

**MANAGED CARE ORGANIZATION  
INSTRUCTION MANUAL FOR ENCOUNTER  
DATA SUBMISSION THROUGH OMNICAID  
DISTRICT OF COLUMBIA DEPARTMENT OF  
HEALTH CARE FINANCE**

APRIL 1, 2014



## 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 dates are noted along with the author, date, and reason for the change.

| Change Control Table |                  |             |                                      |              |
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| Author of Change     | Sections Changed | Description | Reason                               | Date         |
| Sharon Jackson       | Manual           | Contents    | Omnicaid Conversion                  | April 2010   |
| Jane Szymanski       | Manual           | Contents    | Current Information                  | October 2012 |
| Jane Szymanski       | Manual           | Contents    | Reconciliation file and valid values | April 2013   |
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| Jane Szymanski       | Manual           | Contents    | General updates                      | April 2014   |

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## Overview

### Introduction

The District of Columbia (District) Department of Health Care Finance (DHCF) requires each health plan to report all encounters that each participating health plan's providers have with the Medicaid Managed Care Program. 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-04 (UB-04) and Center for Medicare and Medicaid Services-1500 (CMS-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. DHCF chose to adopt these standards for managed care organization (MCO) encounter data reporting.

This manual serves as a guide to supplement contractual requirements, standard HIPAA encounter submission instructions, and companion guides provided by the DHCF's Medicaid Management Information System (MMIS) vendor Xerox. MCO contractual requirements may be more specific than the Federal rules.

### 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 National 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 ANSI ASC X12N Provider-to-Payer-to-Payer COB 837 transactions (837): 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                     | Institutional   |
| Hospice Services                | Institutional   |
| Long Term Care                  | Institutional   |
| Physician                       | Professional    |

**Prescription Drug Records:** proprietary format for reporting to meet pharmacy rebate requirements and reporting needs.

## Encounter Definition

Encounters are records of medically-related services rendered by an MCO provider to a DHCF 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 procedure(s) or service(s) rendered during the contact. Encounters include services paid as FFS, as well as services paid under a capitated vendor arrangement. Encounters for all incurred services in the DHCF 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.
- Durable medical equipment (DME).
- Dialysis center services.
- Nursing home services.
- Long-term care services.
- Physical therapy services.
- Early and periodic screening, diagnosis, and treatment (EPSDT) services.
- Case management services.
- Home health services.
- Behavioral health services.
- Vision services.
- Transportation services.
- Pharmacy services.
- Dental services.

## **Purpose of Encounter Collection**

The purposes of encounter data collection are as follows:

### ***Contractual Requirements***

Contractor shall collect and submit service specific encounter data in the appropriate 837 format or an alternative format if approved by DHCF. The data shall be submitted electronically within thirty days after the claim was paid or the capitated encounter was processed. The data shall include all services reimbursed by the Contractor.

### ***Rate Setting***

The Balanced Budget Agreement of 1997 (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. DHCF began collecting encounter data in 2004 from the Medicaid contracted, risk-sharing MCOs that provide services to the District Medicaid beneficiaries.

### ***Quality Management and Improvement***

DHCF's managed care plan is a Medicaid waiver program partially funded by CMS. Encounter data is analyzed and used by CMS and DHCF 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 DHCF with performance data and indicators. DHCF 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 EPSDT or HealthCheck screenings. DHCF 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 DHCF. 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 Quality Strategic Opportunity Plans (QSOPs).

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

According to the BBA, a written strategy plan is required to serve as the guiding principles for assessing the quality, effectiveness, and efficiency of services rendered to beneficiaries. The goal of the strategy plan is to purchase the best value health care and services for DHCF 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 Xerox EDI Gateway, Inc. (Xerox) Data Center in Tallahassee, Florida, where they are processed through various electronic systems for payment. As a gateway service, Xerox provides connectivity to various health care plans and states where Xerox is the fiscal agent. MCOs should follow the Xerox ANSI X12N 837 Healthcare Claim Institutional, Professional, and Dental DHCF Companion Guides and DHCF Supplemental Companion Guide instructions for submitting claims to Xerox. Xerox will notify the MCOs if any substituted electronic encounter submission will be required.

## Implementation Date

In 2004, Xerox began accepting encounters in the 837 coordination of benefits (COB) formats. MCOs submitted all claims paid on or after October 1, 2003 in the required 837 Provider-to-Payer-to-Payer format.

## DHCF Responsibilities

DHCF is responsible for administering the District's Managed Care program. 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:

|                          |  |
|--------------------------|--|
| <b>Lisa Truitt</b>       |  |
| Telephone                | +1 202 442 9109  |
| E-mail                   | <a href="mailto:lisa.truitt@dc.gov">lisa.truitt@dc.gov</a>               |
| <b>Lawrence Williams</b> |  |
| Telephone                | +1 202 724 8864  |
| Email                    | <a href="mailto:lawrence.williams2@dc.gov">lawrence.williams2@dc.gov</a> |

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

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

## Xerox Responsibilities

Xerox is under contract with the District to provide MMIS services, including the acceptance of electronic encounter reporting through Xerox from the MCOs. Xerox is also responsible for maintaining the EDI gateway.

## 837 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 999 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 277CA Claims Acknowledgement is returned to the submitter.



After encounter adjudication, an ANSI ASC X12N 835 Remittance Advice (835) is delivered to the EDI data delivery (MoveIT) system. The Xerox EDI Support Unit is available to help resolve transmission and production issues.

Xerox provides MCOs with proprietary MMIS encounter adjudication edit reports following the weekly claims payment cycle. A monthly reconciliation file is provided for MCOs to view additional information regarding individual service line submissions and their status is Omnicaid.

## **MCO Responsibilities**

It is the MCO's responsibility to ensure accurate and complete encounter reporting from their providers. MCOs are responsible for submitting vendor encounter files. If it is delegated, all communication must continue to be the MCOs' responsibility.

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 national provider identifier (NPI), taxonomy, and 9-digit zip code or Xerox-provided Generic provider identification number (Generic ID) is on each encounter.

Section C.12 of the MCO contract requires Contractor to collect and submit service-specific encounter data in the appropriate 837 format, or an alternative format, if approved by DHCF. Encounters must be submitted within 30 days after the claim was paid or the capitation encounter was processed. The data shall include all services reimbursed by the Contractor. In addition, MCOs should submit zero-billed immunization records for services provided to members through the vaccine for children (VFC) program. Voids to previous records that are deemed repairable denials by Xerox are submitted in the next monthly cycle. Further, Section C.12 of the MCO contract requires Contractor to submit encounters at least once per week unless otherwise approved by DHCF. In instances where the MCO has received refunds from providers, MCOs should submit voids for any submitted encounters involved as soon as possible after receipt of these funds.

Each MCO has specific day(s) for encounter submissions and should not deviate from that schedule without prior written authorization from DHCF. Currently, Thursday has been set aside for one MCO only but can be used by another MCO also if necessary, but not without prior written authorization. If needed, Thursday should be used in addition to your normal submission day; however, not in lieu of it. The following are general submission rules:

- Submissions sent on Fridays cannot be guaranteed to make that same night's adjudication cycle.
- Submission files should not exceed 10,000 claims each.
- Multiple submissions can be uploaded in one day.
- MCOs must give advance notification of submissions that total greater than 40,000 claims for a given day to the entire Encounter Team, so that all affected parties are aware prior to the initiation of the nightly production cycle.

MCOs are expected to investigate the findings of encounter denials 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 the 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.

## **Transportation and Miscellaneous Service Submissions**

Non-emergent transportation and specific approved services may not always be submitted on an 837 format. Excel workbooks may be utilized for these services. To obtain additional information, methods of delivery, and the delivery schedule, MCOs should discuss with DHCF.

## **Frequency Reports**

Frequency reports are to be submitted to the DHCF encounter team prior to quarterly meetings. Some Omnicaid edits applied to encounter data cannot be corrected by MCOs due to FFS claim processing and known system limitations. These reports are used by DHCF to validate service codes utilized on encounter data submissions for specific non-repairable edits, which cannot be corrected by the MCOs. To obtain additional information, file formats, and methods of delivery, MCOs should discuss with DHCF.

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## Additional Instructions

### 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 DHCF are the 837 Institutional, 837 Professional, and 837 Dental Provider-to-Payer-to-Payer 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. This Manual provides additional instructions and support for DHCF specific encounter requirements and Xerox companion guides and billing instructions.

Prior to 2012, health plans submitted their 837 transactions for DHCF using the HIPAA IGs 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). Beginning January 1, 2012, all MCOs must be fully compliant with the Version 5010 of the ASC X12 837 transactions. Guides are available from the Washington Publishing Company.

### Xerox Companion Guides and Billing Instructions

Xerox provides EDI Gateway Services to DHCF. The Xerox EDI Gateway, Inc. 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 999 Functional Acknowledgement. If the data fails payer-specific edits, the 277CA Claims Acknowledgement is returned to the submitter. The Xerox Companion Guides can be found at <http://www.acs-gcro.com/>. Follow the path to EDI Gateway Clients, then District of Columbia Medicaid, and select 5010 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://store.x12.org/store/healthcare-5010-consolidated-guides>. This guide outlines the procedures necessary for engaging in EDI with Xerox and specifies data clarification, where applicable.

Periodically, Xerox will provide additional billing instructions through Bulletins located at <https://www.dc-medicaid.com/dcwebportal/home>.

## DHCF Supplemental Instructions

DHCF 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.

## Financial Fields

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

- Header and Line Item Submitted Charge Amount.
- Header and Line Item Approved (Allowed) Amount.
- Header and Line Item MCO Paid Amount.

**Header and Line Item Submitted Charge Amount** — MCOs should report the provider's charge or billed amount. The value may be "\$0.00" if the MCO contract with the provider is capitated, and the MCO permits zero as a charged amount or the service is for immunization drugs covered under the VFC program. If the submitted charge is billed as "\$0.00", the MMIS will calculate the paid amount as zero since DHCF pays the lesser of the submitted charge or the calculated fee amount. A value other than "\$0.00" must be submitted when the provider bills on a FFS basis.

**Header and Line Item 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 "\$0.00". The MMIS does not currently store the approved amount in claims history.

**Header and Line Item 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, "\$0.00" is the appropriate Paid Amount. This amount is stored in the encounter as a third party liability (TPL) amount. The MCO paid amount should always be submitted in the first COB loop regardless of other carrier payments.

**Header and Line Item 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.

**Third Party Liability (TPL) Collection** — if a third party carrier is responsible for a portion of a claim, the MCO should submit the primary TPL carrier payment amount in the second COB loop of the 837 formats in encounter submissions. For purposes of submitting complete encounter data, a generic MCO-TPL indicator has been created and should be used for reporting the TPL Carrier: 0000002974.

## Professional Identifiers

MCOs are required to submit the provider's NPI, Taxonomy Code, and 9-digit zip code if the provider is a contracted DHCF provider. The District distributes a provider file monthly to the MCOs to assist in matching encounters to DHCF providers for MCO network and non-network providers. If the provider is not a contracted DHCF provider, MCOs must follow the Xerox instructions to assign a "Generic ID". The Generic IDs are based on provider type and/or specialty. Failure to populate the billing provider's NPI and proper Taxonomy Code or Generic ID will result in an encounter rejection by EDI at the clearinghouse. These encounters are returned to the MCO on a 277CA transaction. Failure to submit a correct DHCF identifier or Generic ID will result in an encounter denial. All encounters denied for reason of invalid ID are returned to MCOs for correction.

## Supplementation of CMS-1500 and UB-04

Certain information may be required that is not routinely present on the UB-04 or CMS-1500. In these circumstances, MCOs must obtain valid medical records to supplement the UB-04 or use logic from the paper claim to derive the required additional information for the 837 transactions.

## Newborn Birth Weight

Birth weight is required on encounters for delivery services to report newborn's birth weight when the value code is "54" in loop 2300 segment HI with the qualifier BE. MCOs are required to obtain the actual birth weight from the original claim and populate the birth weight in grams into the 837 encounter.

## Newborn ID Usage

MCOs should use the baby's Medicaid ID when submitting a baby's facility bill. 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.

## Transaction Type

For a comprehensive list of provider types, please refer to the Xerox provider billing guides. For purposes of encounter data submissions, the following types of provider encounters must be submitted on the associated HIPAA 837 file.

The following provider types use 837D:

| Provider Type Description |
|---------------------------|
| DENTIST                   |
| DENTAL CLINIC             |

The following provider types use 837I:

| Provider Type Description   |
|-----------------------------|
| GENERAL HOSPITAL            |
| PSYCHIATRIC HOSPITAL PUBLIC |

| Provider Type Description              |
|--|
| AMBULATORY SURGICAL CENTER             |
| NURSING FACILITY                       |
| ICF/MR                                 |
| PSYCHIATRIC HOSPITAL PRIVATE           |
| HOSPICE                                |
| LONG TERM ACUTE CARE (LTAC) HOSPITAL   |
| EMERGENCY ACCESS HOSPITAL              |
| HEMODIALYSIS CENTER FREESTANDING       |
| HOME HEALTH AGENCY                     |
| The following provider types use 837P: |

| Provider Type Description       |
|---------------------------------|
| DC SCHOOLS                      |
| PHYSICIAN MD SERVICES           |
| PHYSICIAN DO SERVICES           |
| PODIATRIST                      |
| NURSE PRACTITIONER              |
| DHS CLINICS                     |
| AMBULANCE TRANSPORTATION        |
| SCREENING CLINICS               |
| OTHER MEDICAL TRANSPORTATION    |
| INDEPENDENT X-RAY               |
| INDEPENDENT LAB                 |
| RADIATION THERAPY CENTER        |
| DAY TREATMENT                   |
| ADULT DAY CARE FACILITY         |
| AUDIOLOGIST                     |
| HEARING AID DISPENSER           |
| OPTOMETRIST                     |
| OPTICIAN                        |
| FAMILY PLANNING CLINIC          |
| SPEECH/HEARING CLINIC           |
| FEDERAL QUALIFIED HEALTH CENTER |
| ALCOHOL/SUBSTANCE ABUSE CLINIC  |
| MENTAL HEALTH CLINIC            |
| DME PROVIDER                    |
| BIRTHING CENTER                 |
| COMMUNITY RESIDENTIAL FACILITY  |
| PRIVATE CLINIC                  |

## **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."

## 3

## Repairable Denial Exception Codes and Descriptions

### Introduction

Following the 2009 implementation of Omnicaid, claims processing edits were modified for encounter processing. In order for the most complete data for rate setting and data analysis, the MCO is to repair as many exceptions as possible. 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 DISPOSITION — REPAIRABLE DENIALS EXCEPTION DESCRIPTION | CLAIM TYPES ASSOCIATED WITH REPAIRABLE EDITS |
|----------------|--|--|
| 0046           | TOTAL REV CHARGE 0001 MISSING                                    | H,I,N,V                                      |
| 0075           | SURG PROC CODE IS REQUIRED                                       | I  |
| 0112           | DOS CANNOT SPAN MONTHS   | N  |
| 0113           | 1ST DOS VS ADMIT DATE CONFLICT                                   | I,N  |
| 0114           | INVALID/MISSING ADMIT SOURCE                                     | I,N  |
| 0119           | MISSING/INVALID TOOTH SURFACE                                    | D  |
| 0120           | MISS/INV BILLING PROVIDER NUM                                    | All claim types                              |
| 0124           | MISSING DATE OF SERVICE  | All claim types                              |
| 0126           | FIRST DOS AFTER LAST DOS   | All claim types                              |
| 0127           | LAST DOS AFTER RECEIPT DATE                                      | All claim types                              |
| 0129           | MISSING/INV RECIPIENT NUMBER                                     | All claim types                              |
| 0132           | SUBM CHARGE IS MISSING   | All claim types                              |
| 0147           | MISSING/INVALID ADMIT TYPE                                       | I,N  |
| 0148           | REVENUE CODE MISSING ON UB-04                                    | H,I,N,O,V                                    |
| 0150           | MISSING/INVAL PLACE OF SERV.                                     | C,D,E,K,L,M,P,S,T,V                          |
| 0157           | LINE COUNT IS INVALID  | All claim types                              |
| 0163           | INV LINE ITEM DATE-HOSPITAL                                      | All claim types                              |
| 0167           | MISSING/INVALID ADMIT DATE                                       | I,N  |
| 0359           | HOSPICE DISCHG LESS THAN ADMIT                                   | H  |
| 0364           | PROC/TOOTH NUMBER CNFL   | D  |
| 0425           | PROV NOT A VALID BILL PROV                                       | All claim types                              |
| 0842           | NO MATCH ON RECIPIENT ID   | All claim types                              |
| 0843           | BILL PROV MATCH NOT FOUND  | V  |
| 1135           | INVALID ADJ REASON CODE  | All claim types                              |
| 1713           | PRIN DIAG/AGE CNFL   | All claim types                              |
| 1714           | PRIN DIAG/GENDER CNFL  | All claim types                              |
| 1721           | 1ST DIAGNOSIS/AGE CONFLICT                                       | All claim types                              |



| EXCEPTION CODE | EXCEPTION DISPOSITION — REPAIRABLE DENIALS EXCEPTION DESCRIPTION | CLAIM TYPES ASSOCIATED WITH REPAIRABLE EDITS |
|----------------|--|--|
| 1722           | 1ST DIAGNOSIS/GENDER CONFLICT                                    | All claim types                              |
| 1725           | 2ND DIAGNOSIS/AGE CONFLICT                                       | All claim types                              |
| 1726           | 2ND DIAGNOSIS/GENDER CONFLICT                                    | All claim types                              |
| 1729           | 3RD DIAGNOSIS/AGE CONFLICT                                       | All claim types                              |
| 1730           | 3RD DIAGNOSIS/GENDER CONFLICT                                    | All claim types                              |
| 1818           | PRINC SURG PROC CD/DT MISS/INV                                   | I  |
| 1819           | 1ST SURG PROC/GENDER CNFL  | I  |
| 1822           | INV 1ST SURGICAL PROC DATE                                       | I  |
| 1823           | 2ND SURG PROC/GENDER CNFL  | I  |
| 1826           | INV 2ND SURGICAL PROC DATE                                       | I  |
| 1827           | 3RD SURG PROC/GENDER CNFL  | I  |
| 1830           | INV 3RD SURGICAL PROC DATE                                       | I  |
| 2062           | 1ST ICD9 NOT W/IN FR/THR DATE                                    | All claim types                              |
| 2063           | 2ND ICD9 NOT W/IN FR/THR DATE                                    | All claim types                              |
| 2064           | 3RD ICD9 NOT W/IN FR/THR DATE                                    | All claim types                              |
| 2086           | FIRST/LAST DOS SAME  | A,I  |
| 2094           | NO REFERRING NPI   | S  |
| 3053           | DATE OF DISCHARGE IS INV/MIS                                     | I,N  |
| 5112           | FROM/THRU SPANS MONTHS   | N  |
| 5118           | MISSING ANESTHESIA TIME  | P  |
| 5164           | INVALID MOUTH QUADRANT   | D  |
| 5175           | SURGERY AFTER BILLING DATE                                       | I  |
| 5183           | REV 036X & 049X REQ CPT SURG                                     | O  |
| 5184           | RADIOLOGY REV REQ PROCEDURE                                      | O  |
| 5229           | INVALID TAXONOMY   | C,D,E,H,I,K,L,M,N,O,P,S,U,V                  |
| 5361           | ONLY ONE 50 MODIFIER ALLOWED                                     | C,E,K,L,M,O,P,S,T                            |
| 5405           | SURG PROC REQUIRES REV CODE                                      | O,U  |
| 5660           | BILLING PROVIDER NPI REQ RD                                      | C,D,E,H,I,K,L,M,N,O,P,S,T,V                  |
| 5661           | INVALID BILLING NPI-FAILS LUH                                    | C,D,E,H,I,K,L,M,N,O,P,S,T,V                  |
| 5663           | NO MATCH ON BILLING/PAY-TO PID                                   | C,D,E,H,I,K,L,M,N,O,P,S,T,U,V                |
| 5664           | BILLING/PAY-TO NPI NOT ON FILE                                   | C,D,E,H,I,K,L,M,N,O,P,S,T,V                  |
| 5671           | INVALID REND/ATTEN NPI   | B,D,E,K,L,M,P,S,T                            |
| 5673           | NO MATCHING REND/ATTND PID                                       | D  |

## **Encounter Correction Process**

Xerox will send the reports via the web to the MCOs the Monday following the Friday MMIS payment cycle. The MCOs are required to submit corrections in the next submission cycle.

## **Resubmissions**

Make the correction to the service line(s) to which a repairable exception was applied. Void the original encounter, and resend the entire replacement once the void has been processed. See Section 7 of this Manual for the acceptable service line correction process.

# 4

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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 Xerox. As such, MCOs are required to undergo Trading Partner testing with Xerox 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 encounter data. Xerox does not define the number of encounters in the transmission; however, DHCF will require a minimum set of encounters for each transaction type based on testing needs.

If a MCO treating provider has a valid NPI and taxonomy code and participates in Medicaid FFS, the MCO must submit those values in the 837. If the provider does not participate in FFS, the MCO must assign one of the Generic IDs, as described 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 Xerox provider number from the DHCF provider file.

### Test Process

The Xerox Companion Guides and enrollment forms can be found at <http://www.acs-gcro.com/>. Follow the path to EDI gateway clients District of Columbia Medicaid, and select the appropriate item from the left hand menu. After completing and returning the enrollment package to Xerox, MCOs are assigned a Trading Partner Logon Name and Logon User ID. Trading Partners will contact Xerox 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 levels of testing defined by WEDI Strategic National Implementation Process (SNIP). Testing Partners will correct any errors prior to testing with Xerox. EDIFECS also provides HIPAADesk, a free on-line testing application available to the District. Please refer to the Xerox Companion Guides to obtain instructions for obtaining a free copy of HIPAADesk.

Prior to submitting test files to Xerox, MCOs must obtain permission from DHCF for any further testing and instructions. Once released from testing, all files *must* be submitted in a production-ready status. When submitting test files, MCOs will insert a "T" in data element 15 of the ISA segment of the envelope. At the EDI Gateway, Xerox 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, a 277CA Claims Acknowledgement is returned to the submitter.

Payer-specific edits can be obtained from the Xerox Companion Guides. Supplemental instructions are included in Section 2 of this Manual. The Xerox Companion Guides can be found at <http://www.acs-gcro.com/>. Any discussions should be directed to the DHCF encounter team.

A test plan contains step-by-step account of the Xerox, 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 tiers of testing, which are outlined in detail in Appendix G.

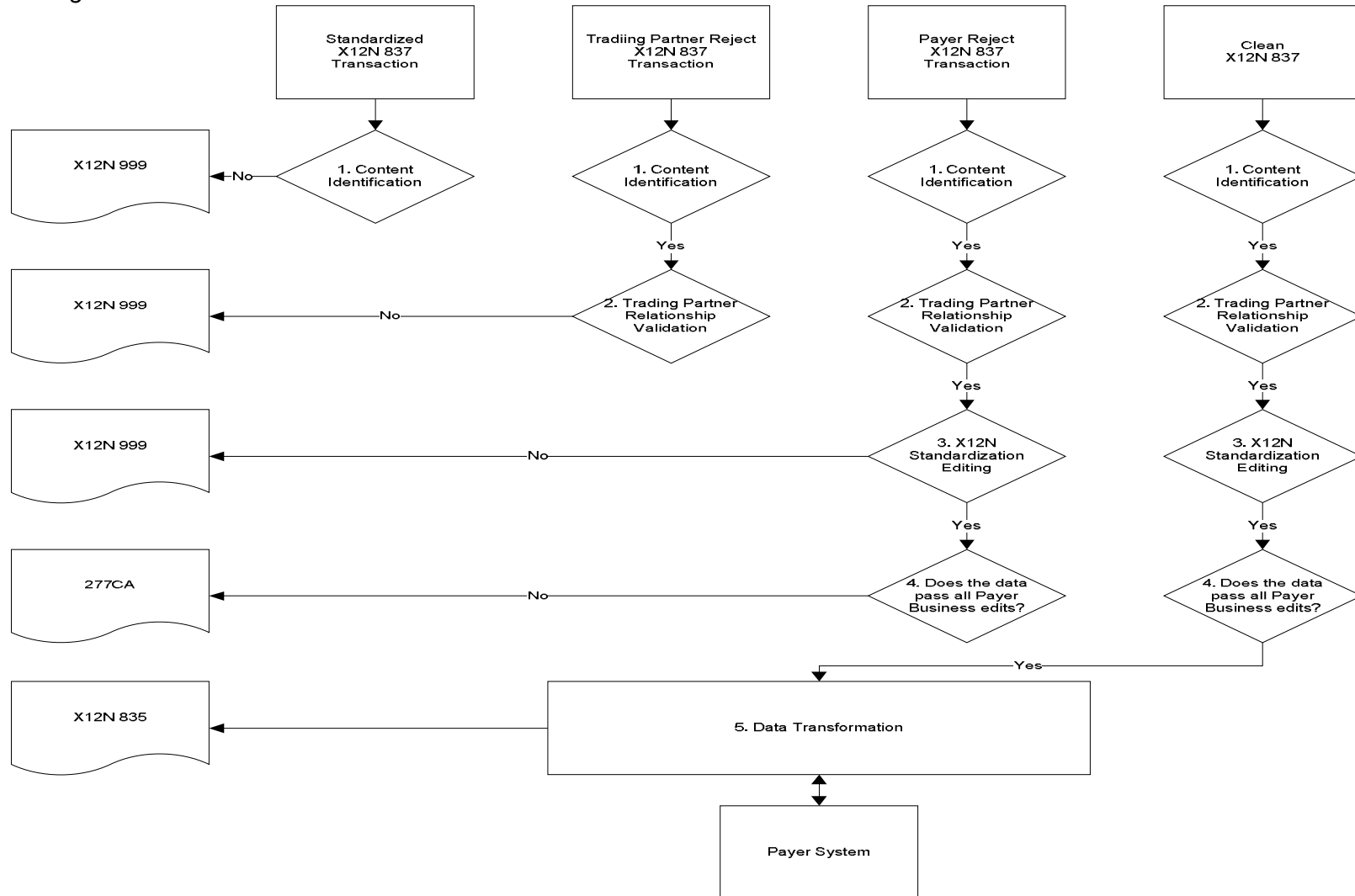
## **Timing**

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

## **Editing and Validation Flow Diagram**

The following process flow chart depicts an incoming ANSI ASC X12N 837 transaction validation for syntax at the Xerox EDI Gateway.

*Editing and Validation Flow:*



## Data Certification<sup>1</sup>

The BBA requires that when State payments to an MCO are based on encounter 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 Data Certification form. A completed, signed form is required to be faxed concurrently with each encounter submission. The data must be certified by each of the following individuals:

1. The MCO's Chief Executive Officer.
2. The MCO's Chief Financial Officer.
3. The MCO's Chief Medical Officer.

An individual may have delegated authority to sign for, and who reports directly to the MCO's Chief Executive Officer, Chief Financial Officer, or Chief Medical 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 Data Certification form. A completed, signed form is required to be submitted concurrently with each encounter submission in order to provide concurrent attestation. Copies of the Data Certification forms for Medicaid and Alliance encounters are located in Appendix H. Contact DHCF for a Word document version of the certification form.

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<sup>1</sup> CFR 42 § 438.604 — Data that must be certified; CFR § 438.606 — Source, content, and timing of certification.

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## Data Management and Error Correction Process

### Introduction

Encounter data is submitted through the Xerox EDI Gateway. 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 Xerox EDI Gateway or during the MMIS encounter processing. At Xerox EDI Gateway, 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. Header or line level errors may occur at the MMIS. DHCF will require MCOs to correct certain MMIS header or line level errors.

### *Entire File*

Each transaction contains four levels of edits. 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 999 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 999 will be forwarded to the Xerox Call Center. In this scenario, the entire transaction is rejected at the header level.

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 999.

### *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 999 transaction contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or element(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 277CA Claims Acknowledgement may be used to report those errors.

### *Service Line*

Data that passes Xerox 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 deny at the header or at a single detailed line.

A full listing of encounter edits is contained in Appendix E. After processing, an 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 “repairable”. A list of repairable denials is contained in Section 3 of this Manual.

### *Entire File*

MCOs will receive either a X12N 999 error report. MCOs are required to work with Xerox Business Support Analysts to determine the cause of the error.

### *Claim*

MCOs will receive either a 277CA or an X12 835 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 DHCF payer-specific data rules, as defined in the Xerox 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 Claim Adjustment Segment (CAS) 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 repairable errors. Repairable 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 Mercer and DHCF 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) with supporting documentation to Xerox, Mercer, and DHCF for reconsideration. The final outcome determined by these entities will prevail.

## Grievances

MCOs have the right to file a grievance regarding rejected or denied encounters that are not denied as non-repairable. Grievances must be filed in a timely manner. An MCO may believe that a rejected encounter is the result of a "Xerox error." Xerox error is defined as a rejected encounter that (1) Xerox 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 Xerox, and therefore, requires Xerox resolution to process the rejection.

An MCO must notify DHCF in writing within a 30-calendar day timeframe if it believes that the resolution of a rejected encounter rests on Xerox rather than the MCO. DHCF will respond in writing within 30 days of receipt of such notification. DHCF encourages MCOs to provide written notice as soon as possible. The DHCF 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 Xerox. The MCO should highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

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

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## Continuous Quality Improvement

### Introduction

In accordance with the BBA, DHCF 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 QSOPs. Interim monitoring and follow-up on identified quality problem areas is an integral component of DHCF's encounter process.

The QSOP is designed to provide DHCF 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. DHCF will meet with MCOs every three months, or as needed. The QSOPs are sent by MCOs to DHCF monthly by the second Friday of the month.

At the site visit, the MCO is expected to have investigated the findings of QSOPs and be prepared to explain the underlying reasons for the identified data quality issue(s). The issue must incorporate action steps and responsible parties. If the issue is not solved in a timely manner, DHCF may require the MCO to establish a corrective action plan (CAP). The CAP should include a listing of issues, responsible parties, and projected resolution dates. Contact DHCF for a copy of the QSOP template and instructions.

### Minimum Standards

There are three components to encounter data quality assessment: Xerox Repairable Denials, Pay-and-Report, and Data Volume Assessment.

#### ***Denials***

Repairable denials must be recorded on the QSOP with an action plan for correcting, voiding, and resubmitting the encounters. Other denials must be recorded with a description of how the MCO will prevent the occurrence of these denials in the future.

#### ***Xerox Pay-and-Report Edits***

Pay-and-Report Edit summaries are provided to DHCF and MCOs the Monday following the weekly processing cycle. These are edits for items priced through the MMIS but reported to DHCF as questionable.

### ***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 DHCF has all of the encounter data generated for a specific period.

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## Void and Replacement Process

### Introduction

MCOs must submit encounter voids as soon as possible after processing in their system. In the case of adjustments, MCOs are required to submit a void and replacement of the entire encounter identified by the Transaction Control Number (TCN). Correction and resubmission of individual lines is not allowed. Adjustments with a claim frequency type code of “7” are not allowed for encounter submissions. Detailed, payer-specific instructions are provided in the Xerox Companion Guides found at [www.acs-gcro.com/gcro/](http://www.acs-gcro.com/gcro/). Select EDI Gateway Clients, District of Columbia Medicaid, and choose 5010 Companion Guides from Additional Information menu on the left. 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<br>To correct or void a previously submitted claim, submit “8” for Encounter Void/Cancel of Prior Claim. See also 2300/REF02.  |
| 2300 | REF01   | 128          | Reference Identification Qualifier<br>To cancel or adjust a previously submitted claim, submit “F8” to identify the Original Reference Number.   |
| 2300 | REF02   | 127          | Original Reference Number<br>To cancel or adjust a previously submitted claim, please submit the <b>17-digit TCN</b> 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. |

In addition, when submitting a void, everything submitted in the Original encounter to be voided should be populated in the submitted void just as it was in the original submission. Once a void is submitted, a Friday payment cycle must take place with validation of the 835 before the corrected encounter can be submitted the following week.

# APPENDIX A

## Definitions

| Term  | Definition  |
|---|---|
| Automated Client Eligibility Determination System (ACEDS) | ACEDS is the information system maintained by the District to document Medicaid claims payment and service provisions.  |
| Xerox EDI Gateway, Inc. (Xerox)                           | Xerox is under contract with the District to provide MMIS services, including the acceptance of electronic encounter reporting through the Xerox 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.   |
| Alliance  | Health coverage for low income DC residents with no other health insurance including Medicare or Medicaid   |
| Beneficiary   | A person eligible to receive medical and/or behavioral health services.   |
| Beneficiary Month   | One enrollee who is enrolled in the Managed Care program for one month.   |
| Capitation Rate   | The monthly rate per enrollee, fixed annually in advance, paid by DHCF 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.  |
| Category of Service (COS)                                 | COS is assigned by Omnicaid based on data submissions with the following values:<br>01 Inpatient Hospital Services.<br>02 Outpatient Hospital Services.<br>03 Laboratory/Radiology Services.<br>04 Skilled Nursing Facility Services.<br>05 Physician Services.<br>06 Mental Retardation and Developmental Disabilities Administration Waiver Services.<br>07 Home Health Services.<br>08 LTAC (LT Acute Care) Services.<br>09 Mental Health Clinic Services.<br>10 EPSDT Screening Services.<br>11 EPSDT Services. |

| Term   | Definition  |
|--|---|
| Category of Service (COS)  | 12 Dental Services.<br>13 Optometric Services.<br>14 Day Treatment Services.<br>15 Prescription Drug Services.<br>16 Elderly Waiver Services.<br>17 Water Filter Services.<br>18 Hearing Services.<br>19 Interm Care Fac (ICF) Services.<br>20 ICF MR Services.<br>21 Residential Treatment Services.<br>22 Family Planning Services.<br>23 Federally Qualified Health Ctr.<br>24 Medical Supply (DME) Services.<br>25 Therapy Services.<br>26 Psychiatric Services.<br>27 Insurance Premiums.<br>28 Nurse Practitioner Services.<br>29 Ambulatory Surgery Services.<br>30 Sterilization Services.<br>31 Hospice Services.<br>32 Clinic Center Services.<br>33 Case Management Services.<br>34 Hospital Based Hemodialysis.<br>35 Free Standing Hemodialysis.<br>36 MCO Payments.<br>37 Ambulance Services.<br>38 Emergency Ambulance Services.<br>39 Air Transportation Services.<br>40 Medicare Part A Services.<br>41 Medicare Part B Services.<br>42 Other Practitioner Services.<br>43 Transportation OSSE Services.<br>44 General Non-Billing Services.<br>46 MCO Abortion Payment.<br>47 Dental Services Reduced Rate.<br>56 NET Broker Services.<br>98 Unknown. |
| Child and Adolescent Supplemental Security Income Program (CASSIP) | Child and Adolescent Supplemental Security Income (SSI) or SSI-related Plans.   |
| 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 DHCF 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 Managed Care program.  |

| Term                                       | Definition   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
|--|--|------------|------------------------|---|----------------|---|----------------------------------|---|------------|---|---------------------------|---|---------------------------|---|---------|---|--------|---|--------------------|---|-----------------------|---|---------|---|-----------|---|----------|---|----------------------|---|---------------|---|-----------------------------------|---|------------|---|------------------------|---|----------|---|----------------------|---|-------------------------------------|---|---|---|-------------|
| 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 eligible.  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| Claim                                      | A bill from a provider of a medical service or product that is assigned a unique identifier that is a claim reference number). A claim does not include an encounter form for which no payment is made or only a nominal payment is made.  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| Claim Types                                | <p>Claim types and their descriptions as defined by the Xerox MMIS are:</p> <table> <tr> <th>CLAIM TYPE</th><th>CLAIM TYPE DESCRIPTION</th></tr> <tr> <td>1</td><td>Credit Request</td></tr> <tr> <td>2</td><td>Replacement (Adjustment) Request</td></tr> <tr> <td>3</td><td>Capitation</td></tr> <tr> <td>A</td><td>Medicare Part A Crossover</td></tr> <tr> <td>B</td><td>Medicare Part B Crossover</td></tr> <tr> <td>C</td><td>Clinics</td></tr> <tr> <td>D</td><td>Dental</td></tr> <tr> <td>E</td><td>Vision and Hearing</td></tr> <tr> <td>F</td><td>Financial Transaction</td></tr> <tr> <td>H</td><td>Hospice</td></tr> <tr> <td>I</td><td>Inpatient</td></tr> <tr> <td>K</td><td>Services</td></tr> <tr> <td>L</td><td>Laboratory and X-ray</td></tr> <tr> <td>M</td><td>Mental Health</td></tr> <tr> <td>N</td><td>Nursing Facility &amp; Long Term Care</td></tr> <tr> <td>O</td><td>Outpatient</td></tr> <tr> <td>P</td><td>Practitioner/Physician</td></tr> <tr> <td>R</td><td>Pharmacy</td></tr> <tr> <td>S</td><td>Medical Supply (DME)</td></tr> <tr> <td>T</td><td>Transportation (includes Ambulance)</td></tr> <tr> <td>U</td><td>Medicare UB Part B Outpatient Crossover</td></tr> <tr> <td>V</td><td>Home Health</td></tr> </table> | CLAIM TYPE | CLAIM TYPE DESCRIPTION | 1 | Credit Request | 2 | Replacement (Adjustment) Request | 3 | Capitation | A | Medicare Part A Crossover | B | Medicare Part B Crossover | C | Clinics | D | Dental | E | Vision and Hearing | F | Financial Transaction | H | Hospice | I | Inpatient | K | Services | L | Laboratory and X-ray | M | Mental Health | N | Nursing Facility & Long Term Care | O | Outpatient | P | Practitioner/Physician | R | Pharmacy | S | Medical Supply (DME) | T | Transportation (includes Ambulance) | U | Medicare UB Part B Outpatient Crossover | V | Home Health |
| CLAIM TYPE                                 | CLAIM TYPE DESCRIPTION   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| 1  | Credit Request   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| 2  | Replacement (Adjustment) Request   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| 3  | Capitation   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| A  | Medicare Part A Crossover  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| B  | Medicare Part B Crossover  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| C  | Clinics  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| D  | Dental   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| E  | Vision and Hearing   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| F  | Financial Transaction  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| H  | Hospice  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| I  | Inpatient  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| K  | Services   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| L  | Laboratory and X-ray   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| M  | Mental Health  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| N  | Nursing Facility & Long Term Care  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| O  | Outpatient   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| P  | Practitioner/Physician   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| R  | Pharmacy   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| S  | Medical Supply (DME)   |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| T  | Transportation (includes Ambulance)  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| U  | Medicare UB Part B Outpatient Crossover  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| V  | Home Health  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |
| Clean Claim                                | Claim submitted on an approved claim format, and containing complete and accurate information for all data fields required by the Contractor and DHCF 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."  |            |                        |   |                |   |                                  |   |            |   |                           |   |                           |   |         |   |        |   |                    |   |                       |   |         |   |           |   |          |   |                      |   |               |   |                                   |   |            |   |                        |   |          |   |                      |   |                                     |   |   |   |             |

| Term                                     | Definition  |
|--|---|
| 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 DHCF.  |
| Contractor                               | A MCO participating in the District's Managed Care program 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.  |
| Denial of Services                       | Any determination made by the Contractor in response to a provider's request for approval to provide DHCF-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 Xerox 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 Xerox for MCOs containing encounter records that have failed Xerox MMIS edits and audits process and have been denied.  |
| Denial Reports                           | Monthly reports generated by Xerox 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.  |
| Department of Health Care Finance (DHCF) | The administration within the District Department of Health responsible for administering all Medicaid services under Title XIX (Medicaid) for eligible beneficiaries, including the Managed Care program and oversight of its managed care contractors.  |
| Disenrollment                            | Action taken by DHCF, or its vendor, to remove a beneficiary's name from the monthly Enrollment Report following the DHCF's receipt of a determination that the beneficiary is no longer eligible for enrollment.   |
| District                                 | Refers to the Government of the District of Columbia.   |



| Term   | Definition  |
|--|---|
| Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) | DSM-5 is the 2013 update to the American Psychiatric Association's classification and diagnostic tool of mental, alcohol, and drug abuse disorders to reflect coding effective October 1, 2014. This replaced the DSM-4 code book.  |
| 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 DHCF benefits. An eligibility period is indicated by the eligibility start and end dates.   |
| 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 DHCF. 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 DHCF. The information provided on these records represents the encounter data provided by the Contractor.  |
| Encounter Edits  | Xerox system processing checks that evaluate submitted encounter data for syntax, format, data quality problems, and duplicate records.   |
| Encounter Reporting Formats  | 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. DHCF requires the 837 transactions to be submitted in the provider-payer-to-payer COB format. The ANSI ASC X12N HIPAA standard transactions for electronic data interchange are: 837 (I, P, and D) health claims (or equivalent encounter information).   |
| Encounter Submission   | The monthly processing of encounter data performed by Xerox, which includes receipt of new and correction encounter files, encounter processing, and distribution of Adjudicated and Denied Correction 835 files to MCOs.   |

| Term  | Definition   |
|---|--|
| Encounter Submission Requirements               | Section C.12 of the MCO contract requires Contractor to collect and submit service-specific encounter data in the appropriate 837 format, or an alternative format, if approved by DHCF. Encounters must be submitted within 30 days after the claim was paid of a capitated encounter was processed. The data shall include all services reimbursed by the Contractor. Adjustments to previous records that are deemed repairable denials by Xerox are submitted in the next monthly cycle. Further, Section C.12 of the MCO contract requires Contractor to submit encounters at least once per week, unless otherwise approved by DHCF. In instances where a claim has been voided, the MCO must submit the encounter void within seven days. |
| Enrollee  | A person eligible for the District's Medicaid program who is enrolled in a Managed Care program 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.  |
| 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, Waste, and Abuse                         | 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.   |
| Generic ID                                      | A provider type-specific provider ID created by Xerox for assignment to providers who do not have a DHCF provider ID.  |
| 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.<br>The ANSI ASC X12N HIPAA standard transactions for electronic data interchange are:<br>837 (I, P, and D) health claims (or equivalent encounter information).<br>834 health plan enrollment and disenrollment.<br>270/271 health plan eligibility.<br>835 health care payment and remittance advice.<br>820 health plan premium payments.<br>276/277 referral certification and authorization.   |

| Term   | Definition   |
|--|--|
| Involuntary Disenrollment                            | The termination of membership of an enrollee under conditions permitted in this agreement.   |
| Managed Care Organization (MCO)                      | 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. MCO is the term used to represent those plans participating in the 1915(b) Managed Care program, 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 Managed Care program 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. Currently the system is Omnicaid, operated by Xerox.  |
| 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 (Managed Care program) | A program for the provision and management of specified Medicaid services through contracted MCOs. Managed Care program 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.   |
| 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.  |
| Non-repairable denials                               | Denials that cannot be corrected and resubmitted to Xerox due to system limitations (that is, valid procedure code not found on the MMIS).   |
| Original Transaction Control Number (TCN)            | The TCN of the originally submitted claim. The original TCN must be submitted on claims when claim frequency type code value 8 (void/cancel of a prior claim) is submitted.  |
| 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 for a service or course of treatment of a specific duration and scope to an enrollee prior to the provision of the service.   |
| Provider   | An individual or organization that delivers medical, dental, rehabilitation, or mental health services within the scope of their license.  |
| Provider File  | A monthly file produced by DHCF for MCOs with information regarding all DHCF registered providers.   |

| Term   | Definition   |
|--|--|
| 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                                 | The reference file is claims code sets maintained by Xerox on behalf of DHCF and reflects the procedure and diagnosis codes approved for FFS recipients.   |
| Repairable Denials                             | Encounter denials that are to be corrected and resubmitted to Xerox.   |
| 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 250 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 as primary for certain health services for a Medicaid-eligible, in addition to Medicaid. Includes Medicare, 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 Xerox 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 Omnicaid 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. The last digit represents the TCN type where 7 equals original and 8 equals credit (void). |

## APPENDIX B

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### 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. DHCF has chosen to adopt these standards for MCO encounter data reporting.

#### **What is Xerox and what is their role with MCOs?**

Xerox provides functions and services to receive and send ANSI ASC X12N transactions on behalf of their clients, including DHCF.

#### **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 Xerox EDI Support Unit Monday through Friday, from 8:00 a.m. to 5:00 p.m. EST, at +1 866 407 2005.

#### **I am preparing for testing with EDIFECs. Whom do I contact for more information?**

For answers to questions regarding specifications and testing, please contact the EDI Business Support Analysts per the Xerox companion guide instructions.

#### **Will DHCF provide us with a paper or electronic remittance advice?**

Xerox will provide MCOs with an electronic 835 Health Care Claim Payment/Remittance 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/products/code-lists/>.

**We understand that DHCF will now require the taxonomy code to process the 837 COB. Is this correct?**

Yes, that is correct. Effective with encounter submissions after May 23, 2008, the Xerox NPI matching algorithm requires taxonomy when a provider has multiple Medicaid IDs.

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

Yes, DHCF does require provider type to process a claim. Xerox 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 2420A of the 837. If the provider does not have a valid Medicaid Provider Number, the MCO must assign one of the Xerox 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 Xerox have any payer-specific instructions for 837 COB transactions?**

Yes, the Xerox Companion Guides contain a number of payer-specific instructions for 837 transactions. The Xerox Companion Guides can be found at [www.acs-gcro.com](http://www.acs-gcro.com). Once on the Xerox website, select Clients, District of Columbia Medicaid, and choose Companion from the left hand menu. 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 Xerox 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 of the MCO contract requires Contractor to collect and submit service-specific encounter data in the appropriate 837 format, or an alternative format, if approved by DHCF. The data shall be submitted electronically within 30 days after the claim or capitation payment was paid. The data shall include all services reimbursed by the Contractor. Adjustments to previous records that are deemed repairable denials by Xerox are submitted in the next monthly cycle.
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.
3. Utilization Review and Clinical Quality Improvement: DHCF's managed care plan is a Medicaid waiver program partially funded by CMS. Encounter data are analyzed and used by CMS and DHCF to evaluate program effectiveness, monitor quality of care, utilization levels and patterns, access to care, and to evaluate MCO performance. The utilization data from encounter records provides DHCF with performance data and indicators. DHCF 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

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## Code Sets

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, DHCF 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, which are valid at the time the transaction is initiated.

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

- A. International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM<sup>2</sup>), 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.
  - 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.
  - Management.

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<sup>2</sup> ICD-9CM will be replaced on October 1, 2014 with ICD-10.

- C. National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:
- Drugs.
  - 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.
  - 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.
  - DME.
- G. The place of service (POS) for professional services valid in the Omnicaid system as of March 2013 are:

| POS | Description   |
|-----|---|
| 03  | School  |
| 04  | Homeless Shelter                                    |
| 05  | Indian Health Services (IHS) free-standing facility |
| 06  | IHS Provider-based Facility                         |
| 07  | Tribal 638 Free-standing Facility                   |
| 08  | Tribal 638 Provider-based Facility                  |
| 09  | Mobile Unit   |
| 11  | Office  |
| 12  | Home  |
| 14  | Group Home  |
| 15  | Day Treatment                                       |

| POS | Description                     |
|-----|---------------------------------|
| 18  | Residential Treatment           |
| 20  | Urgent Care Facility            |
| 21  | Inpatient Hospital              |
| 22  | Outpatient Hospital             |
| 23  | Emergency Room Hospital         |
| 24  | Ambulatory Surgical Center      |
| 25  | Birth Center                    |
| 26  | Military Treatment Facility     |
| 31  | Skilled Nursing Facility        |
| 32  | Nursing Facility                |
| 33  | Custodial Care Facility         |
| 34  | Hospice                         |
| 41  | Ambulance Land                  |
| 42  | Ambulance Air or Water          |
| 50  | Federally Qualified Health Ctr  |
| 51  | Inpatient Psychiatric Facility  |
| 52  | Psych Facility Partial Hosp     |
| 53  | Community Mental Health Center  |
| 54  | Intermediate Care Facility-MR   |
| 55  | Resdntl Sbstnce Abuse Trmt Cntr |
| 56  | Psychiatric Resident Trmt Cntr  |
| 61  | Comprehensive IP Rehab Faci     |
| 62  | Comprehensive OP Rehab Faci     |
| 65  | End Stage Renal Dis Trmt Faci   |
| 71  | State Local Public Hlth Clinic  |
| 72  | Rural Health Clinic             |
| 81  | Independent Laboratory          |
| 99  | Other Unlisted Facility         |

H. Valid values for the provider specialty in the Omnicaid system are:

| Specialty Code | Description     |
|----------------|-----------------|
| 001            | Cardiology      |
| 002            | Radiology       |
| 003            | Pathology       |
| 004            | Pediatrics      |
| 005            | Psychiatry      |
| 006            | OB-GYN          |
| 007            | General Surgery |

| Specialty Code | Description                     |
|----------------|---------------------------------|
| 008            | Orthopedic Surgery              |
| 009            | Neurological Surgery            |
| 010            | Thoracic Surgery                |
| 011            | Plastic Surgery                 |
| 012            | Internal Medicine               |
| 013            | General Preventative Medicine   |
| 014            | Anesthesiology                  |
| 015            | Ophthalmology                   |
| 016            | Otolaryngology                  |
| 017            | Urology                         |
| 018            | Dermatology                     |
| 019            | Pulmonary Disease               |
| 022            | Hematology-Oncology             |
| 023            | Gastroenterology                |
| 024            | Allergy and Immunology          |
| 027            | Rheumatology                    |
| 028            | Endocrinology                   |
| 029            | Infectious Diseases             |
| 030            | Nephrology                      |
| 031            | Family Practice                 |
| 033            | General Dentistry               |
| 034            | Orthodontics                    |
| 035            | Pediatric Dentistry             |
| 036            | Oral & Maxillofacial Surgery    |
| 037            | Endodontic                      |
| 038            | Periodontics                    |
| 039            | Prosthodontics                  |
| 043            | Emergency Medicine              |
| 044            | Geriatric Medicine              |
| 050            | Nuclear Medicine                |
| 060            | Physical Medicine Rehab         |
| 072            | Colon and Rectal Surgery        |
| 078            | Periph Vascular Surgery         |
| 083            | Radiation Therapy               |
| 089            | Neonatal-Perinatal Medicine     |
| 092            | Neurology                       |
| 095            | Adult Substance Abuse Rehab Svc |
| 105            | Medical Genetics                |

| <b>Specialty Code</b> | <b>Description</b>             |
|-----------------------|--------------------------------|
| 111                   | Diabetic Footwear              |
| 112                   | Orthotics Device               |
| 113                   | Pedorthic Device               |
| 114                   | Power Mobility Device          |
| 115                   | Prosthetics                    |
| 116                   | Respiratory Equipment          |
| 117                   | Wheelchairs                    |
| 118                   | DME Supplies                   |
| 119                   | Hospital Bed and Accessories   |
| 120                   | Oxygen and Accessories         |
| 700                   | MRDD Dental Services           |
| 701                   | MRDD Speech, Hearing, Language |
| 702                   | MRDD Nutritional Counselor     |
| 703                   | MRDD Personal Care Aide        |
| 704                   | MRDD Respite Care Aide         |
| 705                   | MRDD Residential Habilitation  |
| 706                   | MRDD Day Habilitation          |
| 707                   | MRDD Supportive Employment     |
| 708                   | MRDD Prevocational             |
| 709                   | MRDD Environment Modification  |
| 710                   | MRDD Personal Emerg Respon Sys |
| 711                   | Case Management                |
| 712                   | Chore Services                 |
| 713                   | Homemaker                      |
| 714                   | Respite Care                   |
| 715                   | Personal Care Aid State Plan   |
| 716                   | Behavioral Supports            |
| 717                   | Community Support Team         |
| 718                   | Family Training                |
| 719                   | One Time Transitional Services |
| 720                   | Vehicle Modifications          |
| 721                   | DME Personal Emerg Resp Sys    |
| 722                   | Acupuncturist                  |
| 723                   | Art Therapist                  |
| 724                   | Dance Therapist                |
| 725                   | Drama Therapist                |
| 726                   | Fitness Trainer                |
| 727                   | Massage Therapist              |

| Specialty Code | Description                    |
|----------------|--------------------------------|
| 728            | Music Therapist                |
| 729            | Sexuality Education Specialist |
| 730            | MRDD Case Management           |
| 731            | MRDD Skilled Nursing           |
| 732            | MRDD Physical Therapy          |
| 733            | MRDD Occupational Therapy      |
| 734            | Host Home                      |
| 735            | In-Home Supports               |
| 736            | Supported Living               |
| 737            | Live-In Caregiver              |
| 738            | EPD Attendant Care             |
| 739            | EPD Part-Dir Goods & Service   |
| 740            | Support Broker                 |
| 741            | EPD Financial Management Svc   |
| 742            | EPD Assisted Living            |

I. Valid values for the provider types in the Omnicaid system as of March 2013 are:

| Provider Type | Description                   |
|---------------|-------------------------------|
| A00           | Physician MD                  |
| A01           | Physician, Group Practice     |
| A02           | Doctor Of Osteopathy          |
| A03           | Psychologist                  |
| A04           | Podiatrist                    |
| A05           | Early Intervention            |
| B00           | Independent Lab               |
| B01           | Ind X-ray And Lab             |
| C00           | Independent X-ray             |
| D00           | Hospital, General             |
| D01           | Hospital, LTAC                |
| D02           | Hospital, Psychiatric Public  |
| D03           | Hospital, Psychiatric Private |
| D04           | Hospital, Emergency Access    |
| D05           | Residential Treatment Center  |
| E00           | Radiation Therapy Center      |
| F00           | Nursing Facility              |
| G00           | ICF/MR                        |
| H00           | Pharmacy, Retail              |

| Provider Type | Description                    |
|---------------|--------------------------------|
| H01           | Pharmacy, Institutional        |
| H02           | Pharmacy, ADAP                 |
| I00           | DME                            |
| J00           | Ambulance, Private             |
| J01           | Ambulance, Public              |
| J02           | Ambulance, Air Transport       |
| K00           | Dentist                        |
| K01           | Dentist, Group Practice        |
| K02           | Dentist, Waiver                |
| L00           | Home Health Agency             |
| L01           | Hospice                        |
| M00           | Audiologist                    |
| M01           | Hearing Aid Dealer             |
| N00           | Optometrist                    |
| N01           | Optician/Optical Dispensary    |
| P00           | Schools, DC Public             |
| P01           | Schools, DC Public Charter     |
| P02           | Office State Superinten of Ed  |
| Q01           | Hemodialysis, Freestanding     |
| Q02           | Hemodialysis, Hospital Based   |
| R01           | Crossover Claims UB            |
| R02           | Crossover Claims Only 1500     |
| S00           | Nurse Practitioner             |
| S01           | Nurse Midwives                 |
| T00           | Rehabilitation Center          |
| T01           | Mental Health Rehab Services   |
| U00           | General Non-Billing            |
| U01           | Insurance Premium Type A       |
| U02           | Insurance Premium Type B       |
| U03           | Insurance Premium Type C       |
| U04           | Recipient Out Of Pocket        |
| U05           | COBRA Insurance                |
| U06           | TPL Case Recovery              |
| U07           | Money Follows Person Financial |
| U08           | EHR Incentive Paymnt Financial |
| V00           | Ambulatory Surgical Centers    |
| V01           | Birthing Centers               |
| V02           | Day Treatment                  |

| Provider Type | Description                   |
|---------------|-------------------------------|
| W01           | MRDD Waiver                   |
| W02           | EPD Waiver                    |
| W03           | Adult Day Care                |
| X00           | Clinic, Private               |
| X01           | Clinic, Dental                |
| X02           | Clinic, Mental Health         |
| X03           | Clinic, Family Planning       |
| X04           | Clinic, Adlt Alc/Subst Abuse  |
| X05           | Clinic, Fed Qualified Health  |
| X06           | Clinic, Youth Alc/Subst Abuse |
| Z00           | Managed Care Organization     |
| Z01           | MCO, Special Needs            |
| Z02           | Medical Transportation Broker |



## APPENDIX D

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### System Generated Reports

The overarching purpose of this set of reports is to enhance the quality of the encounter data by providing DHCF, 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 Xerox. 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 Xerox 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 repairable 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 repairable 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 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 6 of this Manual. These quality reports will also depict accuracy and completeness at a volume and utilization level.

#### **ASC X12N 835**

As discussed above, and in Section 5, MCOs will receive an 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 repairable, are represented in the 835. TCNs are assigned by claim and can be located in the 835 specific to the encounter. Please refer to Section 5 for more information regarding 835 transaction reporting.

#### ***Encounter Claims Summary — Xerox Reports YCMH5700***

This report will serve as the high-level error report for the MCOs as a summarization of the errors incurred. The YCMH5700-RH680 report will represent Medicaid and the YCMH5700-RH681 will represent Alliance submissions. 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, repairable or not.

03/23/2010  
REPT: YCMH5700-RH680  
00:22:58

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)

PROCESSING DATE:

MEDICAID MANAGEMENT INFORMATION SYSTEM

PROCESSING TIME:

ENCOUNTER CLAIMS SUMMARY REPORT  
Health Plan 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     | 25          | 25           | 100          | 0              | 0              | 0                | 0                |
| I          | INPATIENT  | 2           | 2            | 100          | 0              | 0              | 0                | 0                |
| L          | LAB & XRAY | 2           | 2            | 100          | 0              | 0              | 0                | 0                |
| O          | OUTPATIENT | 23          | 22           | 95           | 1              | 4              | 0                | 0                |
| P          | PRACT/PHY  | 23          | 23           | 100          | 0              | 0              | 0                | 0                |
|            |            | 75          | 74           | 98           | 1              | 1              | 0                | 0                |

**Encounter Exception Disposition Summary — Xerox Reports  
YCMH5800**

This report will serve as the high-level edit report for the MCOs as a summarization of the exceptions incurred. The YCMH5800-RH690 report will represent Medicaid and the YCMH5800-RH691 will represent Alliance submissions. 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.

| MM/DD/YYYY                 | DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF) | PROCESSING DATE: |           |                                |              |
|----------------------------|---|------------------|-----------|--------------------------------|--------------|
| REPT: YCMH5800-RH690       | MEDICAID MANAGEMENT INFORMATION SYSTEM                        | PROCESSING TIME: |           |                                |              |
| 00:03:39                   | ENCOUNTER EXCEPTION DISPOSITION SUMMARY<br>MCO NAME HERE      |                  |           |                                |              |
| EXCEPTION DISPOSITION      | CLAIM TYPE  | CLAIM DESC       | EXCP CODE | SHORT DESCRIPTION              | NUM OF EXCPS |
| DENY                       | O   | OUTPATIENT       | 5405      | SURG PROC REQUIRES REV CODE    | 1            |
| DENY                       | O   |                  |           |                                | 1            |
| PAY                        | D   | DENTAL           | 0331      | NO LTC SPAN AVAIL FOR FRST DOS | 67           |
| PAY                        | D   |                  |           |                                | 67           |
|                            | I   | INPATIENT        | 5302      | INELIGIBLE PROVIDER COS        | 2            |
|                            | I   |                  |           |                                | 2            |
| PAY                        | O   | OUTPATIENT       | 0260      | DIAGNOSIS CODE NOT SPECIFIC    | 1            |
|                            | O   | OUTPATIENT       | 0325      | TRAUMA/ACCIDENT CLAIM          | 1            |
| PAY                        | O   | OUTPATIENT       | 5209      | INVALID/MISSING MED. REC. NUM. | 21           |
| PAY                        | O   |                  |           |                                | 23           |
|                            | P   | PRACT/PHY        | 0325      | TRAUMA/ACCIDENT CLAIM          | 4            |
| PAY                        | P   | PRACT/PHY        | 0331      | NO LTC SPAN AVAIL FOR FRST DOS | 27           |
|                            | P   | PRACT/PHY        | 5284      | INELIGIBLE PROGRAM CODE        | 2            |
| PAY                        | O   |                  |           |                                | 23           |
| TOTAL NUMBER OF EXCEPTIONS |   |                  |           |                                | 126          |

**Repairable Exceptions and Pay-but-Report Detail — Xerox Reports  
YCMH5900**

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 repairable. The YCMH5900-RH695 report will represent Medicaid and the YCMH5900-RH696 will represent Alliance submissions. Refer to Section 3 of the Manual for a listing of repairable edits. It is a detailed listing by line item of the edits applied to the encounter data.

MM/DD/YYYY  
REPT: YCMH5900-RH695  
00:03:56

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE (DHCF)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
REPARABLE EXCEPTIONS AND PAY-BUT-REPORT DETAIL  
MCO NAME HERE

PROCESSING DATE:  
PROCESSING TIME:

| CLAIM<br>STATUS<br>EXCEPTIONS        | CLM<br>TYPE | TRANSACTION<br>CONTROL<br>NUMBER | HEADER/<br>LINE CD | RECIP<br>ID | PROVIDER<br>NUMBER | DATES OF<br>SERVICE<br>FIRST | LAST     | MCO PAID<br>AMOUNT | BILLED<br>CHARGE | - - - - - |
|--------------------------------------|-------------|----------------------------------|--------------------|-------------|--------------------|------------------------------|----------|--------------------|------------------|-----------|
| PATIENT ACCOUNT NUMBER: MCO ICN HERE |             |                                  |                    |             |                    |                              |          |                    |                  |           |
| DENIED                               | O           | 10080075130000397                | 02                 |             | MEMBERID 039431900 | 01/01/01                     | 01/01/01 | .00                | .00              | 5209 0331 |
|                                      |             |                                  | 04                 |             | MEMBERID 039431900 | 11/13/09                     | 11/13/09 | 66.17              | .00              | 5405 0331 |

NUMBER OF HEADER/LINE DENIED: 002

## Reconciliation File

This report is provided to each MCO monthly after the last Friday of the month. This reconciliation file provides additional detailed information on encounter data with Omnicaid paid dates of the past month. This can be used for multiple purposes, including but not limited to:

- Validation acceptance or denial of encounter data header and detail.
- Validation of what errors occurred at the header and/or detail for each encounter.
- Comparison of MCO paid amounts to the shadow price by Omnicaid.
- Validation of the Omnicaid claim type applied based on encounter data submitted.
- Validation of the Omnicaid TCN for each encounter submitted.

### Reconciliation File Layout

| WWH7400O-MCO-RECON-REC                       | Data Type | Length | From | To  | Valid Values                           | Description                              |
|--|-----------|--------|------|-----|--|--|
| WWH7400O-MCO-DELIM1                          | char      | 1      | 1    | 1   | "~"                                    |  |
| WWH7400O-MCO-TCN                             | numeric   | 17     | 2    | 18  |  | Omnicaid Transaction control number      |
| WWH7400O-MCO-DELIM2                          | char      | 1      | 19   | 19  | "~"                                    |  |
| WWH7400O-MCO-ACCTING-CODE                    | char      | 1      | 20   | 20  | "0" - Original<br>"1" - Void           |  |
| WWH7400O-MCO-DELIM3                          | char      | 1      | 21   | 21  | "~"                                    |  |
| WWH7400O-MCO-CLM-CRED-IND                    | char      | 1      | 22   | 22  | "0" - Original<br>"1" - Void           | Not populated on line number '00'        |
| WWH7400O-MCO-DELIM4                          | char      | 1      | 23   | 23  | "~"                                    |  |
| WWH7400O-MCO-CLM-FREQ-TYPE                   | char      | 1      | 24   | 24  | "1" - Original<br>"8" - Void           | Not populated on line number '00'        |
| WWH7400O-MCO-DELIM5                          | char      | 1      | 25   | 25  | "~"                                    |  |
| WWH7400O-MCO-CLM-DISPOSITION                 | char      | 1      | 26   | 26  | "P" - Paid claim<br>"D" - Denied claim |  |
| WWH7400O-MCO-DELIM6                          | char      | 1      | 27   | 27  | "~"                                    |  |
| WWH7400O-MCO-EXCP-CODES<br>(occurs 20 times) | char      | 7      | 28   | 167 |  | Values included in MCO Encounter Manual. |

| WWH7400O-MCO-RECON-REC       | Data Type | Length | From | To  | Valid Values                                     | Description                         |
|------------------------------|-----------|--------|------|-----|--|-------------------------------------|
| WWH7400O-MCO-EXCP-CODE       | char      | 4      |      |     |  | Exception code                      |
| WWH7400O-MCO-EXCP-DELIM      | char      | 1      |      |     | "~"  |                                     |
| WWH7400O-MCO-EXCP-DISP       | char      | 1      |      |     | "3" - Deny<br>"5" - Pay &<br>Report<br>"6" - Pay |                                     |
| WWH7400O-MCO-EXCP-DELIM2     | char      | 1      |      |     | "~"  |                                     |
| WWH7400O-MCO-LINE-NUMBER     | char      | 2      | 168  | 169 |  |                                     |
| WWH7400O-MCO-DELIM7          | char      | 1      | 170  | 170 | "~"  |                                     |
| WWH7400O-MCO-CLM-TYPE        | char      | 1      | 171  | 171 | Claim type                                       | See Clm-type List                   |
| WWH7400O-MCO-DELIM8          | char      | 1      | 172  | 172 | "~"  |                                     |
| WWH7400O-MCO-COS             | char      | 2      | 173  | 174 | Category of service                              | See COS List                        |
| WWH7400O-MCO-DELIM9          | char      | 1      | 175  | 175 | "~"  |                                     |
| WWH7400O-MCO-ICN             | char      | 20     | 176  | 195 |  | Transaction number submitted by MCO |
| WWH7400O-MCO-DELIM10         | char      | 1      | 196  | 196 | "~"  |                                     |
| WWH7400O-MCO-SVC-HDR-BEG-DT  | char      | 8      | 197  | 204 | CCYYMMDD   | Claim header service begin date     |
| WWH7400O-MCO-DELIM11         | char      | 1      | 205  | 205 | "~"  |                                     |
| WWH7400O-MCO-SVC-HDR-END-DT  | char      | 8      | 206  | 213 | CCYYMMDD   | Claim header service end date       |
| WWH7400O-MCO-DELIM12         | char      | 1      | 214  | 214 | "~"  |                                     |
| WWH7400O-MCO-SVC-LINE-BEG-DT | char      | 8      | 215  | 222 | CCYYMMDD   | Claim line service begin date       |
| WWH7400O-MCO-DELIM13         | char      | 1      | 223  | 223 | "~"  |                                     |
| WWH7400O-MCO-SVC-LINE-END-DT | char      | 8      | 224  | 231 | CCYYMMDD   | Claim line service end date         |
| WWH7400O-MCO-DELIM14         | char      | 1      | 232  | 232 | "~"  |                                     |
| WWH7400O-MCO-RECEIPT-DT      | char      | 8      | 233  | 240 | CCYYMMDD   | Claim receipt date                  |
| WWH7400O-MCO-DELIM15         | char      | 1      | 241  | 241 | "~"  |                                     |
| WWH7400O-MCO-PD-DT           | char      | 8      | 242  | 249 | CCYYMMDD   | Claim paid date                     |
| WWH7400O-MCO-DELIM16         | char      | 1      | 250  | 250 | "~"  |                                     |
| WWH7400O-MCO-BILLED-AMT-SIGN | char      | 1      | 251  | 251 | "+", "-", "                                      |                                     |
| WWH7400O-MCO-BILLED-AMT-9    | numeric   | 9      | 252  | 260 |  |                                     |
| WWH7400O-MCO-BILLED-AMT-DP   | char      | 1      | 261  | 261 | "."  |                                     |
| WWH7400O-MCO-BILLED-AMT-2    | numeric   | 2      | 262  | 263 |  |                                     |
| WWH7400O-MCO-DELIM17         | char      | 1      | 264  | 264 | "~"  |                                     |

| WWH7400O-MCO-RECON-REC                        | Data Type | Length | From | To  | Valid Values     | Description        |
|---|-----------|--------|------|-----|------------------|--------------------|
| WWH7400O-MCO-PAID-AMT-SIGN                    | char      | 1      | 265  | 265 | "+", "-"         |                    |
| WWH7400O-MCO-PAID-AMT-9                       | numeric   | 9      | 266  | 274 |                  |                    |
| WWH7400O-MCO-PAID-AMT-DP                      | char      | 1      | 275  | 275 | "."              |                    |
| WWH7400O-MCO-PAID-AMT-2                       | numeric   | 2      | 276  | 277 |                  |                    |
| WWH7400O-MCO-DELIM18                          | char      | 1      | 278  | 278 | "~"              |                    |
| WWH7400O-MCO-MAA-PAID-AMT-SIGN                | char      | 1      | 279  | 279 | "+", "-"         |                    |
| WWH7400O-MCO-MAA-PAID-AMT-9                   | numeric   | 9      | 280  | 288 |                  |                    |
| WWH7400O-MCO-MAA-PAID-AMT-DP                  | char      | 1      | 289  | 289 | "."              |                    |
| WWH7400O-MCO-MAA-PAID-AMT-2                   | numeric   | 2      | 290  | 291 |                  |                    |
| WWH7400O-MCO-DELIM19                          | char      | 1      | 292  | 292 | "~"              |                    |
| WWH7400O-MCO-POS                              | char      | 2      | 293  | 294 | Place of service | See POS List       |
| WWH7400O-MCO-DELIM20                          | char      | 1      | 295  | 295 | "~"              |                    |
| WWH7400O-MCO-BILL-TYPE                        | char      | 3      | 296  | 298 | Bill type        | See Bill-type List |
| WWH7400O-MCO-DELIM21                          | char      | 1      | 299  | 299 | "~"              |                    |
| WWH7400O-MCO-TOS                              | char      | 1      | 300  | 300 | Not populated    |                    |
| WWH7400O-MCO-DELIM22                          | char      | 1      | 301  | 301 | "~"              |                    |
| WWH7400O-MCO-DRG-CODE                         | char      | 5      | 302  | 306 |                  |                    |
| WWH7400O-MCO-DELIM23                          | char      | 1      | 307  | 307 | "~"              |                    |
| WWH7400O-MCO-REV-CODE                         | char      | 4      | 308  | 311 | Revenue code     | See Rev-code List  |
| WWH7400O-MCO-DELIM24                          | char      | 1      | 312  | 312 | "~"              |                    |
| WWH7400O-MCO-PRIN-DIAG-CODE                   | char      | 10     | 313  | 322 |                  |                    |
| WWH7400O-MCO-DIAG-DELIM-1                     | char      | 1      | 323  | 323 | "~"              |                    |
| WWH7400O-MCO-DIAG-CODE-ICD-9 (occurs 7 times) |           |        |      |     |                  |                    |
| WWH7400O-MCO-DIAG-CODE                        | char      | 10     | 324  | 400 |                  |                    |
| WWH7400O-MCO-DIAG-DELIM                       | char      | 1      |      |     | "~"              |                    |
| WWH7400O-MCO-PRIN-SURG-CODE                   | char      | 7      | 401  | 407 |                  | UB04 ICD9/10 code  |
| WWH7400O-MCO-PRIN-SURG-DELIM1                 | char      | 1      | 408  | 408 | "~"              |                    |
| WWH7400O-MCO-PRIN-SURG-DT                     | char      | 8      | 409  | 416 | CCYYMMDD         |                    |
| WWH7400O-MCO-PRIN-SURG-DELIM2                 | char      | 1      | 417  | 417 | "~"              |                    |

| WWH7400O-MCO-RECON-REC                         | Data Type | Length | From | To  | Valid Values       | Description                |
|--|-----------|--------|------|-----|--------------------|----------------------------|
| WWH7400O-MCO-SURG-CODE-DATE (occurs 5 times)   |           |        | 418  | 502 |                    |                            |
| WWH7400O-MCO-SURG-CODE                         | char      | 7      |      |     |                    | UB04 ICD9/10 code          |
| WWH7400O-MCO-SURG-DELIM1                       | char      | 1      |      |     | "~"                |                            |
| WWH7400O-MCO-SURG-DATE                         | char      | 8      |      |     | CCYYMMDD           |                            |
| WWH7400O-MCO-SURG-DELIM2                       | char      | 1      |      |     | "~"                |                            |
| WWH7400O-MCO-PROC-CODE                         | char      | 7      | 503  | 509 |                    | Procedure code             |
| WWH7400O-MCO-DELIM25                           | char      | 1      | 510  | 510 | space              |                            |
| WWH7400O-MCO-PROC-MOD                          | char      | 2      | 511  | 512 |                    | Procedure code modifier    |
| WWH7400O-MCO-DELIM26                           | char      | 1      | 513  | 513 | "~"                |                            |
| WWH7400O-MCO-UNITS-SVC                         | numeric   | 9      | 514  | 522 |                    | Number of units of service |
| WWH7400O-MCO-DELIM27                           | char      | 1      | 523  | 523 | "~"                |                            |
| WWH7400O-MCO-PROV-NAME                         | char      | 35     | 524  | 558 |                    | Billing provider name      |
| WWH7400O-MCO-DELIM28                           | char      | 1      | 559  | 559 | "~"                |                            |
| WWH7400O-MCO-PROV-NUM                          | char      | 9      | 560  | 568 |                    | Billing provider number    |
| WWH7400O-MCO-DELIM29                           | char      | 1      | 569  | 569 | "~"                |                            |
| WWH7400O-MCO-PROV-TYPE                         | char      | 3      | 570  | 572 | Provider type      | See Prov-type List         |
| WWH7400O-MCO-DELIM30                           | char      | 1      | 573  | 573 | "~"                |                            |
| WWH7400O-MCO-NPI                               | char      | 10     | 574  | 583 |                    | Billing provider NPI       |
| WWH7400O-MCO-DELIM31                           | char      | 1      | 584  | 584 | "~"                |                            |
| WWH7400O-MCO-PROV-SPECIALTIES (occurs 6 times) |           |        | 585  | 602 |                    |                            |
| WWH7400O-MCO-PROV-SPEC                         | char      | 2      |      |     | Provider specialty | See Prov-spec List         |
| WWH7400O-MCO-PROV-DELIM                        | char      | 1      |      |     | "~"                |                            |
| WWH7400O-MCO-RECIP-ID                          |           | 8      | 603  | 610 |                    | Member ID number           |
| WWH7400O-MCO-DELIM32                           | char      | 1      | 611  | 611 | "~"                |                            |
| WWH7400O-MCO-RECIP-NAME-L                      | char      | 17     | 612  | 628 |                    | Member last name           |
| WWH7400O-MCO-DELIM33                           | char      | 1      | 629  | 629 | "~"                |                            |
| WWH7400O-MCO-RECIP-NAME-F                      | char      | 12     | 630  | 641 |                    | Member first name          |
| WWH7400O-MCO-DELIM34                           | char      | 1      | 642  | 642 | "~"                |                            |
| WWH7400O-MCO-TCN-TO-CREDIT                     | char      | 17     | 643  | 659 |                    | Populated only on voids    |

| <b>WWH7400O-MCO-RECON-REC</b> | <b>Data Type</b> | <b>Length</b> | <b>From</b> | <b>To</b> | <b>Valid Values</b> | <b>Description</b>      |
|-------------------------------|------------------|---------------|-------------|-----------|---------------------|-------------------------|
| WWH7400O-MCO-DELIM35          | char             | 1             | 660         | 660       | "~"                 |                         |
| WWH7400O-MCO-TOOTH-NUMBER     | char             | 2             | 661         | 662       |                     |                         |
| WWH7400O-MCO-DELIM36          | char             | 1             | 663         | 663       | "~"                 |                         |
| WWH7400O-MCO-SUBMITTER        | char             | 9             | 664         | 672       |                     | MCO submitter ID number |
| FILLER                        | char             | 1             | 673         | 673       |                     |                         |

# 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 dispositions:

- Encounter passes all edits and is accepted into the MMIS and priced per DHCF guidelines (Pay).
- Encounter contains a minor exception(s) — an information report is generated and the data is accepted into the MMIS (Pay & Report).
- Encounter contains a fatal error that results in its rejection (Denial).

Below are tables for encounters set to pay, pay and report, and non-repairable denials. Please see prior sections of this Manual for the exceptions that repairable denials and instructions for correction and resubmission by the MCO.

| EXCEPTION CODE | EXCEPTION DISPOSITION — PAY<br>EXCEPTION DESCRIPTION |
|----------------|--|
| 0135           | CLAIM PRICED AT ZERO                                 |
| 0159           | INVALID LINE ITEM EOB CODE                           |
| 0160           | TOTAL CLAIM CHARGE CONFLICT                          |
| 0169           | MEDCARE ALLOWED AMOUNT = ZERO                        |
| 0187           | INVALID HEADER EOB CODE                              |
| 0206           | NONCVD CHARGE CONFLICT                               |
| 0260           | DIAGNOSIS CODE NOT SPECIFIC                          |
| 0264           | MCARE PT A ELIG - W/O ATTACH                         |
| 0320           | CLIA CERT DOES NOT MATCH DOS                         |
| 0325           | TRAUMA/ACCIDENT CLAIM                                |
| 0331           | NO LTC SPAN AVAIL FOR FRST DOS                       |
| 0379           | INVALID DATE OF SERVICE                              |
| 0899           | MAX NUM OF EXCEPTIONS EXCEEDED                       |
| 1186           | INVALID/MISSING ADMIT HOUR                           |
| 1334           | CANNOT ASSIGN PAYTO PROG CD                          |
| 1480           | 1ST VALUE CODE/AMT MISSING                           |
| 1481           | 1ST VALUE CODE INVALID                               |
| 1482           | 2ND VALUE CODE/AMT MISSING                           |
| 1483           | 2ND VALUE CODE INVALID                               |
| 1484           | 3RD VALUE CODE/AMT MISSING                           |



| EXCEPTION CODE | EXCEPTION DISPOSITION — PAY<br>EXCEPTION DESCRIPTION |
|----------------|--|
| 1485           | 3RD VALUE CODE INVALID                               |
| 1486           | 4TH VALUE CODE/AMT MISSING                           |
| 1487           | 4TH VALUE CODE INVALID                               |
| 1488           | 5TH VALUE CODE/AMT MISSING                           |
| 1489           | 5TH VALUE CODE INVALID                               |
| 1490           | 6TH VALUE CODE/AMT MISSING                           |
| 1491           | 6TH VALUE CODE INVALID                               |
| 1492           | 7TH VALUE CODE/AMT MISSING                           |
| 1493           | 7TH VALUE CODE INVALID                               |
| 1494           | 8TH VALUE CODE/AMT MISSING                           |
| 1495           | 8TH VALUE CODE INVALID                               |
| 1496           | 9TH VALUE CODE/AMT MISSING                           |
| 1497           | 9TH VALUE CODE INVALID                               |
| 1498           | 10TH VALUE CODE/AMT MISSING                          |
| 1499           | 10TH VALUE CODE INVALID                              |
| 1500           | 11TH VALUE CODE/AMT MISSING                          |
| 1501           | 11TH VALUE CODE INVALID                              |
| 1502           | 12TH VALUE CODE/AMT MISSING                          |
| 1503           | 12TH VALUE CODE INVALID                              |
| 1504           | 13TH VALUE CODE/AMT MISSING                          |
| 1505           | 13TH VALUE CODE INVALID                              |
| 1506           | 14TH VALUE CODE/AMT MISSING                          |
| 1507           | 14TH VALUE CODE INVALID                              |
| 1508           | 15TH VALUE CODE/AMT MISSING                          |
| 1509           | 15TH VALUE CODE INVALID                              |
| 1510           | 16TH VALUE CODE/AMT MISSING                          |
| 1511           | 16TH VALUE CODE INVALID                              |
| 1512           | 17TH VALUE CODE/AMT MISSING                          |
| 1513           | 17TH VALUE CODE INVALID                              |
| 1514           | 18TH VALUE CODE/AMT MISSING                          |
| 1515           | 18TH VALUE CODE INVALID                              |
| 1516           | 19TH VALUE CODE/AMT MISSING                          |
| 1517           | 19TH VALUE CODE INVALID                              |
| 1518           | 20TH VALUE CODE/AMT MISSING                          |
| 1519           | 20TH VALUE CODE INVALID                              |
| 1520           | 21ST VALUE CODE/AMT MISSING                          |
| 1521           | 21ST VALUE CODE INVALID                              |
| 1522           | 22ND VALUE CODE/AMT MISSING                          |

| EXCEPTION CODE | EXCEPTION DISPOSITION — PAY<br>EXCEPTION DESCRIPTION |
|----------------|--|
| 1523           | 22ND VALUE CODE INVALID                              |
| 1524           | 23RD VALUE CODE/AMT MISSING                          |
| 1525           | 23RD VALUE CODE INVALID                              |
| 1526           | 24TH VALUE CODE/AMT MISSING                          |
| 1527           | 24TH VALUE CODE INVALID                              |
| 1681           | INVALID OTHR2 NPI-FAILS LUHN                         |
| 1682           | MULTIPLE OTHER2 PIDS FOUND                           |
| 1683           | NO MATCHING OTHR2 PID FOUND                          |
| 1684           | OTHR2 NPI NOT ON FILE                                |
| 1691           | INVALID REFERRING NPI-LUHN CHK                       |
| 1692           | MULTIPLE REFERRING PIDS FOUND                        |
| 1693           | NO MATCHING REFERRING PID                            |
| 1694           | REFERRING NPI NOT ON FILE                            |
| 2011           | PRINCIPAL DIAGNOSIS DENIED                           |
| 2012           | ADMITTING DIAGNOSIS DENIED                           |
| 2013           | 1ST DIAGNOSIS CODE DENIED                            |
| 2014           | 2ND DIAGNOSIS CODE DENIED                            |
| 2015           | 3RD DIAGNOSIS CODE DENIED                            |
| 2016           | 4TH DIAGNOSIS CODE DENIED                            |
| 2017           | 5TH DIAGNOSIS CODE DENIED                            |
| 2018           | 6TH DIAGNOSIS CODE DENIED                            |
| 2019           | 7TH DIAGNOSIS CODE DENIED                            |
| 2020           | 8TH DIAGNOSIS CODE DENIED                            |
| 2021           | 9TH DIAGNOSIS CODE DENIED                            |
| 2022           | 10TH DIAGNOSIS CODE DENIED                           |
| 2023           | 11TH DIAGNOSIS CODE DENIED                           |
| 2024           | 12TH DIAGNOSIS CODE DENIED                           |
| 2025           | 13TH DIAGNOSIS CODE DENIED                           |
| 2026           | 14TH DIAGNOSIS CODE DENIED                           |
| 2027           | 15TH DIAGNOSIS CODE DENIED                           |
| 2028           | 16TH DIAGNOSIS CODE DENIED                           |
| 2029           | 17TH DIAGNOSIS CODE DENIED                           |
| 2030           | 18TH DIAGNOSIS CODE DENIED                           |
| 2031           | 19TH DIAGNOSIS CODE DENIED                           |
| 2032           | 20TH DIAGNOSIS CODE DENIED                           |
| 2033           | 21ST DIAGNOSIS CODE DENIED                           |
| 2034           | 22ND DIAGNOSIS CODE DENIED                           |
| 2035           | 23RD DIAGNOSIS CODE DENIED                           |

| EXCEPTION CODE | EXCEPTION DISPOSITION — PAY<br>EXCEPTION DESCRIPTION |
|----------------|--|
| 2036           | 24TH DIAGNOSIS CODE DENIED                           |
| 2037           | PRINCIPAL ICD9 CODE DENIED                           |
| 2038           | 1ST ICD9 CODE DENIED                                 |
| 2039           | 2ND ICD9 CODE DENIED                                 |
| 2040           | 3RD ICD9 CODE DENIED                                 |
| 2041           | 4TH ICD9 CODE DENIED                                 |
| 2042           | 5TH ICD9 CODE DENIED                                 |
| 2043           | 6TH ICD9 CODE DENIED                                 |
| 2044           | 7TH ICD9 CODE DENIED                                 |
| 2045           | 8TH ICD9 CODE DENIED                                 |
| 2046           | 9TH ICD9 CODE DENIED                                 |
| 2047           | 10TH ICD9 CODE DENIED                                |
| 2048           | 11TH ICD9 CODE DENIED                                |
| 2049           | 12TH ICD9 CODE DENIED                                |
| 2050           | 13TH ICD9 CODE DENIED                                |
| 2051           | 14TH ICD9 CODE DENIED                                |
| 2052           | 15TH ICD9 CODE DENIED                                |
| 2053           | 16TH ICD9 CODE DENIED                                |
| 2054           | 17TH ICD9 CODE DENIED                                |
| 2055           | 18TH ICD9 CODE DENIED                                |
| 2056           | 19TH ICD9 CODE DENIED                                |
| 2057           | 20TH ICD9 CODE DENIED                                |
| 2058           | 21ST ICD9 CODE DENIED                                |
| 2059           | 22ND ICD9 CODE DENIED                                |
| 2060           | 23RD ICD9 CODE DENIED                                |
| 2061           | 24TH ICD9 CODE DENIED                                |
| 5215           | SERVICE COVERED BY HOSPICE                           |
| 5217           | UNABLE TO PRICE MODIFIER                             |
| 5258           | RECIP ON REVIEW SUSPECT DUPE                         |
| 5275           | SVC NOT COVERED FOR RECIPIENT                        |
| 5277           | INPT PSYCH-RECIP OVER 21                             |
| 5284           | INELIGIBLE PROGRAM CODE                              |
| 5302           | INELIGIBLE PROVIDER COS                              |
| 5314           | OUT OF DISTRICT                                      |
| 5320           | PROV NOT CERTIF FOR PROC                             |
| 5321           | ANESTHESIA REQUIRES REVIEW                           |
| 5322           | PROCEDURE NOT COVERED ON WEEKEND                     |
| 5332           | PROCEDURE REQ WAIVER PLAN                            |

| EXCEPTION CODE | EXCEPTION DISPOSITION — PAY<br>EXCEPTION DESCRIPTION |
|----------------|--|
| 5337           | EXPAND EPSDT DIAG-RECIP NOT<21                       |
| 5364           | PROCED/PROVIDER TYPE CONFLICT                        |
| 5374           | SERV. NOT COVERED BY MEDICARE                        |
| 5418           | ABORTION PROCEDURE CODE                              |
| 5421           | TREAT PROV HAS PAY TO PRAC TYP                       |
| 5442           | EXPAN EPSDT PROC-RECIP NOT <21                       |
| 5584           | 1ST DIAGNOSIS NOT LOCKIN                             |
| 5585           | 2ND DIAGNOSIS NOT LOCKIN                             |
| 5586           | 3RD DIAGNOSIS NOT LOCKIN                             |
| 5587           | 4TH DIAGNOSIS NOT LOCKIN                             |
| 5588           | 5TH DIAGNOSIS NOT LOCKIN                             |
| 5589           | 6TH DIAGNOSIS NOT LOCKIN                             |
| 5590           | 7TH DIAGNOSIS NOT LOCKIN                             |
| 5591           | 8TH DIAGNOSIS NOT LOCKIN                             |
| 5592           | 9TH DIAGNOSIS NOT LOCKIN                             |
| 5680           | OPER/OTHR1 NPI REQUIRED                              |
| 5681           | INVALID OPER NPI--FAILS LUHN                         |
| 5682           | MULTIPLE OPERATING PID FOUND                         |
| 5683           | NO MATCHING OPER PID FOUND                           |
| 5684           | OPER NPI NOT ON FILE                                 |
| 5691           | NDC PROCEDURE CODE MISMATCH                          |
| 5692           | NDC AND CLAIM DATES CONFLICT                         |
| 5693           | NDC CODE IS NOT REQUIRED                             |
| 5694           | NDC REQUIRED   |
| 6178           | READMISSION WITHIN 24 HOURS                          |

| EXCEPTION CODE | EXCEPTION DISPOSITION – PAY and REPORT<br>EXCEPTION DESCRIPTION |
|----------------|---|
| 0117           | INVALID 1ST PROC CODE MODIFIER                                  |
| 0121           | 2ND MODIFIER INVALID  |
| 0122           | INVALID 3RD PROC CODE MOD                                       |
| 0123           | INVALID 4TH PROC CODE MOD                                       |
| 0182           | CV/NONCV DYS - VAL CD MISS/INV                                  |
| 0280           | PROC CODE REQ REVIEW BY FAS                                     |
| 0297           | DX REQUIRES REVIEW BY FAS                                       |
| 0302           | ATNDG PROV IS NOT ON FILE                                       |
| 0365           | PROC/PLACE OF SVC CNFL  |
| 0381           | RATE RECORD NOT FOUND   |
| 0411           | BILLING PROV IS UNDER REVIEW                                    |
| 0413           | SERV PROV IS UNDER REVIEW                                       |
| 0577           | PRIN DX NOT EXEMPT - POA REQ                                    |
| 0578           | HAC IDENTIFIED, PRICE REDUCED                                   |
| 0579           | HAC IDENTIFIED,PRICE UNCHANGED                                  |
| 0580           | HAC "NEVER-EVENT" DX PRESENT                                    |
| 0581           | HAC "NEVER-EVENT" MOD PRESENT                                   |
| 0584           | NO DRG IN MDC FOR PRIN DX                                       |
| 0586           | OTHER DIAG NOT EXEMPT-POA REQ                                   |
| 1685           | HOME HEALTH\PCA NPI REQ'D                                       |
| 1686           | STAFFING NPI INVALID  |
| 1687           | PERSONAL CARE AIDE NPI INVALID                                  |
| 1731           | 4TH DIAGNOSIS NOT ON DB   |
| 1732           | 4TH DIAGNOSIS NOT COVERED                                       |
| 1733           | 4TH DIAGNOSIS/AGE CONFLICT                                      |
| 1734           | 4TH DIAGNOSIS/GENDER CONFLICT                                   |
| 1735           | 5TH DIAGNOSIS NOT ON DB   |
| 1736           | 5TH DIAGNOSIS NOT COVERED                                       |
| 1737           | 5TH DIAGNOSIS/AGE CONFLICT                                      |
| 1738           | 5TH DIAGNOSIS/GENDER CONFLICT                                   |
| 1739           | 6TH DIAGNOSIS NOT ON DB   |
| 1740           | 6TH DIAGNOSIS NOT COVERED                                       |
| 1741           | 6TH DIAGNOSIS/AGE CONFLICT                                      |
| 1742           | 6TH DIAGNOSIS/GENDER CONFLICT                                   |
| 1743           | 7TH DIAGNOSIS NOT ON DB   |
| 1744           | 7TH DIAGNOSIS NOT COVERED                                       |
| 1745           | 7TH DIAGNOSIS/AGE CONFLICT                                      |
| 1746           | 7TH DIAGNOSIS/GENDER CONFLICT                                   |

| EXCEPTION CODE | EXCEPTION DISPOSITION – PAY and REPORT<br>EXCEPTION DESCRIPTION |
|----------------|---|
| 1747           | 8TH DIAGNOSIS NOT ON DB   |
| 1748           | 8TH DIAGNOSIS NOT COVERED                                       |
| 1749           | 8TH DIAGNOSIS/AGE CONFLICT                                      |
| 1750           | 8TH DIAGNOSIS/GENDER CONFLICT                                   |
| 1751           | 9TH DIAGNOSIS NOT ON DB   |
| 1752           | 9TH DIAGNOSIS NOT COVERED                                       |
| 1753           | 9TH DIAGNOSIS/AGE CONFLICT                                      |
| 1754           | 9TH DIAGNOSIS/GENDER CONFLICT                                   |
| 1755           | 10TH DIAGNOSIS NOT ON DB  |
| 1756           | 10TH DIAGNOSIS NOT COVERED                                      |
| 1757           | 10TH DIAGNOSIS/AGE CONFLICT                                     |
| 1758           | 10TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1759           | 11TH DIAGNOSIS NOT ON DATABASE                                  |
| 1760           | 11TH DIAGNOSIS NOT COVERED                                      |
| 1761           | 11TH DIAGNOSIS/AGE CONFLICT                                     |
| 1762           | 11TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1763           | 12TH DIAGNOSIS NOT ON DATABASE                                  |
| 1764           | 12TH DIAGNOSIS NOT COVERED                                      |
| 1765           | 12TH DIAGNOSIS/AGE CONFLICT                                     |
| 1766           | 12TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1767           | 13TH DIAGNOSIS NOT ON DB  |
| 1768           | 13TH DIAGNOSIS NOT COVERED                                      |
| 1769           | 13TH DIAGNOSIS/AGE CONFLICT                                     |
| 1770           | 13TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1771           | 14TH DIAGNOSIS NOT ON DB  |
| 1772           | 14TH DIAGNOSIS NOT COVERED                                      |
| 1773           | 14TH DIAGNOSIS/AGE CONFLICT                                     |
| 1774           | 14TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1775           | 15TH DIAGNOSIS NOT ON DB  |
| 1776           | 15TH DIAGNOSIS NOT COVERED                                      |
| 1777           | 15TH DIAGNOSIS/AGE CONFLICT                                     |
| 1778           | 15TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1779           | 16TH DIAGNOSIS NOT ON DB  |
| 1780           | 16TH DIAGNOSIS NOT COVERED                                      |
| 1781           | 16TH DIAGNOSIS/AGE CONFLICT                                     |
| 1782           | 16TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1783           | 17TH DIAGNOSIS NOT ON DB  |
| 1784           | 17TH DIAGNOSIS NOT COVERED                                      |

| EXCEPTION CODE | EXCEPTION DISPOSITION – PAY and REPORT<br>EXCEPTION DESCRIPTION |
|----------------|---|
| 1785           | 17TH DIAGNOSIS/AGE CONFLICT                                     |
| 1786           | 17TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1787           | 18TH DIAGNOSIS NOT ON DB  |
| 1788           | 18TH DIAGNOSIS NOT COVERED                                      |
| 1789           | 18TH DIAGNOSIS/AGE CONFLICT                                     |
| 1790           | 18TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1791           | 19TH DIAGNOSIS NOT ON DB  |
| 1792           | 19TH DIAGNOSIS NOT COVERED                                      |
| 1793           | 19TH DIAGNOSIS/AGE CONFLICT                                     |
| 1794           | 19TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1795           | 20TH DIAGNOSIS NOT ON DB  |
| 1796           | 20TH DIAGNOSIS NOT COVERED                                      |
| 1797           | 20TH DIAGNOSIS/AGE CONFLICT                                     |
| 1798           | 20TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1799           | 21ST DIAGNOSIS NOT ON DB  |
| 1800           | 21ST DIAGNOSIS NOT COVERED                                      |
| 1801           | 21ST DIAGNOSIS/AGE CONFLICT                                     |
| 1802           | 21ST DIAGNOSIS/GENDER CONFLICT                                  |
| 1803           | 22ND DIAGNOSIS NOT ON DB  |
| 1804           | 22ND DIAGNOSIS NOT COVERED                                      |
| 1805           | 22ND DIAGNOSIS/AGE CONFLICT                                     |
| 1806           | 22ND DIAGNOSIS/GENDER CONFLICT                                  |
| 1807           | 23RD DIAGNOSIS NOT ON DB  |
| 1808           | 23RD DIAGNOSIS NOT COVERED                                      |
| 1809           | 23RD DIAGNOSIS/AGE CONFLICT                                     |
| 1810           | 23RD DIAGNOSIS/GENDER CONFLICT                                  |
| 1811           | 24TH DIAGNOSIS NOT ON DB  |
| 1812           | 24TH DIAGNOSIS NOT COVERED                                      |
| 1813           | 24TH DIAGNOSIS/AGE CONFLICT                                     |
| 1814           | 24TH DIAGNOSIS/GENDER CONFLICT                                  |
| 1835           | 5TH SURG PROC/GENDER CNFL                                       |
| 1836           | 5TH SURG PROC NOT ON DB   |
| 1837           | 5TH SURG PROC NOT COVERED                                       |
| 1838           | INV 5TH SURGICAL PROC DATE                                      |
| 1839           | 6TH SURG PROC/GENDER CNFL                                       |
| 1840           | 6TH SURG PROC NOT ON DB   |
| 1841           | 6TH SURG PROC NOT COVERED                                       |
| 1842           | INV 6TH SURGICAL PROC DATE                                      |

| EXCEPTION CODE | EXCEPTION DISPOSITION – PAY and REPORT<br>EXCEPTION DESCRIPTION |
|----------------|---|
| 1848           | 8TH SURG PROC NOT ON DB   |
| 1850           | 8TH SURG PROC CD/DT MIS/INV                                     |
| 1854           | 9TH SURG PROC CD/DT MIS/INV                                     |
| 1858           | 10TH SURG PROC CD/DT MIS/INV                                    |
| 1862           | 11TH SURG PROC CD/DT MIS/INV                                    |
| 1866           | 12TH SURG PROC CD/DT MIS/INV                                    |
| 1870           | 13TH SURG PROC CD/DT MIS/INV                                    |
| 1874           | 14TH SURG PROC CD/DT MIS/INV                                    |
| 1878           | 15TH SURG PROC CD/DT MIS/INV                                    |
| 1882           | 16TH SURG PROC CD/DT MIS/INV                                    |
| 1886           | 17TH SURG PROC CD/DT MIS/INV                                    |
| 1890           | 18TH SURG PROC CD/DT MIS/INV                                    |
| 1894           | 19TH SURG PROC CD/DT MIS/INV                                    |
| 1898           | 20TH SURG PROC CD/DT MIS/INV                                    |
| 1902           | 21ST SURG PROC CD/DT MIS/INV                                    |
| 1906           | 22ND SURG PROC CD/DT MIS/INV                                    |
| 1910           | 23RD SURG PROC CD/DT MIS/INV                                    |
| 1914           | 24TH SURG PROC CD/DT MIS/INV                                    |
| 2065           | 4TH ICD9 NOT W/IN FR/THR DATE                                   |
| 2066           | 5TH ICD9 NOT W/IN FR/THR DATE                                   |
| 2067           | 6TH ICD9 NOT W/IN FR/THR DATE                                   |
| 2068           | 7TH ICD9 NOT W/IN FR/THR DATE                                   |
| 2069           | 8TH ICD9 NOT W/IN FR/THR DATE                                   |
| 2070           | 9TH ICD9 NOT W/IN FR/THR DATE                                   |
| 2071           | 10TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2072           | 11TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2073           | 12TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2074           | 13TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2075           | 14TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2076           | 15TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2077           | 16TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2078           | 17TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2079           | 18TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2080           | 19TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2081           | 20TH ICD9 NOT W/IN FR/THR DATE                                  |
| 2082           | 21ST ICD9 NOT W/IN FR/THR DATE                                  |
| 2083           | 22ND ICD9 NOT W/IN FR/THR DATE                                  |
| 2084           | 23RD ICD9 NOT W/IN FR/THR DATE                                  |



| EXCEPTION<br>CODE | EXCEPTION DISPOSITION – PAY and REPORT<br>EXCEPTION DESCRIPTION |
|-------------------|---|
| 2085              | 24TH ICD9 NOT W/IN FR/THR DATE                                  |
| 5172              | INVALID/MISSING PROCEDURE CODE                                  |
| 5229              | INVALID TAXONOMY  |
| 5230              | INVALID PROC CODE FOR MHRS PRV                                  |
| 5236              | MEDICARE ELIG/NOT XOVER PODIAT                                  |
| 5237              | MEDICARE ELIG/NOT XOVER   |
| 5257              | RECIP ON REVIEW NOT SUSP DUPE                                   |
| 5670              | REND/ATTND NPI REQUIRED   |
| 6111              | VISIT AND SURGERY ON SAME DAY                                   |
| 6136              | PROC INCOMPAT WITH DIAGNOSIS                                    |
| 6156              | MULTIPLE OUTPATIENT VISITS                                      |
| 6188              | READMISSION WITHIN 7 DAYS                                       |
| 8500              | NCCI P2P DENIAL   |
| 8501              | NCCI P2P EDIT BYPASSED  |
| 8502              | NCCI MUE LIMIT EXCEEDED   |
| 8503              | NCCI MUE EDIT BYPASSED  |
| 8504              | NCCI HIST CLM FOUND-ADJUST                                      |

Non-repairable exceptions are expected for encounters that cannot be corrected directly by the MCO. Some may require provider training or adherence to accepted Omnicaid values (for example, modifier) in the reference tables.

| EXCEPTION CODE | EXCEPTION DISPOSITION — NON REPAIRABLE DENIALS   | EXCEPTION DESCRIPTION |
|----------------|--|-----------------------|
| 0099           | DUPLICATE MOUTH QUADRANT   |                       |
| 0101           | EXACT DUPLICATE CLAIM  |                       |
| 0117           | INVALID 1ST PROC CODE MODIFIER   |                       |
| 0140           | RECIP NOT FOUND - RECYCLE  |                       |
| 0142           | RECIP NOT ELIG – RECYCLE (if timing of submission issue, plan should resubmit the encounter) |                       |
| 0177           | VOID/ADJUST OF DENIED CLAIM  |                       |
| 0201           | TCN TO CRED OR ADJUST IS ZEROS   |                       |
| 0356           | HOSPICE SPAN ALREADY EXISTS  |                       |
| 0357           | NO HOSPICE LOCKIN AVAILABLE  |                       |
| 0367           | PROC/SERV PROV TYPE CNFL   |                       |
| 0406           | DENIED VOID REQUEST  |                       |
| 0437           | PROC NOT VALID FOR SERV DATE   |                       |
| 0840           | VOID OR ADJUST IS IN PROCESS   |                       |
| 0845           | CLAIM HAS BEEN VOIDED/ADJUSTED   |                       |
| 0850           | NO PD CLAIM FOR ADJUST/CREDIT  |                       |
| 0856           | CREDIT CANNOT BE ADJUSTED  |                       |
| 1186           | INVALID/MISSING ADMIT HOUR   |                       |
| 1711           | PRIN DIAG NOT ON DB  |                       |
| 1719           | 1ST DIAGNOSIS NOT ON DB  |                       |
| 1720           | 1ST DIAGNOSIS NOT COVERED  |                       |
| 1723           | 2ND DIAGNOSIS NOT ON DB  |                       |
| 1724           | 2ND DIAGNOSIS NOT COVERED  |                       |
| 1727           | 3RD DIAGNOSIS NOT ON DB  |                       |
| 1728           | 3RD DIAGNOSIS NOT COVERED  |                       |
| 1820           | 1ST SURG PROC NOT ON DB  |                       |
| 1821           | 1ST SURG PROC NOT COVERED  |                       |
| 1824           | 2ND SURG PROC NOT ON DB  |                       |
| 1825           | 2ND SURG PROC NOT COVERED  |                       |
| 1828           | 3RD SURG PROC NOT ON DB  |                       |
| 1829           | 3RD SURG PROC NOT COVERED  |                       |
| 1831           | 4TH SURG PROC/GENDER CNFL  |                       |
| 1832           | 4TH SURG PROC NOT ON DB  |                       |
| 1833           | 4TH SURG PROC NOT COVERED  |                       |
| 2090           | NO DED/COINS ON XOVER CLM LINE   |                       |

| EXCEPTION<br>CODE | EXCEPTION DISPOSITION — NON REPAIRABLE DENIALS | EXCEPTION DESCRIPTION |
|-------------------|--|-----------------------|
| 5125              | INV BILLING PROV CHECK DIGIT                   |                       |
| 5172              | INVALID/MISSING PROCEDURE CODE                 |                       |
| 5174              | NEGATIVE LENGTH OF STAY                        |                       |
| 5182              | INVALID NH TERMINATION CODE                    |                       |
| 5206              | BIRTH WEIGHT REQD BUT MISSING                  |                       |
| 5420              | INDEP LAB INV PROCEDURE MOD                    |                       |
| 6109              | COVERED BY SURGERY FOLLOW UP                   |                       |

## APPENDIX F

### Medicaid Provider Number Assignment

The following outlines the submission guidelines for Encounter transactions submitted by the Medicaid contracted MCO.

The following table provides the guidelines for completion of the provider information on the 837 Encounter transactions for healthcare providers. If the provider that needs to be indicated is atypical, the Medicaid ID may continue to be used. These guidelines are to be used when applicable. For example, if a referring physician is not required for the encounter being submitted, it would not be sent.

| 837 Professional                  |  |
|-----------------------------------|--|
| Loop                              | Guidelines   |
| 2010AA — Billing                  | Billing Provider's NPI<br>Billing Provider's 9-Digit Zip (if known)  |
| 2000A                             | Billing Provider's Taxonomy (if known)                               |
| 2010AB — Pay-To                   | Address  |
| 2010BB REF*G2                     | MCO's Medicaid ID  |
| 2310A — Referring                 | Referring Provider's NPI <sup>3</sup>                                |
| 2310B — Rendering                 | Rendering Provider's NPI<br>Rendering Provider's Taxonomy (if known) |
| 2420A — Rendering<br>(line level) | Rendering Provider's NPI<br>Rendering Provider's Taxonomy (if known) |

| 837 Institutional |  |
|-------------------|--|
| Loop              | Guidelines   |
| 2010AA — Billing  | Billing Provider's NPI<br>Billing Provider's 9-Digit Zip (if known)  |
| 2000A             | Billing Provider's Taxonomy (if known)                               |
| 2010AB — Pay-To   | Address  |
| 2010BB REF*G2     | MCO's Medicaid ID  |
| 2310A — Attending | Attending Provider's NPI<br>Attending Provider's Taxonomy (if known) |
| 2330D — Operating | Operating Provider's NPI   |
| 2310C — Other     | Other Provider's NPI   |

<sup>3</sup> Referring provider required for DME encounter submissions.

For the purposes of encounters, MCOs should be considered “atypical” providers. In loop 2010AB MCOs should populate the NM108 with a “24” and populate the NM109 with the MCOs EIN. The REF01 segment should be populated with “1D.” The REF02 segment should be populated with the MCO’s Medicaid ID.

If the Generic ID is used to replace the NPI, use Loop 2010AA. Do not code NM108 and NM109. Code REF\*EI with the taxid. In Loop 2010BB, code REF\*G2 with the generic Medicaid ID.

If the provider’s NPI is not known, or if the provider’s taxonomy/9-digit zip code is not known and the encounter is denied, the provider’s generic Medicaid ID number should be used. The NPI and the Medicaid ID should never be sent together for any given provider loop. This will result in rejection. Monthly, a file of active FFS providers’ is provided to the MCOs for use in encounter data matching and submissions.

If the provider is not enrolled in FFS Medicaid, the MCO must assign one of the following Xerox Generic IDs 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 Xerox Generic ID.

### ***Xerox Generic Provider Identifier (Generic ID) by Provider Type***

| <b>Xerox Provider Type</b>             | <b>Xerox Provider Number</b> |
|--|------------------------------|
| 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                    |
| 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 Home Health                | 035048100                    |
| Generic MCO Hospice                    | 035022100                    |

| <b>Xerox Provider Type</b>  | <b>Xerox Provider Number</b> |
|---|------------------------------|
| 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, Chiroprapist, Occupational Therapy, Physical Therapy, etc.)                              | 035015700                    |
| Generic MCO Residential Treatment Center  | 035018100                    |
| Generic MCO Screen Clinic   | 035037600                    |
| Generic MCO Speech/Hearing Clinic   | 035049800                    |
| Generic MCO Transportation  | 035038400                    |
| Generic MCO Waiver  | 035025400                    |

# APPENDIX G

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## Test Plan

This appendix provides a step-by-step account of the Xerox 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 tiers of testing, which are outlined in detail below. Note: see testing requirements in Section 4 of this Manual. Once in production, no testing should occur without prior approval from DHCF.

### Testing Tier I

1. The first step in submitter testing is enrollment performed via Xerox 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.
2. The second step, or performed concurrently with the enrollment, is EDIFECs testing. A partnership exists between EDIFECs and Xerox EDI Gateway Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the Xerox 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.
3. EDI must certify each MCO prior to the MMIS receipt of encounters via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the Xerox 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 5010 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.
  - Generate IRL or paired transaction.

Xerox 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 Medicaid provider number. These fields are used in the 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 Xerox EDI Gateway Services, Inc. *Submitter Testing Report* for the DHCF.

## 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 Xerox EDI Gateway Services, Inc., the MMIS pre-processors will check the data content while converting the encounter data claim into the 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.

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

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' in the frequency code field. Therefore, if an encounter 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, Xerox 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 MoveIT DMZ secure transfer server. Each MCO is required to examine the returned 835s and compare them to the encounter data claims (837s) they submitted to ensure all claims that were submitted are accounted for in the data collection. Xerox will send the new exception reports to the MCOs and DHCF/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. Xerox is available to answer any questions that any MCO may have concerning the exceptions.

When an MCO has successfully completed this process, Xerox will ask the MCO to submit encounters in a test mode. This will give Xerox 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 the Monday following the weekend claims cycle.

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



# APPENDIX H

## Data Certification Forms Medicaid

|   |  |   |                           |                           |
|---|--|---|---------------------------|---------------------------|
| <b>Please Type or Print Clearly</b>   |  |   |                           |                           |
| <b>MEDICAID MCO Name</b>  |  | <b>Name of Preparer/Title</b>             |                           |                           |
| <b>For The Period Ending</b><br>_____, 20____<br><b>(Month &amp; Date) (Yr)</b>   |  | <b>Contact Phone Number/Email Address</b> |                           |                           |
| <b>Medicaid DATA Certification Statement</b><br>On behalf of the above-named Medicaid Managed Care Organization (MCO), I attest, based on best knowledge, information and belief, that all data submitted to the District of Columbia Medical Assistance Administration (DC MAA) is accurate, complete, and true. This statement applies to all documents and data submitted by the Medicaid Managed Care Organization to DC MAA, including, but not limited to, the following information: encounter data, other workbook or claims information, and financial information. I further attest that no material fact has been omitted from the data form and acknowledge that the information described below may directly affect the payments made to the Medicaid Managed Care Organization that I represent. I understand that I may be prosecuted under applicable federal and District laws for any false claims, statements, documents, or concealment of a material fact. Additionally, I attest in accordance with 42 CFR §438.604 that the reports have been reviewed and found to be complete, accurate, and true to the best of my knowledge, information and belief and have been submitted in accordance with the MCO contract with District of Columbia Medical Assistance Administration.<br>I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable federal and District laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the MCO contract. |  |   |                           |                           |
| <b>File Type</b>  | <b>File Name</b>   | <b>Total Number of Records</b>            | <b>Sum Charged Amount</b> | <b>Sum of Paid Amount</b> |
|   |  |   |                           |                           |
|   |  |   |                           |                           |
| Date of Submission: _____   |  |   |                           |                           |
| Please circle as appropriate. Original Submission? Y N Void? Y N Resubmission of Corrected or Voided Encounters? Y N  |  |   |                           |                           |
| <b>Signatures</b><br>This certification must be signed by the Chief Executive Officer, Chief Financial Officer <b>and</b> Chief Medical Officer, or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Office, Chief Financial Officer and/or Chief Medical Director. <input type="checkbox"/> Please check here if a delegated authority is certifying this submission.  |  |   |                           |                           |
| _____<br>Date   | _____<br>MCO Chief Executive Officer/Delegate - Name & Title |   | _____<br>Signature        |                           |
| _____<br>Date   | _____<br>MCO Financial Officer/Delegate - Name & Title       |   | _____<br>Signature        |                           |
| _____<br>Date   | _____<br>Chief Medical Officer - Name & Title                |   | _____<br>Signature        |                           |

## Alliance

|  |  |   |                           |                           |
|--|--|---|---------------------------|---------------------------|
| <b>Please Type or Print Clearly</b>  |  |   |                           |                           |
| <b>Alliance MCO Name</b>   |  | <b>Name of Preparer/Title</b>             |                           |                           |
| <b>For The Period Ending</b><br><div style="text-align: center;">_____, 20____</div> <b>(Month &amp; Date) (Yr)</b>  |  | <b>Contact Phone Number/Email Address</b> |                           |                           |
| <p style="text-align: center;"><b>Alliance DATA Certification Statement</b></p> <p>On behalf of the above-named Medicaid Managed Care Organization (MCO). I attest, based on best knowledge, information and belief, that all data submitted to the District of Columbia Medical Assistance Administration (DC MAA) is accurate, complete, and true. This statement applies to all documents and data submitted by the Medicaid Managed Care Organization to DC MAA, including, but not limited to, the following information: encounter data, other workbook or claims information, and financial information. I further attest that no material fact has been omitted from the data form and acknowledge that the information described below may directly affect the payments made to the Medicaid Managed Care Organization that I represent. I understand that I may be prosecuted under applicable federal and District laws for any false claims, statements, documents, or concealment of a material fact.</p> <p>I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable federal and District laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the MCO contract.</p> |  |   |                           |                           |
| <b>File Type</b>   | <b>File Name</b>   | <b>Total Number of Records</b>            | <b>Sum Charged Amount</b> | <b>Sum of Paid Amount</b> |
|  |  |   |                           |                           |
|  |  |   |                           |                           |
| Date of Submission: _____<br>Please circle as appropriate.    Original Submission?   Y   N    Void?    Y   N    Resubmission of Corrected or Voided Encounters ?<br>Y   N  |  |   |                           |                           |
| <b>Signatures</b><br>This certification must be signed by the Chief Executive Officer, Chief Financial Officer <b>and</b> Chief Medical Officer, or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Officer, Chief Financial Officer and/or Chief Medical Director. <input type="checkbox"/> Please check here if a delegated authority is certifying this submission.  |  |   |                           |                           |
| _____<br>Date  | _____<br>MCO Chief Executive Officer/Delegate - Name & Title |   | _____<br>Signature        |                           |
| _____<br>Date  | _____<br>MCO Financial Officer/Delegate - Name & Title       |   | _____<br>Signature        |                           |
| _____<br>Date  | _____<br>Chief Medical Officer - Name & Title                |   | _____<br>Signature        |                           |

# APPENDIX I

## 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   |
|---|--|
| <a href="http://www.hhs.gov/ocr/privacy/hipaa/administrative/">http://www.hhs.gov/ocr/privacy/hipaa/administrative/</a> | 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. |
| <a href="http://www.hhs.gov/ocr/privacy/">http://www.hhs.gov/ocr/privacy/</a>   | This website contains a shortened version of the Privacy Rule.   |
| <a href="http://www.cms.gov">http://www.cms.gov</a>   | This is the CMS home page.   |
| <a href="http://www.wedi.org/">http://www.wedi.org/</a>   | 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.  |
| <a href="http://www.wpc-edi.com/hipaa/HIPAA_40.asp">http://www.wpc-edi.com/hipaa/HIPAA_40.asp</a>                       | 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 under HIPAA of 1996. They may be downloaded for free.  |
| <a href="http://www.ansi.org">http://www.ansi.org</a>   | 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.   |
| <a href="http://www.x12.org">http://www.x12.org</a>   | This is the Data Interchange 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.  |
| <a href="http://www.nucc.org">http://www.nucc.org</a>   | 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.   |
| <a href="http://www.ada.org">http://www.ada.org</a>   | This is the American Dental Association website.   |

| Website Address   | Website Contents   |
|---|--|
| <a href="http://HL7.org">http://HL7.org</a>   | 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 to support clinical practice and management of health services.   |
| <a href="http://www.cms.hhs.gov/home/medicare.asp">http://www.cms.hhs.gov/home/medicare.asp</a>   | 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. |
| <a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Data-and-Systems.html">http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Data-and-Systems.html</a> | Access 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. Search using the keywords "HIPAA Plus."  |
| <a href="https://www.dc-medicaid.com/dcwebportal/home">https://www.dc-medicaid.com/dcwebportal/home</a>   | DHCF web portal for bulletins, transmittals, news, etc.  |



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