPE FOR PROCEDURE INVALID
381	NO PROVIDER RATE
405	SURGERY PROCEDURE REQUIRES REVENUE CODE
410	TREATING PROVIDER MISSING
411	BILLING PROVIDER IS UNDER REVIEW
412	TREAT PROVIDER NUMBER NOT FOUND
413	TREAT PROVIDER UNDER REVIEW
420	INDEPENDENT LAB INVALID PROCEDURE MODIFIER
422	TREAT PROVIDER INELIGIBLE FOR DOS
424	BILL PROVIDER INELIGIBLE FOR SERVICE DATES
430	PROCEDURE CODE NOT ON PDD FILE
431	PROCEDURE/REVENUE CODE IS NOT COVERED
434	PROCEDURE CODE/AGE CONFLICT
435	PROCEDURE CODE/SEX CONFLICT
437	NO PROCEDURE/REVENUE PRICING SPAN
438	PROCEDURE REQUIRES MANUAL PRICE FOR SERVICE DATE

EXCEPTION CODE	EXCEPTION DESCRIPTION
439	PROCEDURE NOT ALLWED FOR SERVICE DATE
440	PROCEDURE REQUIRES MEDICAL REVIEW FOR SERVICE DATE
444	1ST DIAGNOSIS CODE NOT FOUND
445	1ST DIAGNOSIS CODE NOT COVERED
448	1ST DIAGNOSIS/AGE CONFLICT
449	1ST DIAGNOSIS/SEX CONFLICT
452	2ND DIAGNOSIS CODE NOT FOUND
453	2ND DIAGNOSIS CODE NOT COVERED
456	2ND DIAGNOSIS/AGE CONFLICT
457	2ND DIAGNOSIS/SEX CONFLICT
460	3RD DIAGNOSIS CODE NOT FOUND
461	3RD DIAGNOSIS CODE NOT COVERED
464	3RD DIAGNOSIS/AGE CONFLICT
465	3RD DIAGNOSIS/SEX CONFLICT
468	4TH DIAGNOSIS CODE NOT FOUND
469	4TH DIAGNOSIS CODE NOT COVERED
472	4TH DIAGNOSIS/AGE CONFLICT
473	4TH DIAGNOSIS/SEX CONFLICT
476	5TH DIAGNOSIS CODE NOT FOUND
477	5TH DIAGNOSIS CODE NOT COVERED
480	5TH DIAGNOSIS/AGE CONFLICT
481	5TH DIAGNOSIS/SEX CONFLICT
484	6TH DIAGNOSIS CODE NOT FOUND
485	6TH DIAGNOSIS CODE NOT COVERED
488	6TH DIAGNOSIS/AGE CONFLICT
489	6TH DIAGNOSIS/SEX CONFLICT
492	7TH DIAGNOSIS CODE NOT FOUND
493	7TH DIAGNOSIS CODE NOT COVERED
496	7TH DIAGNOSIS/AGE CONFLICT
497	7TH DIAGNOSIS/SEX CONFLICT
518	PROCEDURE FACTOR NOT COVERED
521	8TH DIAGNOSIS NOT FOUND
522	8TH DIAGNOSIS CODE NOT COVERED
525	8TH DIAGNOSIS/AGE CONFLICT
526	8TH DIAGNOSIS/SEX CONFLICT
529	9TH DIAGNOSIS CODE NOT FOUND

EXCEPTION CODE	EXCEPTION DESCRIPTION
530	9TH DIAGNOSIS CODE NOT COVERED
533	9TH DIAGNOSIS/AGE CONFLICT
534	9TH DIAGNOSIS/SEX CONFLICT
537	1ST SURGERY PROCEDURE NOT FOUND
538	1ST SURGERY PROCEDURE NOT COVERED
541	1ST SURGERY PROCEDURE/AGE CONFLICT
542	1ST SURGERY PROCEDURE/SEX CONFLICT
545	2ND SURGERY PROCEDURE NOT FOUND
546	2ND SURGERY PROCEDURE NOT COVERED
549	2ND SURGERY PROCEDURE/AGE CONFLICT
550	2ND SURGERY PROCEDURE/SEX CONFLICT
552	3RD SURGERY PROCEDURE NOT FOUND
553	3RD SURGERY PROCEDURE NOT COVERED
556	3RD SURGERY PROCEDURE/AGE CONFLICT
557	3RD SURGERY PROCEDURE/SEX CONFLICT
559	4TH SURGERY PROCEDURE NOT FOUND
560	4TH SURGERY PROCEDURE NOT COVERED
563	4TH SURGERY PROCEDURE/AGE CONFLICT
564	4TH SURGERY PROCEDURE/SEX CONFLICT
566	5TH SURGERY PROCEDURE NOT FOUND
567	5TH SURGERY PROCEDURE NOT COVERED
570	5TH SURGERY PROCEDURE/AGE CONFLICT
571	5TH SURGERY PROCEDURE/SEX CONFLICT
573	6TH SURGERY PROCEDURE CODE NOT FOUND
574	6TH SURGERY PROCEDURE CODE NOT COVERED
577	6TH SURGERY PROCEDURE/AGE CONFLICT
578	6TH PROCEDURE/SEX CONFLICT
583	MULTIPLE ANESTHESIA
599	LINE NUMBERS NOT SEQUENTIAL
701	POS-MISSING/INVALID BIN NBR
702	POS-MISSING/INV VERSION NBR
703	POS-MISS/INV TRANSACTION
704	POS-MISS/INV PROCESSOR
706	POS-MISSING/INVALID GROUP
708	POS-MISSING/INVALID PERSON
709	POS-MISSING/INV BIRTH DATE

EXCEPTION CODE	EXCEPTION DESCRIPTION
725	POS-MISC CLAIM DENIAL
743	POS-NO ADDR FOR PROVIDER
766	POS-MAX AGE EXCEEDED
776	POS-PLAN LIMITS EXCEEDED
781	UNIT DOSE ONLY FOR NURSE HOME
783	POS-GENERIC DRUG REQUIRED
784	ASSOC PRESC/SVC DATE MISMATCH
799	POS - PAPER CLAIM REQUIRED
840	ADJUSTMENT IS IN PROCEDURES
841	TCN TO CREDIT OR ADJ IS BUSY
842	NO MATCH ON BENEFICIARY ID
843	NO MATCH ON PROVIDER NUMBER
844	ADJUSTMENT FROM HISTORY
845	CLAIM HAS BEEN CREDITED OR ADJUSTED
850	NO PAID CLAIM FOR ADJUSTMENT/CREDIT
856	CREDIT CANNOT BE ADJUSTED
894	TOO MANY ADJUSTMENTS
899	TOO MANY EXCEPTIONS POSTED TO CLAIM

Appendix F

Medicaid Provider Number Assignment

Each MCO will submit its assigned Medicaid Provider Number in loops 2000A and 2010AA of the 837 COB transactions. Because the Pay-to-Provider is not different from the Billing Provider, submission of loop 2010AB is not required. Loop 1000A is reserved for the SHCH assigned Trading Partner ID.

If an MCO contracted provider has a valid Medicaid Provider Number, the Medicaid Provider Number must be submitted in loops 2310A and 2310B of the 837. If the provider does not have a valid Medicaid Provider Number, the MCO must assign one of the following ACS provider numbers shown below.

MCOs are responsible for assigning numbers based on the provider types indicated in the left hand column. The MMIS will deny encounters with invalid provider type/procedure code combinations. MCOs are responsible for correcting and resubmitting encounters denied for reason of inappropriate provider number assignment. Prior to testing, MCOs must supply documentation from their systems confirming the matching of provider type and ACS provider number.

ACS Provider Number by Provider Type

ACS Provider Type	ACS Provider Number
Generic MCO Adult Day	035043200
Generic MCO Alcohol and Substance	035051300
Generic MCO Ambulance	035036800
Generic MCO Ambulatory Surgical Center	035017300
Generic MCO Birthing Center	035054600
Generic MCO Case Manager	035032700
Generic MCO Community Residential	035055400

ACS Provider Type	ACS Provider Number
Generic MCO Day Treatment	035042400
Generic MCO DCPS	035023800
Generic MCO Dental Clinic	035034300
Generic MCO Dentist	035033500
Generic MCO DHS Clinic	035035100
Generic MCO Dialysis	035045700
Generic MCO DME	035053800
Generic MCO Emergency Hospital	035031900
Generic MCO Family Planning	035047300
Generic MCO FQHC	035050500
Generic MCO Home Health	035048100
Generic MCO Hospice	035022100
Generic MCO Hospital (not LTAC, Psych, or emergency)	035014900
Generic MCO ICF/MR	035020500
Generic MCO Independent X-ray	035039200
Generic MCO Laboratory	035040800
Generic MCO LTAC Hospital	035026200
Generic MCO Mental Health (includes Master of Biblical Science, Foster Care, Doctor of Philosophy, Child Protection, Social Worker, etc.)	035052100
Generic MCO Nurse Practitioner (includes Certified Nurse Midwife, etc.)	035030200
Generic MCO Nursing Facility	035019800
Generic MCO Optician	035046500
Generic MCO Optometrist	035044900
Generic MCO Osteopath	035028700
Generic MCO Pharmacy	035024600
Generic MCO Physician (includes Psychiatrist, Physician Assistance, etc.)	035027900
Generic MCO Podiatrist	035029500
Generic MCO Private Clinic	035056200
Generic MCO Psych Hospital	035016500
Generic MCO Psych Hospital Private	035021300
Generic MCO Radiation Therapy	035041600
Generic MCO Rehab Center (includes Chiropractor, Chiropodist, Occupational Therapy, Physical Therapy, etc.)	035015700
Generic MCO Residential Treatment Center	035018100
Generic MCO Screen Clinic	035037600

ACS Provider Type	ACS Provider Number
Generic MCO Speech/Hearing Clinic	035049800
Generic MCO Transportation	035038400
Generic MCO Waiver	035025400

Appendix G

Test Plan

This appendix provides a step-by-step account of the ACS, Inc. plan for testing the ASC X12N 837 COB and 835 electronic transaction sets for use in submitting encounter data for storage in the MMIS claims history file. The plan consists of three (3) tiers of testing, which are outlined in detail below.

Testing Tier I

1. The first step in submitter testing is enrollment performed via ACS EDI Gateway Services, Inc. Each MCO must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. In most cases, the MCOs will already have an ID, but are only permitted to receive electronic transactions, not to submit them. In this step, permission is granted for the MCOs to be able to both transmit and receive.

   Below is the link to the DC Medicaid Enrollment Forms.
   http://www.acs- gcro.com/Medicaid_Accounts/WashingtonDC_Medicaid/Enrollment/enrollment.htm

2. The second step, or performed concurrently with the enrollment, is EDIFECS testing. A partnership exists between EDIFECS and ACS EDI Gateway Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the ACS EDI Gateway. There are certain errors that will occur while testing with EDIFECS that should not be considered when determining whether an MCO has passed or failed the EDIFECS portion of testing. Specifically, local code rejections should not be considered a test failure. ASC X12N formatted data submissions to EDIFECS will assess the content and form for HIPAA compliance. The presence of local codes will cause a transaction to be non-compliant. This is not a critical issue for Tier I testing. Testing in Tier II with ACS EDI and ACS MMIS will determine whether the transaction passes or fails in the instances where local codes are used.

3. EDI must certify each MCO prior to the MMIS receipt of claims via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the ACS EDI Gateway, and that the transaction can be processed successfully with the resultant IRL, 997 Acceptance, or return transaction. X12 837 transactions (837D, 837I, and 837P) must be in the 4010A (Addenda) format, not in the 4010 format. This phase of testing was designed to do the following:

   - test connectivity with the Clearinghouse;
   - validate Trading Partner IDs;
   - validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;
   - validate the test submission with 997 Acceptance transactions; and
   - generate IRL or paired transaction.

   ACS EDI Gateway Services, Inc. will ensure that the X12 transaction is properly formatted prior to transferring the data to the DC MMIS. The encounter claims data from the MCOs are identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The MCOs must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item MCO paid amount is submitted, they also need to populate the 'Other Payer Primary Identifier' in loop 2430 segment SVD with their DC Medicaid provider number. These fields are used in the DC MMIS pre-processors to indicate that the amount in the accompanying prior paid field is the MCO's paid amount and not TPL or any other COB amount. For more details, please refer to the ACS EDI Gateway Services, Inc. *Submitter Testing Report* for the DC MAA.

   Below is the link to the 837 DC Companion Guide
   http://www.acs- gcro.com/Medicaid_Accounts/WashingtonDC_Medicaid /Companion_Guides/companion_guides.htm.

Testing Tier II

4. The next stage of testing is Tier II and is performed to assure that the data content of the MCO file is satisfactory. Once the file has been accepted by ACS EDI Gateway Services, Inc., the DC MMIS pre-processors will check the data content while converting the encounter data claim into the DC MMIS internal format. There are several reports that are created as part of the pre-processor series that will also be used during this testing phase to aid in validating the encounter claims data.

   The following are the pre-processor reject codes and descriptions that are applied:

035	PAY-TO-PROVIDER NUMBER IS INVALID
063	TRANSACTION CONTROL NUMBER IS INVALID
098	NUMBER OF LINE ITEMS IS NOT CORRECT
100	TYPE OF BILL IS INVALID OR NOT ALLOWED
216	MCARE SVC PROVIDER NOT ON MCARE/MCAID XREF FILE

234 TCN TO CREDIT IS INVALID NUMERIC OR ZERO
235 TCN TO CREDIT NOT FOUND ON HISTORY
236 TCN TO CR FOUND, BUT PRV/RECIP/STATUS/ACCT WRONG
237 PATIENT 03 IRL RECORD IS INVALID
240 INVALID TEST/PROD HEADER TYPE
241 CLAIM HDR AMOUNT NOT EQUAL LINE ITEM TOTAL AMT

ACS is responsible for evaluating the 'reject' reports produced from the pre-processors and forwarding the results to the MCO and to MAA/Mercer. ACS will send the 'accepted' encounter data pre-processor reports to MAA/Mercer for review. However, if the pre-processor editing rejects more than 50% of the encounter data claims, ACS will notify the MCO and assist them with identifying necessary corrections for resubmission purposes.

The MCOs must submit four (4) encounter data claims for each provider type in order to make a thorough test of each generic provider number assignment possible. In addition, some encounter data claims with valid non-generic Medicaid provider numbers for each of the 837s (I, D, and P) are required. The MCOs should submit their most complex encounter data claims during this testing phase in order to make sure the encounter data claims meet as many of the MMIS edits as possible.

Attached is a companion spreadsheet, Tier II Testing — Encounter Data Submission Guidelines by Type and Volume, which will enable each MCO to indicate how many claims they are submitting for each provider type. When the encounter data claims are submitted, the MCOs will email the spreadsheet to ACS with the 'Encounter Data Claims Submitted' column filled in as appropriate. If there is a provider type that they do not have, simply place '0' in the 'Encounter Data Claims Submitted' column for each of the encounter data claim types to the right of that provider type. ACS will use the spreadsheets to account for differences between the encounter data claims submitted and the encounter data claims received, as well as updating the spreadsheets with the results from the pre-processors. After ACS has completed this evaluation, the spreadsheets are emailed back to the MCOs, with a copy to MAA/Mercer.

In order to void or credit an encounter data claim via an 837 transaction, the provider number, beneficiary number, and TCN must match the original encounter data claim being voided. The void transaction is identified by the presence of either an '8' or an 'X' in the frequency code field. Therefore, if an encounter data claim was submitted in the 837P format, and was voided, use the original 837P transaction and simply change the frequency code and populate the original reference number segment fields being sure to use the TCN that is to be voided. Please refer to Section 8 of the Submission Manual for further details.

Testing Tier III

5. Once each MCO has successfully passed more than 50% of their encounter data claims through the pre-processors, ACS will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the MCOs via IDEX. Each MCO is required to examine the returned 835s and compare them to the encounter data claims (837s) they submitted to insure all claims that were submitted are accounted for in the data collection. ACS will send the new exception reports to the MCOs and MAA/Mercer for evaluation as well as a DC MMIS exceptions explanation document which details the conditions under which each exception will post to an encounter data claim in order to assist them with their research. ACS is available to answer any questions that any MCO may have concerning the exceptions.

6. When an MCO has successfully completed this process, ACS will ask the MCO to submit a full month file in a test mode. This will give ACS a better idea of how best to phase-in the remaining months of historical encounter data that need to be processed. It will also help EDI ensure that they are handling the transmissions most efficiently for the number of encounter data claims that they are receiving. Exception reports are generated on this first full month of data submission. This is scheduled to occur in July 2004.

7. Once satisfactory test results have occurred, ACS will move the MCO into production. ACS anticipates receiving files from each of the MCOs in production mode approximately once a month.

8. The timeline for submission of the bulk of encounter data back to October 2003 are determined by ACS.

9. Pharmacy encounter data testing is scheduled to begin in July 2004, and submission of subcapitated encounter data is scheduled for August 2004. Submission guidelines will also be developed for pharmacy encounter data submission.

10. Data quality improvement plans (DQIP) are to begin in July 2004, with the first full month of encounter data submission as the baseline for improvement. Corrective action plans (CAP) are established monthly by each plan. Once the data improvement actions have stabilized, the DQIP/CAP process will move to a quarterly schedule.

Tier II Testing — Encounter Data Submission Guidelines by Type and Volume

Generic Provider Number	Provider Type	Description	HIPAA Transaction	MMIS Enc. Data Claim Type	Enc. Data Claims to Submit	Enc. Data Claims Submitted	Enc. Data Claims Received in MMIS	Enc. Data Claims Accepted by the MMIS Pre-processors	Enc. Data Claims Rejected by the MMIS Pre-processors
035043200	36	Generic MCO Adult Day	837P	M	4				
035051300	46	Generic MCO Alcohol and Substance	837P	M	4				
035036800	25	Generic MCO Ambulance	837P	M	4				
035017300	05	Generic MCO Ambulatory Surgical Center	837I	O	4				
035054600	50	Generic MCO Birthing Center	837I	O	4				
			837P	M	4				
035032700	20	Generic MCO Case Manager	837P	M	4				
035055400	51	Generic MCO Community Residential	837P	M	4				
035042400	32	Generic MCO Day Treatment	837P	M	4				
			837I	N	4				
035023800	11	Generic MCO DCPS	837P	M	4				
035034300	23	Generic MCO Dental Clinic	837D	D	4				
035033500	22	Generic MCO Dentist	837D	D	4				
035035100	24	Generic MCO DHS Clinic	837P	M	4				
035045700	29	Generic MCO Dialysis	837P	M	4				
			837I	O	4				
			837I	I	4				
035053800	48	Generic MCO DME	837P	M	4				
035031900	19	Generic MCO Emergency Hospital	837P	M	4				
			837I	O	4				
			837I	I	4				
035047300	41	Generic MCO Family Planning	837P	M	4				
035050500	44	Generic MCO FQHC	837P	M	4				
035048100	42	Generic MCO Home Health	837P	M	4				
035022100	10	Generic MCO Hospice	837P	M	4				

Generic Provider Number	Provider Type	Description	HIPAA Transaction	MMIS Enc. Data Claim Type	Enc. Data Claims to Submit	Enc. Data Claims Submitted	Enc. Data Claims Received in MMIS	Enc. Data Claims Accepted by the MMIS Pre-processors	Enc. Data Claims Rejected by the MMIS Pre-processors
			837I	O	4				
			837I	I	4				
035014900	01	Generic MCO Hospital	837P	M	4				
			837I	O	4				
			837I	I	4				
035020500	08	Generic MCO ICF/MR	837P	M	4				
			837I	I	4				
			837I	N	4				
035039200	28	Generic MCO Independent X-ray	837P	M	4				
035040800	30	Generic MCO Laboratory	837P	M	4				
			837I	O	4				
035026200	14	Generic MCO LTAC Hospital	837P	M	4				
			837I	O	4				
			837I	I	4				
			837I	N	4				
035052100	47	Generic MCO Mental Health	837P	M	4				
			837I	O	4				
035030200	18	Generic MCO Nurse Practitioner	837P	M	4				
035019800	07	Generic MCO Nursing Facility	837I	N	4				
035046500	40	Generic MCO Optician	837P	M	4				
035044900	39	Generic MCO Optometrist	837P	M	4				
035028700	16	Generic MCO Osteopath	837P	M	4				
035027900	15	Generic MCO Physician	837P	M	4				
035029500	17	Generic MCO Podiatrist	837P	M	4				
035056200	52	Generic MCO Private Clinic	837P	M	4				
035016500	03	Generic MCO Psych Hospital	837P	M	4				
			837I	O	4				

Generic Provider Number	Provider Type	Description	HIPAA Transaction	MMIS Enc. Data Claim Type	Enc. Data Claims to Submit	Enc. Data Claims Submitted	Enc. Data Claims Received in MMIS	Enc. Data Claims Accepted by the MMIS Pre-processors	Enc. Data Claims Rejected by the MMIS Pre-processors
			837I	I	4				
035021300	09	Generic MCO Psych Hospital Private	837P	M	4				
			837I	O	4				
			837I	I	4				
035041600	31	Generic MCO Radiation Therapy	837P	M	4				
035015700	02	Generic MCO Rehab Center	837P	M	4				
035018100	06	Generic MCO Residential Treatment Center	837P	M	4				
			837I	I	4				
035037600	26	Generic MCO Screen Clinic	837P	M	4				
035049800	43 (& 37,38)	Generic MCO Speech/Hearing Clinic	837P	M	4				
035038400	27	Generic MCO Transportation	837P	M	4				
035025400	13	Generic MCO Waiver	837P	M	4				
Claims with non-generic Medicaid Provider Id's			837D	D	4				
			837I	I, O, or N	4				
			837P	M	4				
Provider number and type should = those of the original claim		Credit claims should contain the original TCN and either an '8' or 'X' in the frequency code field	837*	Z	4				
TOTALS:					272	0	0	0	0

Appendix H

Websites

The following websites are provided as references for useful information not only for managed care entities, but also for consumers, health care providers, health care organizations, and other impacted entities.

Website Address	Website Contents
http://www.hipaadirect.com	HIPAAdirect is a free health care portal that provides over 1,000 categorized HIPAA links for consumers, employers, doctors, dentists, other health care providers, health care organizations, health plan HMOs, health insurers, group health plans, benefit plans, and health care clearinghouses.
http://aspe.os.dhhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.

Website Address	Website Contents
http://aspe.os.dhhs.gov/admnsimp/final/pvcfact1.htm	This website contains a shortened version of the Privacy Rule.
http://www.cms.gov	This is the **CMS home page**.
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.ncpdp.org	This site links to the **National Council for Prescription Drug Programs website**. This site contains information on how to order the implementation guide and other documentation for the proposed retail drug claim standard: Telecommunications Standard Format Version 3.2 and its batch equivalent. Moreover, this site contains membership information, meeting minutes, and dates for upcoming conferences
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange**

Website Address	Website Contents
	Standards Association website. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://www.ada.org	This is the **American Dental Association website**. This site includes information regarding ADA's position on electronic commerce.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.
http://www.wpc-edi.com/codes/	This links to the **Washington Publishing website** where one may find the X12N Provider Information Workgroup Taxonomy that is being considered for the National Provider System under HIPAA.

Website Address	Website Contents
http://cms.hhs.gov/providers/edi/default.asp	This is the **Medicare EDI website**. At this site you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.
http://www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.asp	This is a **monthly newsletter published by CMS's Data and System Group within the Center for Medicaid and State Operations**. It is a very good source of information for HIPAA developments. If you cannot access the website with the direct address, use http://www.cms.gov. Click on Medicaid and search using the keywords "HIPAA Plus".
http://www.gpoaccess.gov/fr/index.html	This is the **National Archives and Records website** to obtain copies of the Federal Register. The NPRMs for the National Provider Identifier and for the Standards for Electronic Transactions were published in Volume 63, Number 88, 5/7/1998.

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