Medallion 3
Encounters
Technical Manual

Virginia Department of Medical Assistance

Health Care Services Division

Version 5.0

[This page intentionally left blank]

Table of Contents

Version Change Summary 5
Version Effective Dates 6
1 Encounters 8
1.1 HIPAA Administrative Simplification 9
1.1.1 Version and Model 10
1.1.2 EDI Resources 11
1.2 Encounter Submission Process 12
1.2.1 Service Center Registration 13
1.2.2 Transmission Protocol 14
1.2.3 Test Transmissions 15
1.2.4 Production Transmissions 18
1.2.5 Submission Response Reports 22
1.2.6 Encounter Submission Calendar 35
1.3 Encounter Processing Requirements 42
1.3.1 Encounter Data Certification 43
1.3.2 Adjustments & Voids 44
1.3.3 Denied Services 45
1.3.4 National Provider Identifier 52
1.3.5 Line-Level Processing 53
1.3.6 Drug Rebate Collection 57
1.3.7 MCO Payment Amount & Date 59
1.3.8 Enrollment Determination Based on Admit Date 65
1.3.9 Newborns without Medicaid IDs 66
1.3.10 Procedure, Diagnosis, Revenue Code 67
1.3.11 Transportation Encounters 68
1.4 Proprietary MMIS Code Sets 69
1.4.1 MMIS Claim Type 70
1.4.2 Provider Class Type 71
1.4.3 Provider Specialty 74
1.4.4 Edit Codes / Error Sequence Codes (ESC) 77
1.4.5 Encounter Exception Error Code List 82
1.5 Encounter Data Quality (EDQ) Process 83
1.5.1 DMAS Reporting 84
1.5.2 Compliance and Corrections 85
1.5.3 Critical Issues 87

1.5.4 Emerging Issues 92
2 Enrollment Roster & Payment Files 95
2.1 Enrollment Roster (834) 96
2.2 Capitation Payment Remittance (820) 97
2.2.1 Capitation Payment Remittance (820) Schedule 98
2.2.2 Capitation Payment Remittance (820) – “Best Practices” in Reconciliation 99

Version Change Summary

Ver	Description	Date
5.0	Created separate Medallion 3.0 Encounter Technical Manual	07/01/17
5.0	Section 1.2.6: Updated Encounter Submission Calendar for Jul-Dec 2017	07/01/17
5.0	Section 1.5.3: Provided instructions for drugs that do not have a Procedure Code	07/01/17
5.0	Section 2.1: Updated Enrollment Roster (834) schedule for 2017-2018	07/01/17
5.0	Section 2.2: Updated Capitation Payment Remit (820) schedule for 2017-2018	07/01/17

Version Effective Dates

Version	Effective Date
5.0	07/01/17

DMAS Contact Information

Subject	DMAS Contact
MCO questions about contract, services, payments, member eligibility/enrollment, appeals, MCTM, contract deliverables, reporting specifications, DMAS reports	MCOhelp@dmas.virginia.gov
Encounter submissions, testing, requirements, EDQ.	HCSEncounters@dmas.virginia.gov
Archive of MCTM versions, report templates	http://www.dmas.virginia.gov/Content_pgs/mc-rpt.aspx

These mailboxes are to be used by contracted Medallion 3.0 MCOs and their designees only.

All other questions from external (non-MCO) parties should be directed to ManagedCare.Help@dmas.virginia.gov.

1 Encounters

This section contains information to assist existing and prospective Virginia Medicaid managed care contractors with the development of processes and procedures for encounter data submission. This information intended to supplement the Virginia Medicaid Medallion 3.0 and FAMIS contracts and the ANSI X12 Implementation Guide (IG). Hereafter the terms 'Contractor' and/or 'MCO' will refer to the Contractor and any subcontractor used by the Contractor.

The HIPAA Implementation Guides and Addenda are the official standard for electronic submission of health care encounter data. However, there are many areas in these IGs that are situational, open to interpretation, or that require further clarification by the receiving entity. The following documentation is specific to managed care encounter data submitted by a Medallion 3.0 or FAMIS contractor. Nothing in this documentation is intended to conflict or contradict the ANSI X12 / NCPDP Implementation Guides (IG). If you identify any conflicts, please notify DMAS by contacting HCSEncounter@dmas.virginia.gov.

Note that DMAS's fiscal agent, Xerox, has published separate fee for service Companion Guides, and these are published on DMAS' web site. Those Companion Guides do not apply to managed care encounter data and are not to be used for submission of encounter data.

Once the contractor is an established Service Center, any updates to their contact information should be made in writing and directed to the EDI coordinator at Xerox.

1.1 HIPAA Administrative Simplification

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered entities must use standard transaction sets when exchanging certain information. HIPAA did not specifically define the exchange of encounter data between a Medicaid plan and a managed care organization as a covered transaction. However, since health care claim transaction sets are national standards for data exchange, DMAS has elected to use the HIPAA transaction sets as its standard for Virginia Medicaid encounter data submission.

HIPAA adopted national code sets for use in all transaction sets. These code sets include most of the information currently codified in the UB92 and CMS 1500 paper claims and their electronic counterparts. Information about the required code sets can be found at the wpc-edi and NCPDP web sites referenced below. One impact of this provision of HIPAA was the use of local procedure codes. These codes are no longer considered valid; only valid procedure codes adopted for national use should be coded in transaction sets.

1.1.1 Version and Model

DMAS currently requires use of a variation of the Provider-to-Payer-to-Payer COB model of the 837 transaction sets, Version 5010, Addendum 1 for facility and professional services. For prescription drugs, the mandated transaction set is the NCPDP Batch Version D.0 Telecommunication Standard. As new versions of the transaction sets are adopted by HIPAA, DMAS will use the newer versions in accordance with HIPAA requirements.

Contractors should use the matrix below to determine which transaction set is appropriate for the type of encounter to be reported (based on billing entity):

Billing Entity	Transaction
Inpatient Urgent Care Facility	837 Institutional
Outpatient Urgent Care Facility	837 Institutional
Inpatient Mental Health Facility	837 Institutional
Outpatient Mental Health Facility	837 Institutional
Federally Qualified Health Center	837 Professional
Long Term Care Facility	837 Institutional
Skilled Nursing Facility	837 Institutional
Home Health Provider	Either 837 Institutional or 837 Professional, depending on contract between the MCO and the provider.
Pharmacy Benefit Manager	NCPDP
Retail Pharmacy	NCPDP
Hospital Pharmacy	837 Institutional
Independent Laboratory	837 Professional
Hospital-based Laboratory	837 Institutional
Non-Emergency Transportation	837 Professional
Emergency Transportation	837 Professional
Hospital-based Clinic	837 Institutional
Free-standing Clinic	837 Professional
Physicians	837 Professional
Other medical professionals	837 Professional
Dentist	837 Dental

If in doubt about the transaction to use for a specific type of claim, please contact the Health Care Services Division at: HCSEncounter@dmas.virginia.gov.

1.1.2 EDI Resources

1.1.2.1 Implementation Guides

Detailed information on how each of the 837 transaction sets should be used is contained in each Implementation Guide (IG) and its corresponding Addendum. There are separate IGs and Addenda for professional and institutional services and they can be downloaded for free at www.wpc-edi.com. The same site also has purchase options for the IGs, which can be quite lengthy and take some time to download and/or print.

The IGs and Addenda provide details about which loops, segments and data elements are required in various health care situations. If Contractors carefully follow the instructions in these IGs and Addenda, the certification and testing processes outlined in Sections IV.C and IV.D of this guide should be completed smoothly and expeditiously.

For prescription drug encounters, the NCPDP documentation is available through its Web site: www.ncpdp.org. This site also contains other helpful information for implementing this transaction set.

1.1.2.2 Other EDI Documentation

WEDI, the Workgroup for Electronic Data Interchange, is an organization that was formed specifically to promote and assist in the development of better information exchange and management in health care. WEDI's Strategic National Implementation Process or SNIP was formed to facilitate the implementation of national standards, such as HIPAA, within the health care industry. The SNIP Web site provides a wealth of information from white papers on numerous topics to workgroups and LISTSERVS. You can access the WEDI site at www.wedi.org and follow the links to SNIP.

Other Web sites Contractors may find helpful in understanding the HIPAA regulations and in preparing HIPAA-compliant transaction sets include:

- www.cms.gov - Follow the links for Regulations and Guidance and scroll down to the HIPAA Administrative Simplification selection to access information on the regulations, education, and code sets
- www.x12.org - ACS X12 is the Accredited Standard Committee and maintains electronic data interchange standards globally. Work and task groups under X12 developed the transactions sets and implementation guides that have been adopted under HIPAA.
- www.hipaa-dsmo.org - This site contains information on Designated Standard Maintenance Organization (DSMO). These DSMOs have formed a committed to focus on managing HIPAA standard change requests.
- www.wedi.org - Workgroup for Electronic Data Interchange or WEDI is committed to the implementation of electronic commerce in healthcare and EDI standards for the healthcare industry. WEDI's members include providers, health plans, consumers, vendors, government organizations and standards groups.

Most of the above sites also contain links to other sites that may provide additional assistance with implementation of outbound HIPAA transaction sets.

1.2 Encounter Submission Process

1.2.1 Service Center Registration

All Contractors must submit encounters to DMAS electronically using the appropriate HIPAA-mandated transaction sets noted in Section I.B above. Contractors must be registered with the EDI Coordinator at DMAS's fiscal intermediary, Xerox, as a Service Center.

Registration as a Service Center involves the completion of three forms: Submission of Electronic Transactions Agreement for Service Centers (Form 101); Service Center Operational Information Sheet (Form 102); and Provider Service Center Authorization Agreement (Form 103). Once completed, these forms are faxed or emailed to the EDI coordinator at Xerox to initiate the enrollment process. These forms and instruction for completing them are available in the Electronic Claims Submission Enrollment Packet at the following link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDIFormsLinks

Once Xerox has received these forms from the Contractor and verified their accuracy, it will assign a four-digit Service Center ID within 24 hours of receipt of completed forms. If the service center ID is not received within that time period, the contractor should follow up with Xerox at 1-866-352-0766 Monday – Friday between 8:00 am and 5:00 pm EST. This four-digit number will identify the Contractor as a registered Service Center that has the ability to submit electronic transactions. Once the contractor is a registered Service Center, any updates needed to contact information should be made in writing and directed to the EDI Coordinator via email or fax.

1.2.2 Transmission Protocol

Virginia Medicaid requires a secure method of transferring files electronically utilizing a SSL (Secure Socket Layer) connection. Contractors will need to send and receive data electronically using FTP server/client software that supports 128-bit Explicit SSL encryption. See the Electronic Claims Submission Enrollment Packet referenced above for additional information on FTP software requirements. This packet also provides instructions for connecting to the Xerox server, including password requirements and minimum setting requirements.

1.2.3 Test Transmissions

Prior to submitting production files each Contractor is required to submit test files for any event that will impact the submission and/or content of the encounter data. Examples of an event are: a new Contractor, a change to the Contractor's subcontractor, a system change, etc. A test plan may be issued by DMAS if the event affects multiple claim types or the source of the data (i.e. new subcontractor) is changed. Test files will be reviewed by DMAS and the Contractor to determine if the file is acceptable, with ultimate approval by DMAS.

Within twelve weeks of the start of a new Contractor, subcontractor change, system change or any event that impacts the encounter submission, testing should be submitted and successfully completed.

1.2.3.1 Limit on Number of Records in Test Transmission

For 837 file types the maximum number of records in a test file is limited to 5,000 claims or 10% of a normal production month, whichever is less. For NCPDP files, the limit is 3,000 claims or 10% or a normal production month, whichever is less. DMAS defines a claim as the individual line items, not a document.

1.2.3.2 Test File Delivery / Test Results Pickup

- MCO test files must be delivered to the following folder using the VaMMIS file transfer website: **/Distribution/EDI/<*service center ID*>/Test/To-VAMMIS/**
- DMAS will post all response files and MMIS reports relating to test file submissions in the following folder using the VaMMIS file transfer website: **/Distribution/EDI/<*service center ID*>/Test/From-VAMMIS/**
- Emails relating to testing should be sent to: **HCSEncounters@dmas.virginia.gov**

1.2.3.3 Testing Procedures

1. The MCO must notify DMAS via email when testing is needed due to an event such as a new subcontractor or software/system changes on the MCO's side.
2. Test files may be submitted at will (without prior notification or authorization) as long as the test file record limit is respected (see section 1.2.3.1).
3. The following events will <u>automatically</u> occur within one hour of receipt of the test file submission:
   - An Acknowledgement Report (ACK) will be available for pickup from the VaMMIS FTP website. This report will contain an eight-digit Media Control Number (MCN) that is associated with the submitted test file. The MCN format is shown below. See Section 1.2.5.3 for additional ACK report details.

     Example: MCN 32940043

     - Position 1 = 3 last digit of year CCYY (2013)
     - Position 2-4 = 294 julian date (Oct. 21)
     - Position 5-8 = 0043 sequential number (43rd file received on this date)

- The EDI Compliance check will execute and the following reports/files will be available for pickup from the FTP VAMMIS website.
  - 999 File - for 837 test files only (see section 1.2.5.4)
  - NCPDP Response File – for NCPDP test files only (see section 1.2.5.7)
    Note: If the 999/RSP file is not returned, it may indicate that there is a structural or envelope issue. When this happens, the ANSI translator is unable to generate the appropriate response file. Please review the submitted file and/or perform a local compliance check before contacting DMAS.
  - Compliance Error Report Summary (CER) - exception report (see section 1.2.5.5)
  - Compliance Error Report (CED) – exception report (see section 1.2.5.6).

4. The MCO must review the 999/NCPDP Response files. If compliance errors are present, the CER/CED Compliance reports must be reviewed (837 test files).

   The 999 or NCPDP Response file will indicate a positive or negative result for the compliance check. If compliance errors exist on an 837 test file, the CER/CED Compliance reports may be used for error resolution. If compliance errors exist on a NCPDP test file, NCPDP Response file may be used for error resolution as DMAS does not have a compliance error report available for NCPDP files.

5. If the records/file fail(s) compliance, the MCO may submit a corrected file to the FTP VAMMIS website, at will. This step must be repeated until ALL compliance errors are resolved.

6. If the records/file passé(s) compliance please send an email to DMAS that contains the following information:

   - Indicate TEST file in email subject line
   - Indicate that test file is ready for adjudication
   - MCN
   - File Type (837P, 837I, or NCPDP)
   - Submitter name or service center
   - Approximate number of encounters
   - High level description of what is being tested (i.e. adjustment/void processing)

7. Upon email receipt, DMAS will request adjudication for the test file. The MMIS adjudication reports listed below will be available for pickup from the FTP VAMMIS website within 2-3 business days. See sections 1.2.5.9, 10, 11, and 12 for detailed report information.

   - Encounter Summary Report (CP-O-507)
   - Encounter Error Report (CP-O-506-01)
   - Encounter Detail Report (CP-O-506-02)
   - EFL File (CP-F-010)

8. MMIS adjudication reports should be carefully reviewed. Once test results are approved by the MCO, an email should be sent to indicate that reports are ready for DMAS review. Please include the MCN and the “As Of” date from the reports.

   Note: If the adjudication fails, **different** test data is required (i.e., different unique MCO claim identifiers). Encounters in the MMIS test system are deleted only when the test

system is refreshed (approximately twice a year). Correcting the same data and resending will result in the failure of all resubmitted records as fatal edits for duplicates.

9. Upon email receipt, DMAS will review the MMIS adjudication reports and send an email indicating approval for production file submission.

1.2.3.4 MMIS Adjudication Test Schedule

There are two scheduled windows for MMIS adjudication in the test environment: **Tuesday and Thursday afternoons. Reports will be posted to the FTP folder by the next morning.**

Requests for MMIS testing may be sent to HCSEncounters@dmas.virginia.gov at any time. For a test file to be included in the afternoon window, requests must be received no later than **11am on Tuesday/Thursday**. As always, please confirm that test files have passed the EDI compliance check before sending the email request for MMIS adjudication.

1.2.3.5 Approval for Production

After the test file passes compliance, passes adjudication, and the adjudication results are accepted by DMAS and the Contractor, production approval will be established.

If any backlog of data has occurred, a submission plan should be developed and sent to DMAS. Unless otherwise approved, backlogs of encounter data should be submitted with oldest dates first and in file sizes consistent with what would have been submitted in production. For example, if in production weekly files are submitted, weekly catch-up files would be expected. Do not combine into one or more larger files, unless approved in advance.

1.2.4 Production Transmissions

1.2.4.1 Production Encounter Data Submission Requirements

After the Contractor receives authorization for production transmission, they may submit files on a monthly, semi-monthly or weekly schedule as approved by DMAS. DMAS will work with the Contractor to determine an appropriate submission schedule. Xerox plans its work around the encounter submission calendar (see below). The MCO must notify DMAS (at HCSEncounter@dmas.virginia.gov) ahead of schedule if a scheduled submission will be missed. You can also schedule a new date for submission at that time.

The following are DMAS expectations of the contractor regarding encounters:

- All encounters (production or test) should not be scheduled or submitted without DMAS approval.
- Production encounters cannot be submitted on Friday's, unless agreed to in advance. Test encounters can be submitted on Friday when previously scheduled and approved by DMAS.
- Any process change, vendor change, format change, etc. by the Contractor, fiscal agent or DMAS will require the Contractor to pass a testing stage before resuming production
- The Contractor will submit all encounters to DMAS. DMAS will not accept files from a subcontractor. Service center agreements are between the State's fiscal agent and the MCO. Subcontractors are not included.
- If the Contractor subcontracts with an entity to process claims or provide services, the Contractor is responsible for assuring that data from this vendor contains all the information necessary to create the appropriate encounter record for DMAS. This includes, but is not limited to: pharmacy benefits, laboratory, transportation, vision, and mental health. Prior to delivery to DMAS, the Contractor is responsible for verifying the accuracy of the encounter data being sent to DMAS, particularly with respect to the format and edits. Pass through files cannot be delivered to DMAS.
- For any services rendered under a global billing arrangement (e.g., maternity and delivery), an encounter must be submitted for every service. The MCO cannot submit an encounter just for the initial service that triggered the global payment. The Contractor is responsible for ensuring that providers submit all appropriate records in connection with services paid under a global billing arrangement.
- Compliance errors must be reviewed and corrected. Files failed as non-compliant have not made it into the Virginia MMIS system.
- Failures within an ST/SE segment (negative 999 or RSP) must be reviewed and corrected. ST/SE segment failed have not made it into the Virginia MMIS system.
- The Contractor must review the response files and forward to their appropriate subcontractors (when applicable). The Contractors will act upon all response files to correct.
- The Contractor should employ all of its resources to ensure that duplicate encounter files are not passed to DMAS. DMAS incurs expense for every encounter processed by our Fiscal Agent.
- Encounters that have been adjudicated by the Contractor and denied as a duplicate should not be submitted to DMAS.

1.2.4.2 Production Encounter Files – BEST PRACTICES

The following is a list of best practices concerning production encounter files that are posted to DMAS. At this point in time, these are not requirements but are recommendations.

- Original and replacement/void encounters should be in separate physical files.
- Each file should be limited to approximately 5,000 transactions.
- There should be one ST-SE transaction set in each EDI file. This will cause a "full-file" rejection when there are one or more encounters that fail the EDI compliance-check. DMAS has found that this works best for corrections as the entire file can be resubmitted as opposed to "carving out" the erroneous transaction set(s) for resubmission.
- DMAS does not have specific file naming standards. However, it can be helpful if the filename is meaning and descriptive. For example, the filename should contain the service center id, transaction type (837P, 837I), date/time, file content (orig, void, etc.).

1.2.4.3 Production Processing

Production files will be delivered to the Contractor's mailbox on the VaMMIS File Transfer Website using the folder: ***Distribution/EDI/Service Center ID/Prod/To-VAMMIS/***. NOTE: If the MCO drops files in a folder other than "***To-VAMMIS***", the file will not be acknowledged or processed.

Every 15 minutes, the File Transfer System checks for newly posted production files. All files found will be automatically picked-up and processing begins.

The file is renamed by assigning an eight digit Media Control Number or MCN. The MCN is a "smart" number and would breakdown as follows: YJJJSSSS - Sample MCN: 21270043

- Position 1 = Last digit of the calendar year (2012)
- Position 2-4 = Julian Date (127 / May 6th)
- Position 5-8 = Sequential number (43rd file received by DMAS on this day)

An ACK report is returned to the Contractor with the MCN number within an hour of receipt. See below for a sample ACK report. This report shows the original file name and the MCN assigned by the MMIS.

At the half-hour, any files picked up will post a 999 (837) or an RSP (NCPDP). The naming convention is: ***<Service Center ID>_RSP_<MCN number>_<EDI Runid>***. These files will be zipped. NOTE: The EDI Runid is used internally by the EDI System. (See below for a sample of this file.)

ALL 999/RSP files should be picked-up and reviewed by the Contractor. This will indicate if the file was accepted for adjudication, or if the file or any of segment(s) within the file have failed or rejected.

In the event that the ISA or ISE segments are invalid and a 999 cannot be created, Xerox will contact the Contractor directly using the Virginia.EDISupport@xerox.com e-mail address. If there is a negative 999 (that is, the ST and/or SE segments fail), a trace report will be downloaded to the FTP site. (See example below.) Contact Xerox for assistance reading this

report at 1-866-352-0766. The naming convention for this report is: ***<4-digit Service Center ID>_ERROR_<MCN>***.

If at any time the Contractor fails to meet the expected production standards, DMAS may retract production approval and place the Contractor back into test in whole or in part. The Contractor would then be required to correct, retest and resume production within the twelve-week time frame as specified in the Medallion 3.0 and FAMIS contracts.

1.2.4.4 File Notification

In the past, DMAS has requested a follow-up email of a list of all encounter files posted during the MCO's encounter submission window. This email is no longer required.

1.2.4.5 Data Submission Feedback

837 encounters received from a Contractor during the week are adjudicated that weekend. NCPDP encounters will be processed as they are received. Several adjudication reports are generated and posted on the ftp site for the MCO. These reports are zipped and posted in the "***OUTGOING***" folder on Monday morning for the 837 encounters and daily for the NCPDP encounters. The naming convention for this file is <***Four-digit service center ID>_<MCN>***. Once the file is unzipped, four reports are displayed:

- CP-O-507: Encounter Summary Report – summarizes the entire submission
- CP-O-506-01: Encounter Error Report – lists every claim that was submitted with an error status of 2 or higher
- CP-O-506-02: Encounter Detail Report – includes **all** claims submitted, including those passed with an error code of zero
- CP-F-010: EFL – electronic version of the Encounter Error Report

DMAS considers status codes 0 through 8 to be paid claims and REQUIRES a payment amount and date to be submitted for each encounter. DMAS considers status 9 to be a claim denied by the contractor and would expect the amount paid to be zero. Exceptions to this rule are:

- FAMIS pharmacy encounter where the co-pay covers the complete cost of prescription
- Contractor coordinating benefits and primary payer paid - No payment made by MCO

1.2.4.6 Contractor Responsibilities for Correction and/or Resubmission

Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or IEA records will be rejected and a negative 999 sent back to the submitter. If there is a negative 999, two compliance error reports will be sent to the MCO: CED and CER. Both will contain detail of the compliance errors found in the negative 999. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 999 will be sent back to the submitter identifying the loop. Any other ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) days of the date.

When an entire file is rejected (i.e., has only a 999 transaction in the OUTGOING folder), the Contractor must correct any formatting or syntax errors in the file and resubmit.

Once an encounter has passed all front-end compliance checks, it is processed in the MMIS using the existing fee for service (FFS) claims adjudication logic. Every encounter that passes the EDI compliance checks is processed in the Virginia MMIS and captured in the DMAS encounter data warehouse.

During MMIS processing, the FFS logic may assign one or more 'edit' codes (AKA Error Sequence Codes / ESC). These codes identify error conditions based on the existing payment logic that is applied to FFS provider claim submissions. **Refer to section 1.5 of this document for a detailed explanation of the Encounter Data Quality (EDQ) process that is effective July 1, 2015.** This process includes the State's error identification/reporting process and correction requirements.

Whenever possible, all corrections (adjust/void) should be re-submitted as part of the MCO's normal submission schedule. In cases where a large volume of accumulated encounter corrections needs to be resubmitted, the MCO must request a special schedule for this submission from DMAS via HCSEncounter@dmas.virginia.gov. A large volume is defined as 10,000 or more encounter lines.

1.2.5 Submission Response Reports

1.2.5.1 Unzip Results file - Successful

Purpose: To report unzip result of submitted zip file
Frequency: A report is returned for each zip file indicating unzip success or failure
Transaction Type: 837, NCPDP
File Format: Text

Sample File Name: `1003_ZIP_20130619094930_ALLHC_D05_50.zip.rpt`
<*ServiceCenter*><**ZIP**><*CCYYMMDDHHMMSS*><*MCOfilename*><.rpt>

Sample File Contents:

```
The Zip file you uploaded has been successfully unzipped.  You will
receive individual acknowledgement report(s) for the contents.
```

1.2.5.2 Unzip Results file - Unsuccessful

Purpose: To report unzip result of submitted zip file
Frequency: A report is returned for each zip file indicating unzip success or failure
Transaction Type: 837, NCPDP
File Format: Text

Sample File Name: `1003_BZF_20130619094930_VPHP_File_07112014032730.zip.rpt`
<*ServiceCenter*><**BZF**><*CCYYMMDDHHMMSS*><*MCOfilename*><.rpt>

Sample File Contents:

```
The Zip file you uploaded was unable to be unzipped.  Please verify
the file is a valid Zip and upload again.
```

1.2.5.3 Acknowledgement (ACK) Report

Purpose: Returns Media Control Number (MCN) and basic info about the submitted file
Frequency: An acknowledgement report is returned for each file in the zipped file submission
Transaction Type: 837, NCPDP
File Format: Text

Sample File Name:
1003_ACK_20130619094930_31700124_ALLHC_D05_50_2821.txt.rpt

<*ServiceCenter*><**ACK**><*CCYYMMDDHHMMSS*><*MCN*><*MCOfilename*><.rpt>

Sample File Contents:

```
MCN:        31700124
Submitter: 1003
Type:       Virginia Medicaid
Prod:       P
Date:       06/19/2013
Time:       09:49:30
Bytes:           53260
Records:         53260
File Name: 1003_20130619094930_ALLHC_D05_50_2821.TXT
```

File Content Description:

MCN:	Eight-digit MCN assigned to the file by MMIS
Submitter:	MCO's four-digit Service Center ID
Type:	Virginia Medicaid
Prod:	Valid values are 'P' (Production) and 'T' (Test)
Date:	mm/dd/yyyy
Time:	hh:mm:ss
Bytes:	Size of file in bytes
Records:	Size of file in bytes (Same as Bytes field above)
File Name:	Name of the file as it was labeled by the MCO

1.2.5.4 999 Report

Purpose: ANSI positive or negative response to 837 transactions
Frequency: An ANSI 999 file is returned for each ANSI 837 file
Transaction Type: 837
File Format: Compressed

Sample File Name: `1003_999_31700124_5468335.zip`
<ServiceCenter><**999**>*<MCN>*<*EDIrunID* ><.zip>

Sample File Contents (unwrapped):

```
ISA*00*              *00*              *ZZ*VAMMIS  FA         *ZZ*1003
*130619*0949*^*00501*000000638*0*P*>~
GS*FA*VAMMIS FA*1003*20130619*094930*55*X*005010X231A1~
ST*999*55001*005010X231A1~
AK1*HC*696*005010X222A1~
AK2*837*000000006*005010X222A1~
IK5*A~
AK9*A*1*1*1~
SE*6*55001~
GE*1*55~
IEA*1*000000638~
```

1.2.5.5 Compliance Error Report (CER) Summary

Purpose:	Displays compliance error location and description
Frequency:	Exception report – only returned when compliance errors are found
Transaction Type:	837
File Format:	Compressed

Sample File Name: `1003_CER_20130619094930_31700124_5468335.zip`
<*ServiceCenter*><**CER**><*CCYYMMDDHHMMSS*><*MCN*><*EDIrunID*><.zip>

Sample File Contents:

```
Compliance Error Report for MCN: XXXXXXXX
Input filename: XXXX_XXXXXXXXXXXXXX.txt
RunID:    895677
Service Center ID: XXXX
Run date and time: CCYY-MM-DD 12:50:20

Error: 1 Segment No. 92 Element: GE01 (7025) - ERROR: GE   Control
Count Mismatch 708 vs 1

Compliance report Complete: 1 Errors Encountered.
```

1.2.5.6 Compliance Error (CED) Report

Purpose: Displays compliance error location, description, and error data image
Frequency: Exception report – only returned when compliance errors are found
Transaction Type: 837
File Format: Compressed

Sample File Name: `1003_CED_20130619094930_31700124_5468335.zip`
<ServiceCenter><**CED**>*<CCYYMMDDHHMMSS><MCN><EDIrunID>*<.zip>

Sample File Contents: See Managed Care Technical Manual, Section 1.2.6

```
Compliance Error Report for MCN: XXXXXXXX
Input filename: XXXX_XXXXXXXXXXXXXX.txt
RunID:    895677
Service Center ID: XXXX
Run date and time: CCYY-MM-DD 12:50:20

SKIP GOOD TRANSACTIONS flag is ON.   This report will only list
transactions with compliance errors.

ISA*00*            *00*            *ZZ*1003             *ZZ*VAMMIS FA
*121112*1549*^*00501*000000256*0*P*|~
GS*HC*1003*VAMMIS FA*20121112*1549*256*X*005010X223A2~

Skipping Transaction Sequence Number: 000008448 - From segment:
3 to:        45

GE*708*256~
IEA*1*000000256~
Error: 1 Segment No. 49 Element: GE01 (7025) - ERROR: GE   Control
Count Mismatch 708 vs 1

Compliance report Complete: 1 Errors Encountered.
```

1.2.5.7 NCPDP Response File

Purpose:	Positive and/or negative response to NCPDP transactions
Frequency:	A NCPDP response file is returned for each NCPDP file
Transaction Type:	NCPDP
File Format:	Compressed

Sample File Name: `1003_RSP_31700124_5468335.zip`
<ServiceCenter><**RSP**>*<MCN><EDIrunID>*<.zip>

Sample File Contents:

```
▯00R1003                    071213120130717120 0P125148010900
▯▯G10012759394D0B11A011255434981
20130605▯▯▯AM21▯ANC▯F3201319890000001010▯▯AM22▯EM1▯D2865969▯▯G10012758185D0B11A011467597096
   20130604▯▯▯AM21▯ANC▯F3201319890000002010▯▯AM22▯EM1▯D2174978▯▯99071213100000000004
                           ▯
```

1.2.5.8 NCPDP Compliance Report

There is no compliance error report available for NCPDP transactions at this point in time. The NCPDP Response file may be used for detecting compliance errors in a NCPDP transaction file (see Virginia Medicaid NCPDP Companion Guide for NCPDP Response file definition).

1.2.5.9 Encounter Summary Report (CP-O-507)

Purpose:	The following reports are produced during adjudication and are compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file
Frequency:	Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions
Transaction Type:	837, NCPDP
File Format:	Compressed

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

CPD320 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO. CP-O-507
AS OF MM/DD/CCYY PAGE NO. ZZ,ZZ9
RUN DATE: MM/DD/CCYY HH:MM ENCOUNTER SUMMARY REPORT
(1)
MCN: 9999999 (1a) (1b)
SERVICE VENDOR: XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

	TOTAL	% OF PROCESSED
TOTAL ENCOUNTERS RECEIVED	(4) ZZZ,ZZ9	
HMO DENIALS RECEIVED	ZZ,ZZ9 (5)	
TOTAL ENCOUNTERS PROCESSED	ZZ,ZZ9 (6)	ZZ9.99 (7)
ENCOUNTERS WITH NO WARNINGS	ZZ,ZZ9 (8)	ZZ9.99 (9)
ENCOUNTERS WITH WARNINGS	ZZ,ZZ9 (10)	ZZ9.99 (11)
LEVEL 2 WARNINGS	ZZ,ZZ9 (12)	ZZ9.99 (13)
LEVEL 4 WARNINGS	ZZ,ZZ9 (14)	ZZ9.99 (15)
LEVEL 6 WARNINGS	ZZ,ZZ9 (51)	ZZ9.99 (52)
ENCOUNTERS WITH FATAL ERRORS (LEVEL 8)	ZZ,ZZ9 (16)	ZZ9.99 (17) (TRANSMISSION NOT ACCEPTED/TRANSMISSION ACCEPTED)
ENCOUNTERS WITH DUPLICATE ERRORS	ZZ,ZZ9 (18)	ZZ9.99 (19)
ORIGINAL ENCOUNTERS	ZZ,ZZ9 (20)	ZZ9.99 (21)
ADJUSTMENT ENCOUNTERS	ZZ,ZZ9 (22)	ZZ9.99 (23)
VOID (REVERSAL) ENCOUNTERS	ZZ,ZZ9 (24)	ZZ9.99 (25)

MSG CODE (26)	DESCRIPTION (27)	STATUS (28)	COUNT (29)	% OF ERRORS (30)	% OF ERR RECS (31)	% OF PROC RECS (32)
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
	ALL ERROR CODES		(33) ZZ,ZZ9	(34) ZZ9.99	N/A	N/A

*** END OF REPORT ***

Report Notes:

5. HMO Denials Received = Number of encounters where Status = 9
6. Total Encounters Processed = Number of encounters processed for this Service Center
7. Total Encounters Processed % = (Total Encounters Processed / Total Encounters Processed for all Service Centers during this cycle)*100
8. Encounters with No Warnings = Number of encounters where Status = 0
9. Encounters with No Warnings % = (Encounters with No Warning / Total Encounters Processed)*10
10. Encounters with Warnings = Number of encounters where Status > 0 and < 8
11. Encounters with Warnings % = (Encounters with Warnings / Total Encounters Processed)*100
12. Level 2 Warnings = Number of encounters where Status = 2
13. Level 2 Warnings % = (Level 2 Warnings / Total Encounters Processed)*100

14. Level 4 Warnings = Number of encounters where Status = 4
15. Level 4 Warnings % = (Level 4 Warnings / Total Encounters Processed)*100
16. Level 6 Warnings = Number of encounters where Status = 6
17. Level 6 Warnings % = (Level 6 Warnings / Total Encounters Processed)*100
18. Encounters with Fatal Errors (Level 8) = Number of encounters where Status = 8
19. Encounters with Fatal Errors (Level 8) % = (Encounters with Fatal Errors / Total Encounters Processed)*100
20. Encounters with Duplicate Errors = Number of encounters where ESC = 510 (duplicate error)
21. Encounters with Duplicate Errors % =(Encounters with Duplicate Errors / Total Encounters Processed)*100
22. Original Encounters = Number of encounters where Claim Type Modifier = 1
23. Original Encounters % = (Original Encounters / Total Encounters Processed)*100
24. Adjustment Encounters = Number of encounters where Claim Type Modifier = 2
25. Adjustment Encounters % = (Adjustment Encounters / Total Encounters Processed)*100
26. Void (Reversal) Encounters = Number of encounters where Claim Type Modifier = 4
27. Void (Reversal) Encounters % = (Void Encounters / Total Encounters Processed)*100
28. MSG Code = MMIS ESC
29. Description=MMIS ESC short description
30. Status = Status assigned by MMIS
31. Count = Number of occurrences of each ESC
32. % of Errors = (Count / Total Count)*100
33. % of Err Recs = Percentage of Error Records
34. % of Proc Recs = Percentage of Processed Records
35. All Error Codes = Total number of all occurrences of an ESC
36. % of Errors = (All Error Codes / Total Encounters Processed)*100

1.2.5.10 Encounter Error Report (CP-O-506-01)

Purpose: The following reports are produced during adjudication and are compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file

Frequency: Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions

Transaction Type: 837, NCPDP

File Format: Compressed

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

```
CPD320                          VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES          REPORT NO: CP-O-506-01
AS OF MM/DD/CCYY                                                                            PAGE NO: ZZ,ZZ9
RUN DATE: MM/DD/CCYY                          ENCOUNTER ERROR REPORT
  (1)
MCN: 9999999        (28)                    (29)
SERVICE VENDOR: XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                 (16)/ (18)/
     (5)       (4)          (6)(7)(7.1)      (8)  (9)     (10) (10.1)  (11)        (12)    (14)    (15)  (17)  (19)        (20)              (21)

HMO CLM NO/FH          ENROL/SRVC-BILL      FR/TO DOS     DXS/SERVICE        QTY   CHRGS/PYMT  T/D  PRV  MESSAGE/ERROR CODES  STAT
                            PROV-IDS                                                             MOD  TYP
999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999  999  999  999  999   9
99999999999999999         9999999999 9999999999 MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999  999  999  999  999

                    (23) TOTAL ERROR ENCOUNTERS          Z,ZZ9
                    (24) STATUS 8 (FATAL) ENCOUNTERS     Z,ZZ9
                    (25) STATUS 6 ENCOUNTERS             Z,ZZ9
                    (26) STATUS 4 ENCOUNTERS             Z,ZZ9
                    (27) STATUS 2 ENCOUNTERS             Z,ZZ9

                                  *** END OF REPORT ***

                      ****** CONFIDENTIAL INFORMATION ******
```

No.	Field Name	Source/Calculations
1	MCN	Claims MCN Number
4	FH	Claim Request ICN
5	HMO Clm No	Claim Patient Account Number
6	Enroll	Enrollee Identification Number
7	Service Provider ID	National Provider Identifier
7.1	Billing Provider ID	National Provider Identifier
8	FR DOS	Claim Service From Date
9	TO DOS	Claim Service Through Date
10	DXS	Diagnosis Code
10.1	DXS	Diagnosis Code
11	Service	Category of Service. If the service is Practitioner, then the service number is Proc/Mod code. If the service is UB, then the service number is Rev Code1, Code2, Code3 and Code4. If the service is Dental, then the service number Dent Proc and Quad Code. If the

No.	Field Name	Source/Calculations
		service is Pharmacy, then the service number is NDC.
12	QTY	Claim Number of Units/Visits/Studies
13	(Proc Cd)	Procedure Code
14	Chrgs	Claim Billed Charge
15	Pymt	Payment Amount. THIS IS NOT THE MCO PAID AMOUNT but rather the DMAS allowed or Tentative Payment Amount.
16	Inv Type	Claim Type
17	Disposition	Claim Type Modifier
18	PRV TYP	Provider Type
19	PRV	Provider Specialty Code
20	Message/Error Codes	Error Text Error Code
21	Stat	Claim Status
23	Total Error Encounters	Add 1 to total error encounters
24	State 8 (Fatal) Encounter	If status equal 8, add 1 to status 8 encounter errors
25	Status 6 Encounters	If status equal 6, add 1 to status 6 encounter errors
26	Status 4 Encounters	If status equal 4, add 1 to status 4 encounter errors
27	Status 2 Encounters	It status equal 2, add 1 to status 2 encounter errors
28	Service Vendor	Provider Service Center
29	Service Vendor Name	Service Center Name

1.2.5.11 Encounter Detail Report (CP-O-506-02)

Purpose: The following reports are produced during adjudication and are compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file

Frequency: Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions

Transaction Type: 837, NCPDP

File Format: Compressed

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

```
CPD320                                VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                REPORT NO: CP-O-506-0:
AS OF MM/DD/CCYY                                                                                        PAGE NO: ZZ,ZZ9
RUN DATE: MM/DD/CCYY                              ENCOUNTER DETAIL REPORT
 (1)
MCN: 9999999          (28)                  (29)
SERVICE VENDOR: XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                          (16)/ (18)/
   (5)      (4)          (6)(7)(7.1)     (8)  (9)    (10) (10.1) (11)      (12)   (14)   (15)  (17)  (19)          (20)                  (21)
HMO CLM NO/FH        ENROL/SRVC-BILL   FR/TO DOS      DXS/SERVICE         QTY   CHRGS/PYMT  T/D   PRV   MESSAGE/ERROR CODES  STAT
                          PROV-IDS                                                            MOD   TYP
999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

                    (23) TOTAL ENCOUNTERS                    Z,ZZ9
                  (23.1) TOTAL STATUS 9 ENCOUNTERS           Z,ZZ9
                    (24) STATUS 8 (FATAL) ENCOUNTERS         Z,ZZ9
                    (25) STATUS 6 ENCOUNTERS                 Z,ZZ9
                    (26) STATUS 4 ENCOUNTERS                 Z,ZZ9
                    (27) STATUS 2 ENCOUNTERS                 Z,ZZ9
                  (27.1) STATUS 0 ENCOUNTERS                 Z,ZZ9

                                  *** END OF REPORT ***

                      ****** CONFIDENTIAL INFORMATION ******
```

No.	Field Name	Source/Calculations
1	MCN	Claims MCN Number
4	FH	Claim Request ICN
5	HMO Clm No	Claim Patient Account Number
6	Enroll	Enrollee Identification Number
7	Service Provider ID	National Provider Identifier
7.1	Billing Provider ID	National Provider Identifier
8	FR DOS	Claim Service From Date
9	TO DOS	Claim Service Through Date
10	DXS	Diagnosis Code
10.1	DXS	Diagnosis Code
11	Service	Category of Service - If the service is Practitioner, then the service number is Proc/Mod code. If the service is UB, then the service number is Rev Code1, Code2, Code3 and Code4. If the service is Dental, then the service number Dent Proc and Quad Code. If the service is Pharmacy, then the service number is NDC.
12	QTY	Claim Number of Units/Visits/Studies
13	(Proc Cd)	Procedure Code
14	Chrgs	Claim Billed Charge
15	Pymt	Payment Amount – This represents the DMAS fee for service calculated payment amount. It is not the MCO's paid amount.
16	Inv Type	Claim Type
17	Disposition	Claim Type Modifier
18	PRV TYP	Provider Type
19	PRV	Provider Specialty Code
20	Message/Error Codes	Error Text Error Code
21	Stat	Claim Status
23	Total Error Encounters	Add 1 to total error encounters
23.1	Status 9 Encounters	
24	State 8 (Fatal) Encounter	If status equal 8, add 1 to status 8 encounter errors

No.	Field Name	Source/Calculations
25	Status 6 Encounters	If status equal 6, add 1 to status 6 encounter errors
26	Status 4 Encounters	If status equal 4, add 1 to status 4 encounter errors
27	Status 2 Encounters	It status equal 2, add 1 to status 2 encounter errors
28	Service Vendor	Provider Service Center
29	Service Vendor Name	Service Center Name

1.2.5.12 Electronic Error 'EFL' File (CP-F-010)

Purpose: The following reports are produced during adjudication and are compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file

Frequency: Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions

Transaction Type: 837, NCPDP

File Format: Compressed, Logical Record Length = 295 characters

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

```
10093108002000000010112330895                                                    2013108900001201
52002110601513169648932013040220130402
10093108002000000020112330910                                                    2013108900002701
16902296406710433137452013040320130403
10093108002000000030112330911                                                    2013108900002801
16902296406710433137452013040320130403
31080020100000099 0TOTAL ERROR ENCOUNTERS                    0000003
31080020100000099 1STATUS 9 ENCOUNTERS                       0000000
31080020100000099 2STATUS 8 (FATAL) ENCOUNTERS               0000003
31080020100000099 3STATUS 6 ENCOUNTERS                       0000000
31080020100000099 4STATUS 4 ENCOUNTERS                       0000000
31080020100000099 5STATUS 2 ENCOUNTERS                       0000000
31080020100000099 6STATUS 0 ENCOUNTERS                       0000000
```

File Description:

Field Name	Data Type / Length X=alphanumeric 9=numeric V=implied decimal S=sign	Start Position	End Position
DETAIL RECORD			
MCO Service Center	X(04)	1	4
Media Control Number (MCN)	X(08)	5	12
Sequence Number	9(07)	13	19
MCO Claim Number	X(24)	20	43
Internal Sequence Number (ICN)	X(17)	44	60
Enrollee ID Number	X(12)	61	72

Field Name	Data Type / Length X=alphanumeric 9=numeric V=implied decimal S=sign	Start Position	End Position
Nation Provider ID (NPI)	X(10)	73	82
DOS From Date (CCYYMMDD)	X(08)	83	90
DOS Thru Date (CCYYMMDD)	X(08)	91	98
Diagnosis Code-1	X(07)	99	105
Diagnosis Code-2	X(07)	106	112
Procedure Code	X(07)	113	119
Procedure Code Modifier	X(02)	120	121
Place of Service	X(02)	122	123
Principle Procedure Code	X(07)	124	130
Dental Quadrant	X(02)	131	132
Dental Surface Codes	X(05)	133	137
Pharmacy - National Drug Code (NDC)	X(11)	138	148
Pharmacy - Prescription Number	X(09)	149	157
Quantity - Number of Units/Visits	S9(07)V999	158	167
Claim Bill Charge	S9(09)V99	168	178
Claim Payment Amount	S9(09)V99	179	189
Claim Type	X(02)	190	191
Error Disposition	X(01)	192	192
Provider Type	X(03)	193	195
Provider Specialty Code	X(03)	196	198
Claim Status	X(02)	199	200
Encounter Status	X(02)	201	202
Error Code-1	9(04)	203	206
Error Code-2	9(04)	207	210
Error Code-3	9(04)	211	214
Error Code-4	9(04)	215	218
Error Code-5	9(04)	219	222
Error Code-6	9(04)	223	226
Error Code-7	9(04)	227	230
Error Code-8	9(04)	231	234
Error Code-9	9(04)	235	238
Error Code-10	9(04)	239	242
UB Revenue Code-1	9(04)	243	246
UB Revenue Code-2	9(04)	247	250
UB Revenue Code-3	9(04)	251	254
Filler	X(01)	295	295
TOTAL RECORD			
Total Key	X(18)	1	18
Total Count Description	X(46)	19	64
Total Count (calculated)	9(07)	65	71
Filler	X(224)	72	295

1.2.6 Encounter Submission Calendar

The following pages represent the calendar for MCO encounter submissions for the current contract year.

The VAMMIS FTP server is available to accept encounters on holidays. If an automated script is used for file submission and the submission date falls on a holiday, encounter files may be submitted as scheduled. Please note that there will be limited or no human support available. If an alternate date is required or desired, please send a request to the HCS encounters mailbox. DMAS will not assign alternate submission dates, unless requested.

January 2017 **Encounter Submission Calendar**				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
2 ~~IT: HCFA, UB, RX~~ (rescheduled to 1/03) ~~AE: HCFA, UB, RX~~ (rescheduled to 1/03) KP: HCFA, UB, RX *------- DMAS holiday -------* *New Year's Day Observed*	3 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX IT: HCFA, UB, RX (IT: holiday schedule) AE: HCFA, UB, RX (AE: holiday schedule)	4 VP: HCFA, UB, RX	5 OP: HCFA, UB, RX	6
9 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	10 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	11 VP: HCFA, UB, RX	12 OP: HCFA, UB, RX	13 *-------- DMAS holiday --------* *Lee-Jackson Day*
16 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX *------- DMAS holiday --------* *Martin Luther King, Jr. Day*	17 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	18 VP: HCFA, UB, RX	19 OP: HCFA, UB, RX	20
23 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	24 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	25 VP: HCFA, UB, RX	26 OP: HCFA, UB, RX	27
30 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	31 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX			

Key: AE=Aetna; IT=INTotal Health; OP=Optima; VP=VA Premier; KP=Kaiser Permanente; HK=Anthem HealthKeepers

*Only encounters with DOS < 11/01/2014 for Anthem Peninsula (PE) and Anthem Priority (PR)

February 2017 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
		1 VP: HCFA, UB, RX	2 OP: HCFA, UB, RX	3
6 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	7 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	8 VP: HCFA, UB, RX	9 OP: HCFA, UB, RX	10
13 IT: HCFA, UB, RX AE: HCFA, UB,RX KP: HCFA, UB, RX	14 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	15 VP: HCFA, UB, RX	16 OP: HCFA, UB, RX	17
20 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX *-------- DMAS holiday --------* *George Washington Day*	21 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	22 VP: HCFA, UB, RX	23 OP: HCFA, UB, RX	24
27 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	28 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX			

Key: AE=Aetna; IT=INTotal Health; OP=Optima; VP=VA Premier; KP=Kaiser Permanente; HK=Anthem HealthKeepers

*Only encounters with DOS < 11/01/2014 for Anthem Peninsula (PE) and Anthem Priority (PR)

March 2017 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
		1 VP: HCFA, UB, RX	2 OP: HCFA, UB, RX	3
6 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	7 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	8 VP: HCFA, UB, RX	9 OP: HCFA, UB, RX	10
13 IT: HCFA, UB, RX AE: HCFA, UB,RX KP: HCFA, UB, RX	14 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	15 VP: HCFA, UB, RX	16 OP: HCFA, UB, RX	17
20 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	21 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	22 VP: HCFA, UB, RX	23 OP: HCFA, UB, RX	24
27 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	28 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	29 VP: HCFA, UB, RX	30 OP: HCFA, UB, RX	31

Key: AE=Aetna; IT=INTotal Health; OP=Optima; VP=VA Premier; KP=Kaiser Permanente; HK=Anthem HealthKeepers

*Only encounters with DOS < 11/01/2014 for Anthem Peninsula (PE) and Anthem Priority (PR)

April 2017 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
3 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	4 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	5 VP: HCFA, UB, RX	6 OP: HCFA, UB, RX	7
10 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	11 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	12 VP: HCFA, UB, RX	13 OP: HCFA, UB, RX	14
17 IT: HCFA, UB, RX AE: HCFA, UB,RX KP: HCFA, UB, RX	18 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	19 VP: HCFA, UB, RX	20 OP: HCFA, UB, RX	21
24 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	25 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	26 VP: HCFA, UB, RX	27 OP: HCFA, UB, RX	28

Key: AE=Aetna; IT=INTotal Health; OP=Optima; VP=VA Premier; KP=Kaiser Permanente; HK=Anthem HealthKeepers

*Only encounters with DOS < 11/01/2014 for Anthem Peninsula (PE) and Anthem Priority (PR)

May 2017 **Encounter Submission Calendar**				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
1 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	2 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	3 VP: HCFA, UB, RX	4 OP: HCFA, UB, RX	5
8 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	9 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	10 VP: HCFA, UB, RX	11 OP: HCFA, UB, RX	12
15 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	16 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	17 VP: HCFA, UB, RX	18 OP: HCFA, UB, RX	19
22 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	23 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	24 VP: HCFA, UB, RX	25 OP: HCFA, UB, RX	26
29 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX *------- DMAS Holiday -------* *Memorial Day*	30 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	31 VP: HCFA, UB, RX		

Key: AE=Aetna; IT=INTotal Health; OP=Optima; VP=VA Premier; KP=Kaiser Permanente; HK=Anthem HealthKeepers

*Only encounters with DOS < 11/01/2014 for Anthem Peninsula (PE) and Anthem Priority (PR)

June 2017 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
			1 OP: HCFA, UB, RX	2
5 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	6 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	7 VP: HCFA, UB, RX	8 OP: HCFA, UB, RX	9
12 IT: HCFA, UB, RX AE: HCFA, UB,RX KP: HCFA, UB, RX	13 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	14 VP: HCFA, UB, RX	15 OP: HCFA, UB, RX	16
19 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	20 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	21 VP: HCFA, UB, RX	22 OP: HCFA, UB, RX	23
26 IT: HCFA, UB, RX AE: HCFA, UB, RX KP: HCFA, UB, RX	27 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	28 VP: HCFA, UB, RX	29 OP: HCFA, UB, RX	30

Key: AE=Aetna; IT=INTotal Health; OP=Optima; VP=VA Premier; KP=Kaiser Permanente; HK=Anthem HealthKeepers

*Only encounters with DOS < 11/01/2014 for Anthem Peninsula (PE) and Anthem Priority (PR)

1.3 Encounter Processing Requirements

1.3.1 Encounter Data Certification

By the 15th of each month, Contractors must certify the completeness and accuracy of all encounter data submitted in the prior calendar month. Please reference the data certification reporting requirements in the Medallion 3.0 and FAMIS contracts, as well as the detailed reporting specifications provided in the 'Medallion 3.0 Technical Manual', section 1.2.10.

The Encounter Data Certification Form includes protection of the privacy and confidentiality of MCO payment information that is collected from the Contractor on the encounter records. It is important that you use the current version of the Data Certification form in order to insure MCO payment information is not released under Freedom of Information Act requests.

1.3.2 Adjustments & Voids

If the Contractor adjusts or voids a claim that has been or will be submitted to DMAS, the Contractor must submit that void or adjustment to DMAS as well. DMAS has the following requirements with respect to adjustments and/or voids:

Virginia's MMIS uses a line level adjudication process for all 837P records. MMIS adjustment processing of 837P encounters is based on the MCO claim control number provided by the MCO on the encounter record. In order for adjustments and voids to be correctly applied within the MMIS, the MCO must provide a unique identifier for each line of an 837P encounter. Note that MCOs may choose to utilize document level processing within their own claims payment processing, but a unique identifier must be provided on the encounters submitted to DMAS.

The claim number that appeared on the original encounter must be coded in Loop 2300, REF Segment of the 837 (see page 196 of the professional or page 166 of the institutional ASC X12N Implementation Guide, Version 5010A1). If the number in this segment does not match the original claim number, the record will receive a fatal error. Sample:

Original Encounter: `CLM*123456*20***11:B:8*Y*A*Y*Y*P`

Adjustment:
```
CLM*123456_A*20***11:B:8*Y*A*Y*Y*P
REF*F8*123456
```

The unique number allows the MMIS to identify the single line being adjusted. Submitting adjustment/voids for all lines on an encounter document and submitting those lines in the same order as the original is no longer required. If the Contractor's adjustment process still requires that the entire encounter document be adjusted, DMAS will accommodate those adjustments.

Replacements and Voids should not be submitted in the same adjudication cycle as the original claim. The MMIS sorts all incoming claim and encounter files as follows: voids, originals, and replacements. Failure to submit voids/adjustments in separate adjudication cycles will result in MMIS fatal error codes 0396 or 0397.

The following MMIS 'claim type modifier' code values are used by the MMIS to identify original, adjustment, and void encounters in the MMIS. The MCO will see these code values on MMIS reporting on encounters that have been processed in the MMIS.

Code	Description
1	Original Claim
2	Debit Adjustment
3	Credit Adjustment *
4	Voided Claim

* Internally created by MMIS

If an MCO submits a file that contains only voids and there are no errors on the file, the file will be processed by the MMIS, but the proprietary reports will not be generated.

1.3.3 Denied Services

All encounters adjudicated by the Contractor or any subcontractor used by the Contractor, should be submitted to DMAS in the prescribed format, including any denied claims, except for the following:

- Encounters that are rejected (the term reject used here does not refer to denied encounters)
- Encounters that are duplicates of records previously submitted
- Encounters that contain an invalid Medicaid member ID
- Encounters for Medicaid members who are not enrolled

If the encounter being submitted is one that has been denied, the encounter should be submitted to DMAS with the appropriate denial reason code from the HIPAA Adjustment Reason Code set (code source 139) appearing in the CAS segment of the encounter. Refer to the table below to see how these codes are mapped to the MMIS error code values (ESC).

Codes identified in the table as 'deny' will be assigned a four-digit DMAS ESC. This is the code that will display on the proprietary error reports, internal system and ad-hoc reports.

The HIPAA adjustment reason code is critical to setting the status of the encounter. Unless the encounter is submitted and interpreted as a denial, all other reason codes are considered approved. Additionally, as this status determines if the encounter will be a paid or denied, each HIPAA adjustment reason code was assigned a status. Mixing paid and denied statuses is not permitted. Each encounter will have only one status value.

The MMIS crosswalk process to identify MCO denials based on the HIPAA adjustment reason code value was implemented only for professional and institutional encounters. Pharmacy (NCPDP) encounter denials are not recognized by the MMIS and should not be submitted to DMAS.

In addition to providing the proper HIPAA adjustment reason code, denied encounters should also include the denial date.

The DMAS crosswalk table below has been updated with new denial codes that are available for use starting on **February 24, 2014**.

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	**MMIS ESC**	**Type**	**Description**	**Begin Date**	**Last Modified**
4	0500	Deny	The procedure code is inconsistent with the modifier used or a required modifier is missing.	1/1/1995	9/20/2009
5	0501	Deny	The procedure code/bill type is inconsistent with the place of service.	1/1/1995	9/20/2009
6	0502	Deny	The procedure/revenue code is inconsistent with the patient's age.	1/1/1995	9/20/2009
7	0503	Deny	The procedure/revenue code is inconsistent with the patient's gender.	1/1/1995	9/20/2009
8	0504	Deny	The procedure code is inconsistent with the provider type / specialty (taxonomy).	1/1/1995	9/20/2009
9	0505	Deny	The diagnosis is inconsistent with the patient's age.	1/1/1995	9/20/2009

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
10	0506	Deny	The diagnosis is inconsistent with the patient's gender.	1/1/1995	9/20/2009
11	0507	Deny	The diagnosis is inconsistent with the procedure.	1/1/1995	9/20/2009
12	0508	Deny	The diagnosis is inconsistent with the provider type.	1/1/1995	9/20/2009
13	0509	Deny	The date of death precedes the date of service.	1/1/1995	
14	0510	Deny	The date of birth follows the date of service.	1/1/1995	
16	0512	Deny	Claim/service lacks information which is needed for adjudication.	1/1/1995	9/20/2009
18	0514	Deny	Exact duplicate claim/service.	1/1/1995	9/30/2012
19	0515	Deny	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	1/1/1995	9/30/2007
20	0516	Deny	This injury/illness is covered by the liability carrier.	1/1/1995	9/30/2007
21	0517	Deny	This injury/illness is the liability of the no-fault carrier.	1/1/1995	9/30/2007
26	0521	Deny	Expenses incurred prior to coverage.	1/1/1995	
27	0522	Deny	Expenses incurred after coverage terminated.	1/1/1995	
29	0523	Deny	The time limit for filing has expired.	1/1/1995	
31	0524	Deny	Patient cannot be identified as our insured.	1/1/1995	9/30/2007
32	0525	Deny	Our records indicate that this dependent is not an eligible dependent as defined.	1/1/1995	
33	0526	Deny	Insured has no dependent coverage.	1/1/1995	9/30/2007
34	0527	Deny	Insured has no coverage for newborns.	1/1/1995	9/30/2007
35	0528	Deny	Lifetime benefit maximum has been reached.	1/1/1995	10/31/2002
39	0530	Deny	Services denied at the time authorization/pre-certification was requested.	1/1/1995	
40	0531	Deny	Charges do not meet qualifications for emergent/urgent care.	1/1/1995	10/16/2003
49	0535	Deny	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	1/1/1995	9/20/2009
50	0536	Deny	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	1/1/1995	9/20/2009
51	0537	Deny	These are non-covered services because this is a pre-existing condition.	1/1/1995	9/20/2009
53	0539	Deny	Services by an immediate relative or a member of the same household are not covered.	1/1/1995	
54	0540	Deny	Multiple physicians/assistants are not covered in this case.	1/1/1995	9/20/2009

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
55	0541	Deny	Procedure/treatment is deemed experimental/investigational by the payer.	1/1/1995	9/20/2009
56	0542	Deny	Procedure/treatment has not been deemed 'proven to be effective' by the payer	1/1/1995	9/20/2009
60	0546	Deny	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	1/1/1995	6/1/2008
78	0550	Deny	Non-Covered days/Room charge adjustment.	1/1/1995	
95	0552	Deny	Plan procedures not followed.	1/1/1995	9/30/2007
96	0553	Deny	Non-covered charge(s).	1/1/1995	9/20/2009
97	0554	Deny	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	1/1/1995	9/20/2009
107	0557	Deny	The related or qualifying claim/service was not identified on this claim.	1/1/1995	9/20/2009
109	0559	Deny	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1/1/1995	1/29/2012
110	0560	Deny	Billing date predates service date.	1/1/1995	
111	0561	Deny	Not covered unless the provider accepts assignment.	1/1/1995	
114	0564	Deny	Procedure/product not approved by the Food and Drug Administration.	1/1/1995	
116	0566	Deny	The advance indemnification notice signed by the patient did not comply with requirements.	1/1/1995	9/30/2007
119	0568	Deny	Benefit maximum for this time period or occurrence has been reached.	1/1/1995	2/29/2004
128	0570	Deny	Newborn's services are covered in the mother's Allowance.	2/28/1997	
129	0571	Deny	Prior processing information appears incorrect	2/28/1997	1/30/2011
133	0572	Deny	The disposition of the claim/service is pending further review	2/28/1997	9/30/2012
135	0573	Deny	Interim bills cannot be processed.	10/31/1998	9/30/2007
138	0575	Deny	Appeal procedures not followed or time limits not met.	6/30/1999	9/30/2007
140	0576	Deny	Patient/Insured health identification number and name do not match.	6/30/1999	
146	0578	Deny	Diagnosis was invalid for the date(s) of service reported.	6/30/2002	9/30/2007
147	0579	Deny	Provider contracted/negotiated rate expired or not on file.	6/30/2002	
148	0580	Deny	Information from another provider was not provided or was insufficient/incomplete.	6/30/2002	9/20/2009
149	0543	Deny	Lifetime benefit maximum has been reached for this service/benefit category.	10/31/2002	
155	2004	Deny	Patient refused the service/procedure.	6/30/2003	9/30/2007

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
157	0563	Deny	Service/procedure was provided as a result of an act of war.	9/30/2003	9/30/2007
158	2032	Deny	Service/procedure was provided outside of the United States.	9/30/2003	9/30/2007
159	2005	Deny	Service/procedure was provided as a result of terrorism.	9/30/2003	9/30/2007
160	2007	Deny	Injury/illness was the result of an activity that is a benefit exclusion.	9/30/2003	9/30/2007
165	2008	Deny	Referral absent or exceeded.	10/31/2004	9/30/2007
166	0533	Deny	These services were submitted after this payers responsibility for processing claims under this plan ended.	2/28/2005	
167	0534	Deny	This (these) diagnosis(es) is (are) not covered.	6/30/2005	9/20/2009
168	0599	Deny	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	6/30/2005	9/30/2007
170	0584	Deny	Payment is denied when performed/billed by this type of provider.	6/30/2005	9/20/2009
171	2015	Deny	Payment is denied when performed/billed by this type of provider in this type of facility.	6/30/2005	9/20/2009
174	0594	Deny	Service was not prescribed prior to delivery.	6/30/2005	9/30/2007
175	2016	Deny	Prescription is incomplete.	6/30/2005	9/30/2007
176	2017	Deny	Prescription is not current.	6/30/2005	9/30/2007
177	2020	Deny	Patient has not met the required eligibility requirements.	6/30/2005	9/30/2007
178	2021	Deny	Patient has not met the required spend down requirements.	6/30/2005	9/30/2007
179	2024	Deny	Patient has not met the required waiting requirements.	6/30/2005	9/20/2009
180	2027	Deny	Patient has not met the required residency requirements.	6/30/2005	9/30/2007
181	0595	Deny	Procedure code was invalid on the date of service.	6/30/2005	9/30/2007
182	2019	Deny	Procedure modifier was invalid on the date of service.	6/30/2005	9/30/2007
183	0538	Deny	The referring provider is not eligible to refer the service billed.	6/30/2005	9/20/2009
184	0548	Deny	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	6/30/2005	9/20/2009
185	0549	Deny	The rendering provider is not eligible to perform the service billed.	6/30/2005	9/20/2009
188	2028	Deny	This product/procedure is only covered when used according to FDA recommendations.	6/30/2005	
189	2009	Deny	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	6/30/2005	
190	2010	Deny	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	10/31/2005	

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
191	2029	Deny	Not a work related injury/illness and thus not the liability of the workers' compensation carrier.	10/31/2005	10/17/2010
192	2012	Deny	Nonstandard adjustment code from paper remittance.	10/31/2005	9/30/2007
193	0532	Deny	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	2/28/2006	1/27/2008
194	0545	Deny	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	2/28/2006	9/30/2007
195	2006	Deny	Refund issued to an erroneous priority payer for this claim/service.	2/28/2006	9/30/2007
197	0513	Deny	Precertification/authorization/notification absent.	10/31/2006	9/30/2007
198	0518	Deny	Precertification/authorization exceeded.	10/31/2006	9/30/2007
199	0583	Deny	Revenue code and Procedure code do not match.	10/31/2006	
200	0547	Deny	Expenses incurred during lapse in coverage	10/31/2006	
201	2011	Deny	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement.	10/31/2006	9/30/2012
202	0588	Deny	Non-covered personal comfort or convenience services.	2/28/2007	9/30/2007
203	2013	Deny	Discontinued or reduced service.	2/28/2007	9/30/2007
204	0519	Deny	This service/equipment/drug is not covered under the patient's current benefit plan	2/28/2007	
206	0544	Deny	National Provider Identifier - missing.	7/9/2007	9/30/2007
207	0551	Deny	National Provider identifier - Invalid format	7/9/2007	6/1/2008
208	0555	Deny	National Provider Identifier - Not matched.	7/9/2007	9/30/2007
209	2018	Deny	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected.	7/9/2007	9/30/2012
210	0596	Deny	Payment adjusted because pre-certification/authorization not received in a timely fashion	7/9/2007	
211	0597	Deny	National Drug Codes (NDC) not eligible for rebate, are not covered.	7/9/2007	
212	0574	Deny	Administrative surcharges are not covered	11/5/2007	
213	2022	Deny	Non-compliance with the physician self-referral prohibition legislation or payer policy.	1/27/2008	
214	2023	Deny	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	1/27/2008	10/17/2010
216	0556	Deny	Based on the findings of a review organization	1/27/2008	
220	0567	Deny	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and	1/27/2008	9/30/2012

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
			supporting documentation if required.		
221	2025	Deny	Workers' Compensation claim is under investigation. Claim is under investigation.	1/27/2008	
222	2026	Deny	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	6/1/2008	9/20/2009
224	0577	Deny	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	6/1/2008	
226	0569	Deny	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	9/21/2008	9/30/2012
227	0558	Deny	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete.	9/21/2008	9/20/2009
228	2030	Deny	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008	
230	0562	Deny	No available or correlating CPT/HCPCS code to describe this service.	1/25/2009	
231	2014	Deny	Mutually exclusive procedures cannot be done in the same day/setting.	7/1/2009	9/20/2009
234	0565	Deny	This procedure is not paid separately.	1/24/2010	
236	2001	Deny	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	1/30/2011	9/30/2012
238	2002	Deny	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period.	3/1/2012	9/30/2012
239	2003	Deny	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	3/1/2012	1/29/2012
240	2033	Deny	The diagnosis is inconsistent with the patient's birth weight.	6/3/2012	
242	2034	Deny	Services not provided by network/primary care providers.	6/3/2012	
243	2035	Deny	Services not authorized by network/primary care providers.	6/3/2012	
244	2036	Deny	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation.	9/30/2012	
246	2037	Deny	This non-payable code is for required reporting only.	9/30/2012	
250	2038	Deny	The attachment content received is inconsistent with the expected content.	9/30/2012	
251	2039	Deny	The attachment content received did not contain the content required to process this claim or service.	9/30/2012	
252	2040	Deny	An attachment is required to adjudicate this claim/service.	9/30/2012	
A1	0511	Deny	Claim/Service denied.	1/1/1995	9/20/2009
A6	2031	Deny	Prior hospitalization or 30 day transfer requirement not met.	1/1/1995	
A8	0581	Deny	Ungroupable DRG.	1/1/1995	9/30/2007

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
B1	0582	Deny	Non-covered visits.	1/1/1995	
B7	0585	Deny	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	1/1/1995	9/20/2009
B8	0586	Deny	Alternative services were available, and should have been utilized.	1/1/1995	9/20/2009
B9	0587	Deny	Patient is enrolled in a Hospice.	1/1/1995	9/30/2007
B11	0589	Deny	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	1/1/1995	
B12	0590	Deny	Services not documented in patients' medical records.	1/1/1995	
B13	0591	Deny	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1/1/1995	
B14	0592	Deny	Only one visit or consultation per physician per day is covered.	1/1/1995	9/30/2007
B15	0593	Deny	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	1/1/1995	9/20/2009
B16	0520	Deny	'New Patient' qualifications were not met.	1/1/1995	9/30/2007
B23	0598	Deny	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	1/1/1995	9/30/2007
W3	2041	Deny	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	9/30/2012	
Y1	2042	Deny	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable.	9/30/2012	

1.3.4 National Provider Identifier

The final rule on National provider Identifiers (NPI) specifies that a covered provider must use its assigned NPI where called for on all HIPAA-specified electronic transactions exchanged between covered entities.

DMAS will issue an atypical provider identifier (API) for providers who are not already on the MMIS provider master file. These include non-healthcare providers who cannot obtain an NPI (e.g., taxi drivers), and any providers who are not already enrolled in Virginia Medicaid fee for service. The API number is ten-digits long and mimics the NPI (although using a different algorithm than the one for NPPES).

The Contractor is responsible to ensure that all encounter claims are submitted with a National Provider Identification (NPI) or Administrative Provider Identification (API) number that is on file and active in the MMIS. DMAS produces a monthly provider listing that includes all active and terminated Virginia Medicaid Providers. The Contractor is responsible for maintaining the correct provider identification number for the claim and service date. The Contractor will make maximum effort that all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program.

Upon receipt of the DMAS provider file, the Contractor will add, update, edit, etc. their system with the MMIS NPI/API information, to include effective dates as appropriate. The Contractor will submit a monthly request file to DMAS for every provider who is not on file in the MMIS. Detailed specifications for this request file are provided in the 'Medallion 3.0 Technical Manual'.

An encounter cannot be processed in the MMIS unless the servicing and billing provider on the encounter have a record (NPI/API) on the MMIS provider master file, and that record is active on the encounter date(s) of service. A provider request must be processed by DMAS and confirmation sent to the MCO before the MCO can submit any encounter(s) for a provider who is not on the MMIS.

1.3.5 Line-Level Processing

The MMIS adjudicates professional (837P) encounters at the service line level. The MCO claim identifier at the document level is used to uniquely identify each service. For the MMIS to successfully process the encounter, multi-service line claims must be split into individual encounters with each encounter containing only one service line. Because the MMIS uses a document/claim level X12 value to uniquely identify each service line, the claim must be split when multiple service lines are present. MMIS line-level processing requirements for 837P encounters are listed below.

- The MCO is responsible for providing a unique claim identifier for each claim within their system.
- When the MCO generates the encounter, multi-service line claims must be split into individual encounters with each encounter containing only one service line.
- The encounter must contain a "combined" identifier that uniquely identifies the encounter and uniquely identifies the service line within the encounter. The encounter will contain only the service line that is reflected in the identifier.
- The MCO may use any method that uniquely identifies the claim and service line. One recommended approach is to append the service line number to the unique claim id as shown in the example below.

  Example: MCO unique claim id = 4216000006
  Service line number on claim = 01
  837P claim number (unique claim id/unique service line id) = 421600000601
- 837P EDI reference:
  Loop 2300, CLM01 = 837P claim number (unique claim id/unique service line id)
- Loop 2300, CLM01 may contain a maximum of 20 characters.

See examples below.

ORIGINAL ENCOUNTER

New Claim

Claim Frequency Code
1 (original)

Unique Claim Number
4216000006

Service Line(s)
01 07/12/14, 52678
02 07/12/14, 82115
03 07/12/14, 96745

Original - Encounter 1	**837P reference**
Claim Frequency Code 1 (original)	2300, CLM05-3
Unique Claim Number 421600000601	2300, CLM01
Service Line 01 07/12/14, 52678	2400, LX*1

Original - Encounter 2	**837P reference**
Claim Frequency Code 1 (original)	2300, CLM05-3
Unique Claim Number 421600000602	2300, CLM01
Service Line 01 07/12/14, 82115	2400, LX*1

Original - Encounter 3	**837P reference**
Claim Frequency Code 1 (original)	2300, CLM05-03
Unique Claim Number 421600000603	2300, CLM01
Service Line 01 07/12/14, 96745	2400, LX*1

REPLACEMENT ENCOUNTER

Example where provider updates service line 1 & 3 and generates a replacement claim accordingly

Replacement Claim

Claim Frequency Code
7 (replacement)

Unique Claim Number
4216000007

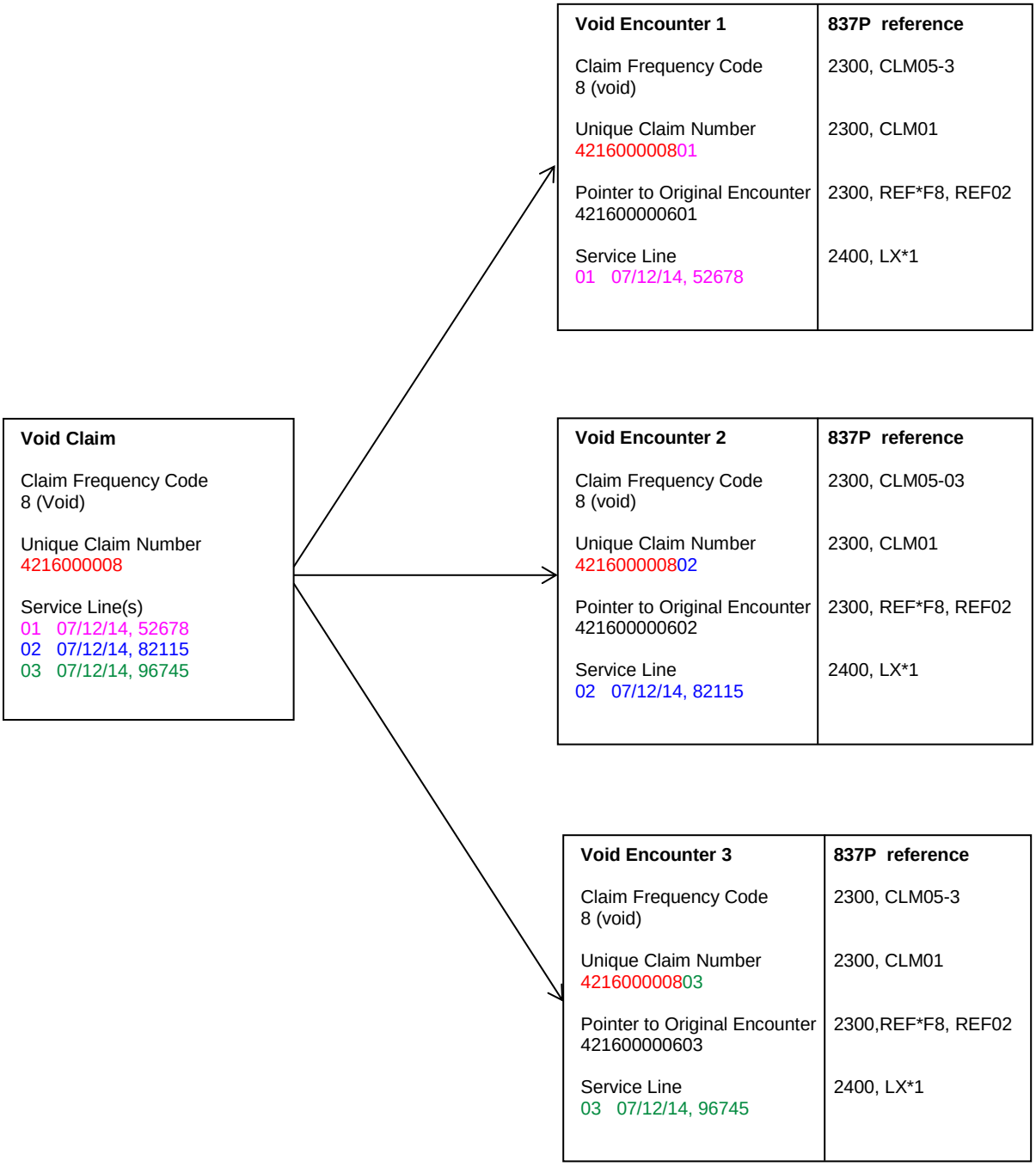
Service Line(s)
01 07/12/14, 45321
02 07/12/14, 82115
03 07/12/14, 26743

Replacement - Encounter 1	**837P Reference**
Claim Frequency Code 7 (replacement)	2300, CLM05-03
Unique Claim Number 421600000701	2300, CLM01
Pointer to Original Encounter 421600000601	2300, REF*F8, REF02
Service Line 01 07/12/14, 45321	2400, LX*1

Replacement - Encounter 2	**837P reference**
Claim Frequency Code 7 (replacement)	2300, CLM05-03
Unique Claim Number 421600000703	2300, CLM01
Pointer to Original Encounter 421600000603	2300, REF*F8, REF02
Service Line 03 07/12/14, 26743	2400, LX*1

VOID ENCOUNTER

Example where the provider voids the original claim



1.3.6 Drug Rebate Collection

DMAS is required by the Affordable Care Act to collect pharmacy rebates for drugs provided to Medicaid members in an outpatient setting who are enrolled in a managed care arrangement. For successful rebate collection, pharmacy/drug encounters have to contain certain required fields, e.g., NDC, MCO payment date, MCO payment amount. Drugs may be submitted as pharmacy or medical for the following transaction types: Pharmacy (NCPDP), Professional (837P), and Institutional (837I).

1.3.6.1 Required Data for Rebate Collection on Eligible Drugs

The following data elements must be populated on the EDI transaction to DMAS for successful rebate collection from the manufacturer.

Data Element	EDI Reference		
	NCPDP Field	**837P Loop.Segment.Element**	**837I (outpatient only) Loop.Segment.Element**
MCO payment amount	431-DV	2430.SVD.02	Claim level: 2320.AMT.01=D 2320.AMT.02 OR Service level: 2430.SVD.02
MCO payment date	443-E8	2430.DTP.01=573 2430.DTP.03	Claim level: 2330B.DTP01=573 2330B.DTP03 OR Service level: 2430.DTP.01=573 2430.DTP.03
Medicaid member ID	302-C2	2010BA.NM1.09	2010BA.NM1.09
NDC	407-D7	2410.LIN.02=N4 2410.LIN.03	2410.LIN.02=N4 2410.LIN.03
Drug unit of measure (837 only)	N/A	2410.CTP.05-1	2410.CTP.05-1
Drug unit/quantity	442-E7	2410.CTP.04	2410.CTP.04

Effective 07/01/2015, DMAS will begin to identify and track errors that prevent collection of rebates through the Encounter Data Quality (EDQ) process. These errors will be subject to compliance assessment.

1.3.6.2 Compound Drugs

NCPDP compound drug encounters must be submitted with multiple ingredients. A NCPDP single-ingredient compound must be submitted as a non-compound, single drug. If a NCPDP compound drug encounter is submitted with only one ingredient, it will be flagged by the MMIS with an ESC error code 0044 (NDC missing or not in valid format).

1.3.6.3 340B Drugs

340B drugs are not eligible for rebate. The MCO must have a process in place to identify 340B drugs so that the drug may be excluded from rebate collection. The technical requirements for 340B drug identification are shown below.

Transaction	Field/Data Element	EDI Reference Field Id/Element	Value
NCPDP	Submission Clarification Code Basis of Cost Determination	420-DK 423-DN	20 08
Note: Submission Clarification Code AND Basis of Cost Determination must be populated. Maximum number of occurrences supported for Submission Clarification Code is 1.			
837P	Procedure Modifier	2400.SV1.01 (3-6)	UD
837I	Procedure Modifier	2400.SV2.02 (3-6)	UD
Note: Each drug line must be submitted with modifier UD on the revenue line with the procedure code and NDC code.			

1.3.7 MCO Payment Amount & Date

The amount that the Contractor paid the servicing provider must be submitted to the State on each encounter record for a paid (non-denied) claim. The paid amount should reflect what the servicing provider was paid to render care to the member and should not reflect a capitated or salaried reimbursement arrangement.

Each encounter must also include the MCO's payment/remit date. If the MCO payment date is different from the remit date, the MCO should populate the "MCO payment date" with the remit date value.

A member with other insurance coverage (TPL) will be disenrolled from the MCO once that coverage has been verified by DMAS and added to the State's MMIS system. Until the member is disenrolled, the Contractor is required to submit the primary carrier's payment on the encounter along with the MCO payment amount (if any).

For all transaction types, values must be present for the MCO payment amount and MCO payment/remit date (including denials). MMIS will not recognize MCO payment date values that are submitted without a corresponding MCO payment amount value. Zero is an acceptable value for MCO payment amount when appropriate.

1.3.7.1 Sample 837P – Contractor Payment Only

The CN1 segment on the 837 record should be used to identify the method of payment. Refer to the 837 IG for valid values for the CN1 segment. The information below shows an example of how an 837P record should look when the only payment made was made by the Contractor:

<u>2000B Subscriber Loop</u>

```
HL*2*1*22*0
SBR*P*18*******MC
NM1*IL*1*SMITH*BARNEY****MI*999999999999
N3*17 BROADWAY
N4*RICHMOND *VA*23229
DMG*D8*19430621*M
NM1*PR*2*BOMBAY,DOCTOR*****PI*547777777
```

<u>2300 Claim Loop</u>

```
CLM*4995757*115***21||1*Y*A*Y*Y*C**01
DTP*431*D8*20120501
DTP*435*D8*20120501
CN1*04
HI*BK|51884*BF|49121
NM1*82*1*BOMBAY*DOCTOR****XX*1234567890
```

<u>2320 Other Subscriber Information Loop</u>

This is the loop where the Contractor will indicate the paid amount. NM109 = 7777 = MCO Service Center ID. This is associated with the appropriate SVD segment = 7777 to pick up the paid amount of $80.00 The DTP segment (with qualifier 573) is used for the MCO paid date.

```
SBR*S*18***HM****HM
DMG*D8*19430621*M
OI***Y*B**A
NM1*IL*1*SMITH*BARNEY****MI*999999999999
NM1*PR*2*MCO CARE*****PI*7777
LX*1
SV1*HC|99239*213*UN*1*21**1****Y
DTP*472*D8*20120501
SVD*7777*80*HC|99239**1
CAS*CO*45*133
DTP*573*D8*20120811
```

1.3.7.2 Sample 837P – Contractor and Other Carrier Payments

The following is an example of how an 837P record should look when there is other TPL coverage also involved:

2000B Subscriber Loop

```
HL*2*1*22*0
SBR*P*18*******MC
NM1*IL*1*SMITH*BARNEY****MI*999999999999
N3*17 BROADWAY
N4*RICHMOND*VA*23229
DMG*D8*19430621*F
NM1*PR*2*BOMBAY,DOCTOR*****PI*547777777
```

2300 Claim Loop

```
CLM*4995757*115***21||1*Y*A*Y*Y*C**01
DTP*431*D8*20120501
DTP*435*D8*20120501
CN1*04
HI*BK|51884*BF|49121
NM1*82*1*BOMBAY*DOCTOR****XX*1234567890
```

2320 Other Subscriber Information Loop

2 loops (Contractor and Other Carrier) – NM109 = 7777 = MCO Service Center ID. This is associated with the appropriate SVD segment = 7777 to pick up the paid amount of $75 on this claim. Other Carrier 1234 paid $30.00 on this claim. The DTP segment (with qualifier 573) is used for the MCO's paid date (carrier 7777).

```
SBR*S*18***HM****HM
DMG*D8*19430621*M
OI***Y*B**A
NM1*IL*1*SMITH*BARNEY****MI*999999999999
NM1*PR*2*MCO CARE*****PI*7777
SBR*S*18***OT****CI
DMG*D8*19430621*M
OI***Y*B**A
```

```
NM1*IL*1*SMITH*BARNEY****MI*999999999999
NM1*PR*2*OTHER INSUR*****PI*1234
LX*1
SV1*HC|99232*115*UN*1*21**1****Y
DTP*472*D8*20120501
SVD*7777*75*HC|99232**1
CAS*CO*45*40

DTP*573*D8*20120811
SVD*1234*30*HC|99232**1
CAS*CO*45*85

DTP*573*D8*20120811
```

1.3.7.3 Sample 837I – Contractor Payment Only

The following is an example of how an 837I record would look like when the only payment made was made by the Contractor:

2000B Subscriber Loop

```
HL*2*1*22*0~
SBR*P*18*SSSSS******MC~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
N3*4 BROAD WAY~
N4*RICHMOND *VA*23229~
DMG*D8*19901008*M~
NM1*PR*2*MCO CARE*****PI*9999~
```

2300 Claim Loop

```
CLM*0523155346*367.7***13:A:1*Y*A*Y*Y*********N~
DTP*096*TM*1900~
DTP*434*RD8*20120810-20120810~
CL1*1*1*01~
CN1*02*30~
REF*D9*052999346~
HI*BK:3129*ZZ:4489~
HI*BF:3009*BF:31401~
HI*BE:A3:::36770~
NM1*71*2*SMITH*****XX*1014567890~
```

2320 Other Subscriber Information Loop

This is the loop where the Contractor will indicate the paid amount. NM109 = 7777 = MCO Service Center ID. This is associated with the appropriate SVD segment = 7777 to pick up the paid amount of $100. The DTP segment is used for the paid date.

```
SBR*S*18*7777*559999504051*****HM~
DMG*D8*19901008*M~
OI***Y***Y~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
NM1*PR*2*MCO CARE*****PI*7777~
```

```
LX*1~
SV2*0450*HC:99284*367.7*UN*1~
DTP*472*RD8*20120810-20120810~
SVD*7777*100*HC:99284*0450*1~
CAS*CO*45*267.7~
DTP*573*D8*20120904~
```

Another HL or end of transaction.

1.3.7.4 Sample 837I – Contractor and Other Carrier Payments

The following is an example of how an 837I record would look when there is other coverage involved:

2000B Subscriber Loop

```
HL*2*1*22*0~
SBR*T*18*SSSSS******MC~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
N3*4 BROAD WAY~
N4*RICHMOND*VA*23229~
DMG*D8*19901008*M~
NM1*PR*2*MCO CARE*****PI*9999~
```

2300 Claim Loop

```
CLM*0523155346*367.7***13:A:1*Y*A*Y*Y*********N~
DTP*096*TM*1900~
DTP*434*RD8*20120810-20120810~
CL1*1*1*01~
CN1*02*30~
REF*D9*052999346~
HI*BK:3129*ZZ:4489~
HI*BF:3009*BF:31401~
HI*BE:A3:::36770~
NM1*71*2*SMITH*****24*1014567890~
```

2320 Other Subscriber Information Loop

2 loops (Contractor and Other Carrier) – Carrier 7777 paid $50 on this claim. Carrier 1234 paid $100 on this claim. The $50 TPL payment needs to be in the amount segment (AMT) in the appropriate 2320 loop.

```
SBR*S*18*2222*GROUP NAME*****CI~
AMT*C4*50~
DMG*D8*19901008*M~
OI***Y***Y~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
NM1*PR*2*CIGNA*****PI*1234~
SBR*T*18*1234*GROUP NAME*****HM~
DMG*D8*19901008*M~
OI***Y***Y~
```

```
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
NM1*PR*2*MCO CARE*****PI*7777~
LX*1~
SV2*0450*HC:99284*367.7*UN*1~
DTP*472*RD8*20050810-20050810~
SVD*7777*100*HC:99284*0450*1~
CAS*CO*42*217.7**23*50~
DTP*573*D8*20050904~
```

1.3.7.5 Sample NCPDP – Contractor Payment Only

The following is an example of how a NCPDP record would look like when the only payment made was by the Contractor. The AM05 segment is used for reporting payment information by the MCO. The HC field must be set to "07" to indicate that the payment information is for the MCO. Each encounter must ALWAYS contain the MCO payment information.

Example – NCPCP, AM05 segment:

```
AM05FS4C1FS5C01FS6C99FS7C9999FSE820160122FSHB1FSHC07FSDV71EETX
```

NCPDP FIELD NAME	FIELD #	VALUE	NOTES
Segment Identification	AM	05	05 = COB/Other Payments Segment
COB/Other payment count	4C	1	Count of payment occurrences. MCO Encounters will support up to 2 occurrences.
PRIMARY PAYER			
Other payer coverage type	5C	01	01 = Primary payer
Other payer ID Qualifier	6C	99	
Other payer ID	7C	9999	MCO identifier
Other payer date	E8	20160122	MCO payment date (CCYYMMDD)
Other payer amount paid count	HB	1	
Other payer amount paid qualifier	**HC**	**07**	**07 = MCO payment qualifier**
Other payer amount paid	DV	7.15	MCO payment amount

1.3.7.6 Sample NCPDP – Contractor and Other Carrier Payment(s)

The following is an example of how a NCPDP record should look when other insurance coverage is involved. The AM05 segment is used for reporting payment information by the other carrier and also by the MCO. The MMIS can accommodate two occurrences of payment information. The HC field must be set to “08” in one occurrence to indicate that the payment information is for the other carrier(s). In a separate occurrence, the HC field must be set to “07” to indicate that the payment information is for the MCO. If there are multiple carriers involved, the sum of the payments should be reported under the other carrier (HC=08). The sum will not include the MCO payment amount as this is reported separately (HC=07). Each encounter must ALWAYS contain the MCO payment info (HC=07).

Example - NCPDP, AM05 segment:

AM05FS4C2FS5C01FS6C99FS7C999999FSE820160122FSHB1FSHC08FSDV138GFS5C02FS6C99FS7C9999FSE820160205FSHB1FSHC07FSDV214BETX

NCPDP FIELD NAME	FIELD #	VALUE	NOTES
Segment Identification	AM	05	05 = COB/Other Payments Segment
COB/Other payment count	4C	2	Count of payment occurrences. MCO Encounters will support up to 2 occurrences.
PRIMARY PAYER			
Other payer coverage type	5C	01	01 = Primary Payer
Other payer ID Qualifier	6C	99	
Other payer ID	7C	999999	Other payer identifier
Other payer date	E8	20160122	Other payer payment date (CCYYMMDD)
Other payer amount paid count	HB	1	
Other payer amount paid qualifier	**HC**	**08**	**08 = Other payer payment qualifier**
Other payer amount paid	DV	13.87	Other payer payment amount (sum of all other payments, not including MCO payment amount).
SECONDARY PAYER			
Other payer coverage type	5C	02	02 = Secondary payer
Other payer ID Qualifier	6C	99	
Other payer ID	7C	9999	MCO identifier
Other payer date	E8	20160205	MCO payment date (CCYYMMDD)
Other payer amount paid count	HB	1	
Other payer amount paid qualifier	**HC**	**07**	**07 = MCO payment qualifier**
Other payer amount paid	DV	21.42	MCO payment amount

1.3.8 Enrollment Determination Based on Admit Date

Member eligibility in the MMIS is being determined based on the discharge date (MMIS edit 0453). A system change has been submitted to correct the edit logic to use the admission date. Eligibility for member's coverage is actually based on the member's enrollment at the start of the admission (admit date).

1.3.9 Newborns without Medicaid IDs

ORIGINAL PROCEDURE

Originally, DMAS had instructed the MCOs to use a workaround when submitting encounters for newborns that have not been assigned a Medicaid ID. For this workaround, the MCO would submit the newborn encounter with an identifier that consists of the first 9 digits of the mother's ID with a 3 digit sequence number representing each unique child for that mother (e.g., 001 for the first child, 002 for the second, etc.). The sequence number must be in the range of 001 – 005. The MCOs were instructed to submit this identifier instead of a valid Medicaid ID on the newborn encounters whenever a valid Medicaid ID was not available. The MMIS is programmed to process newborn encounters using the original procedure through March 25, 2016. DMAS is requiring the MCOs to phase out this procedure and start using the new procedure described below on March 28, 2016 or shortly thereafter.

NEW PROCEDURE

The new procedure will be functional in the MMIS starting March 28, 2016

Newborns without a Medicaid Id Requirement

The newborn encounter will contain a Medicaid Id that consists of the first 11-digits of mother's Medicaid Id plus an alpha character in the 12th position. The alpha character is to be uppercase and in the range of "A" through "Z". Alpha characters should be used in succession, ascending to descending for each baby.

Example: Mom's Medicaid Id = 111222333449

Baby #1 Medicaid Id = 11122233344A

Baby #2 Medicaid Id = 11122233344B

Baby #3 Medicaid Id = 11122233344C

Transitioning to the New Procedure

Once the MCO is ready to use the new procedure, the preferred approach is for all encounter transactions (originals, replacements, and voids) to contain a member id with the alpha postfix. The only exception will be NCPDP pharmacy reversals as member id is not included in this transaction. If using the new procedure is a hardship for runout transactions, the old procedure may be used. The MMIS may flag transactions using the 3-digit postfix with an error. These errors can be ignored.

EDQ Impact

DMAS will reinstate the Enrollment category (via the Emerging list first) in the EDQ process sometime in the near future. When this happens, we will initially exclude the evaluation of encounters for newborns using the alpha postfix. Once all runout is complete and all MCOs are fully transitioned to the new procedure, the newborn requirement will become part of the normal EDQ process.

1.3.10 **Procedure, Diagnosis, Revenue Code**

A workaround was previously implemented in MMIS to accept invalid diagnosis, revenue, and procedure codes in encounter submissions when submitted with all X's in the field. The original intent was for the MCO to use these values when a claim was denied for an invalid or missing code. Effective 01/01/2010, the X codes have been end dated in the MMIS, resulting a 0995 or 0996 edit being set on the encounter.

1.3.11 Transportation Encounters

The MMIS truncates fractional mileage on transportation encounters. On rare occasion, a transportation encounter will contain mileage (units) that are less than 1 mile. In this case, the MCO will be required to round the fractional value to 1.

1.4 Proprietary MMIS Code Sets

The following proprietary code sets are used in the Virginia MMIS for processing and reporting. The MCO is not required to submit these values on the encounters. However, the MCO may need to utilize the coding values for reconciliation and/or error correction of encounter data.

1.4.1 MMIS Claim Type

The MMIS assigns a proprietary claim type value to each encounter record submitted by the MCO. This claim type value is used extensively in the MMIS to drive reporting and editing. The following table lists the claim types along with their associated 'form' and description.

Code	Form	Description
01	FAC	Inpatient Hospital
02	FAC	Skilled Nursing Home (SNF)
03	FAC	Outpatient Hospital/Home Health
04	MED	Personal Care
05	MED	Practitioner
06	DRUG	Pharmacy
08	MED	Lab
10	FAC	Intermediate Care (ICF)
11	MED	Dental
13	MED	Transportation

1.4.2 Provider Class Type

Code	Description
001	Hospital, in-state, General
002	State Mental Hospital (Aged)
003	Private Mental Hospital (inpatient psych)
004	Long Stay Hospital
005	TB Hospital
006	Skilled Nursing Home Mental Health
007	State Mental Hospital (less than age 21)
008	State Mental Hospital (Med-Surge)
009	Medical Surgery - Mentally Retarded
010	Skilled Nursing Home Non Mental Health
011	Skilled Nursing Facility - Mentally Retarded
012	Long Stay Inpatient Hospital - Mental Health
013	Med-Surge Mental Health Retardation
014	Rehab Hospital
015	Intermediate Care Facility
016	Intermediate Care Facility - Mental Health
017	ICF - Mentally Retarded - State Owned
018	ICF - Mentally Retarded - Community Owned
019	CORF (Outpatient Rehab Facility)
020	Physician
021	Licensed Professional Counselor
022	Treatment Foster Care Program
023	Nurse Practitioner
024	Licensed Psychologist
025	Clinical Psychologist
026	Chiropractor
027	Christian Science SNF
028	Skilled Nursing Facility - State
029	Intermediate Care Facility - State
030	Podiatrist
031	Optometrist
032	Optician
033	Nurse Anesthetist
034	Clinical Nurse Specialist - Psychiatric only
035	Nurse Midwife
036	Case Management
037	Prenatal Nutrition
038	Hearing Aid
039	Respiratory Therapist
040	Dentist
041	Dental Clinic
042	Dental Clinic MH/MR
043	Speech/Language Pathologist
044	Audiologist
045	Occupational Therapist
046	Hospice
047	Respite Care
048	Adult Day Health Care
049	Ambulatory Surgical Center

Code	Description
050	Renal Unit
051	Health Department Clinic
052	Federally Qualified Health Center
053	Rural Health Clinic
054	Physical Therapist
055	Personal Care
056	Mental Health Mental Retardation
057	Rehab Agencies
058	Home Health Agency - State
059	Home Health Agency - Private
060	Pharmacy
061	Family Caregiver Training
062	Durable Medical Equipment/Supplies
063	Private Duty
064	Prosthetic Services
065	Eldercare Program
067	HMO Medallion 3.0 - Immunization
070	Independent Laboratory
071	Substance Abuse Clinic (FAMIS)
072	Education Services
073	Case Management Waiver
074	Head Start Clinic
075	Mental Retardation Waiver Services
076	Licensed Clinical Social Worker
077	Psych Residential Inpatient Facility
078	Licensed Social Worker
079	Assisted Living
080	Transportation
081	Registered Driver
082	Emergency Air Ambulance
083	Out-of-State Transportation
084	Out-of-State Emergency Air Ambulance
085	Out-of-State Rehab Hospital
086	Out-of-State Intermediate Care Facility
087	HMO Medallion 3.0
088	Tax Group
090	Out-of-State Supply Equipment
091	Out-of-State Hospital
092	Out-of-State Skilled Care Facility
093	Out-of-State Clinic
094	Out-of-State Home Health
095	Out-of-State Physician
096	Out-of-State Pharmacy
097	Out-of-State Dental
098	Out-of-State Laboratory
099	Medicare Crossover
100	Non-Medicaid TDO
101	School Psychologist
102	Marriage and Family Therapist
103	Substance Abuse Practitioner
104	PACE Provider
105	Certified Professional Midwives

Code	Description
106	Transition Coordinator
107	MMIS Contractors or Vendors
108	Early Intervention
109	Out of State ICF Provider

1.4.3 Provider Specialty

Code	Description
000	No Specialty
001	Ambulance
002	Wheelchair Van
003	Taxi
004	Ambulance/WC Van
005	Ambulance/Taxi
006	Ambulance/WC Van/Taxi
007	Wheelchair Van/Taxi
008	Taxi Non-Enrolled
009	Neo-natal Ambulance
010	Not used
011	Registered Driver
012	Locked Facility
013	Unlocked Facility
014	Fiscal Agent - State
015	Fiscal Agent - Private
016	DD Waiver
017	DD Waiver Support Coord
018	Special ED Audiologist
019	Special ED Personal Care Services
020	Special ED Transportation
021	Air Ambulance
022	OB/GYN Nurse Practitioner
023	Family Nurse Practitioner
024	Pediatric Nurse Practitioner
025	Special ED Nursing Services
026	Special ED PSYCH services
027	Physical Therapy
028	Occupational Therapy
029	Speech/Language
030	ACR (Adult Care Residence)-AAA
031	ACR-CSB
032	ACR-DOH
033	ACR-CILS
034	ACR-DSS
035	EPSDT Special
036	Case Management
037	Nutrition
038	Patient Education
039	Homemaker Services
040	Consumer-Directed Personal Attendant
041	Mental Health Clinic
042	CSB Mental Health
043	CSB MR St Plan
044	MR Waiver: CSB ONLY
045	Private MHSA Services
046	MR Waiver: MR
047	Substance abuse
048	Regular Assisted Living
049	Intensive Assisted Living

Code	Description
050	Not used
051	School Practitioner
052	Quality Health Center
053	Family Practice
054	Hosp-Home Health
055	Free Standing Home Health
056	General Practice
057	Anesthesiology
058	Colon/Rectal Surgery
059	Dermatology
060	Internal Medicine
061	Neurological Surgery
062	Obstetrics and Gynecology
063	Ophthalmology
064	Orthopedic Surgery
065	Otolaryngology
066	Pathology
067	Neonatology, Pediatrics
068	Physical Med/Rehab
069	Unit Dose/Plastic Surgery
070	Preventive Medicine
071	PSY and NEUR
072	Radiology
073	General Surgery
074	Thoracic Surgery
075	Urology
076	Other
077	Psychologist
078	Dentist (General Practice)
079	Orthodontist
080	Oral Surgery
081	Periodontist
082	Pedodontist
083	Endodontist
084	Other
085	Not used
086	Ventilator
087	AIDS
088	Unknown
089	Complex
090	Elderly Case Mg
091	NF Private Room Rate
092	Rehabilitation
093	Durable Equipment/Supply
094	Health Department Pharmacy
095	Not used
096	Not used
097	Not used
098	Not used
099	Not used
100	Mammography
101	Plastic Surgery

Code	Description
102	LTC Pharmacy Non-UD
103	Public Transportation
104	Stretcher Van
105	Alzheimer's Assisted Living
106	E Medicaid
107	Adult Nurse Practitioner
108	Geriatric Nurse Practitioner
109	Neonatal Nurse Practitioner
110	Acute Care Nurse Practitioner
111	Psychiatric Nurse Practitioner
112	Certified Nurse Midwife Nurse Practitioner
113	Full PACE(Program for All Inclusive Care for Elderly)
114	Children's Group Home Level A
115	Therapeutic Group Home Level B
116	Early Intervention Provider Specialty
117	CMHP Transition Coordinator
118	Residential Respite Care
119	Early Intervention Targeted Case Management
120	EPSDT Behavioral Therapy
121	Board Certified
122	60% E&M Threshold Attestation
123	ORP Physician Assistant
124	ORP Intern
125	ORP Other
126	DME Incontinence Supplies
127	Telemedicine
128	BHSA

1.4.4 Edit Codes / Error Sequence Codes (ESC)

ESC	Error Description
0001	Provider Not Certified for Neonatal Care
0002	Invalid Reference Number
0003	Invalid Billing Provider Number
0004	Invalid or Missing Enrollee ID
0005	Invalid Accident Indicator/Hour
0007	Invalid Date of Service
0009	Invalid Tooth Code (dental)
0010	Invalid Surface Code (dental)
0012	Invalid Procedure Code
0022	Servicing Provider is Not Eligible to Bill this Payment Request Type
0023	Units Missing/Not in Valid Format
0025	Service 'Thru' Date Missing/Invalid
0028	Admit Date Missing or Invalid
0030	Primary Diagnosis Not on File/Invalid
0031	Patient Status is Missing or Invalid
0033	Total Charge Omitted/Out of Balance
0035	Missing/Invalid Accommodation Code
0038	Invalid Place of Treatment Code
0038	Invalid Place of Treatment Code
0040	Invalid Type of Service
0041	Invalid Procedure Modifier
0044	NDC Missing or Not in Valid Format
0045	Invalid Metric Quantity
0054	Principal procedure date is invalid or is outside dates of service billed.
0055	Type of Bill Missing or Invalid
0056	Prescription Number Missing
0057	Refill Indicator Invalid
0065	The number of passengers is invalid.
0066	Invalid wait time
0071	Invalid Void/Adjustment Reason Code
0077	Adjustment Denied - Original Payment Request Already Adjusted
0078	Void Denied - Original Payment Request Already Voided
0085	Admit Source Code Missing/Invalid
0098	Key Entry Error
0100	Invalid Mileage
0101	Date of Service After Date Payment Request Received
0103	Admission Date After Date Received
0104	Thru DOS is After Date Payment Request Received
0107	Surgical Procedure Omitted for O/R Charge
0109	Diagnosis Code Does Not Agree with Sex Code
0110	Diagnosis Code Does Not Agree with Age
0111	From Service Date After Thru Date
0112	Admit Date After From Date of Service
0113	ICD-9-CM Procedure/Sex Restriction
0116	Invalid/Missing Prescribing Physician Number

ESC	Error Description
0117	Invalid Service/Modifier Combination
0119	The statement covers period disagrees with the service units.
0129	Revenue Code Not Covered
0130	Billing Provider Number Not On File
0131	The first other procedure code is not in the correct format or not on file.
0133	Revenue Code Missing
0143	Enrollee Not Eligible on DOS
0144	Billing Provider Not Eligible on DOS
0146	The Procedure Code Billed is Not on File
0147	Procedure Code Not In Use on Service Date
0148	Rendering provider is not certified to perform procedure.
0153	Invalid Tooth Number/Procedure
0176	Bill Mother and Baby Separately
0178	Invalid Diagnosis Code
0179	Invalid Discharge Status for Type Bill
0183	Procedure Code Does Not Agree with Service
0186	Procedure code billed not compatible with enrollee's sex.
0201	Duplicate Payment Request - Same Provider, Same DOS
0202	Duplicate of History File Record - Different Provider, Same DOS
0211	Enrollee Less than Minimum Age
0212	Enrollee Greater Than Maximum Age
0231	Verify Enrollee Eligibility in HMO
0249	Duplicate Payment Request - Same Provider, Overlap DOS
0257	Length of Stay Exceeds Percentile Limit
0301	Duplicate Payment Request - Same Provider, Same DOS
0302	Duplicate of History Record - Same Provider, Same DOS
0305	Contraindicated Audit - Same Provider, Within 32 Days
0307	Drug Not Covered for Enrollee's Age 21 or Older
0318	Enrollee Not Eligible on DOS
0330	Duplicate of History File Record - Same Provider, Overlap DOS
0360	Contraindicated Audit - Same Provider, Same DOS
0374	Duplicate HMO Copay Payment Request
0394	Drug Not Covered
0396	Adjustment Denied - Original Payment Request Not on File
0397	Void Denied - Original Payment Request Not on File
0400	Duplicate Rx Number/Different Drug Code
0401	Charges exceed maximum allowance
0403	NDC Not Covered
0415	Servicing provider ID is not the approved provider.
0423	NDC Not on File, Check NDC
0435	Invalid Drug Code for Compound Rx
0448	Neonatal/Nurse Days not Allowed Patient Over 3 Yrs
0449	Adult and nursery/neonatal days are not allowed on the same pmt request
0451	Two Nursery Revenue Codes on Same Invoice
0452	Overlapping Program Eligibilities
0453	Enrolled in HMO or Encounter Claim for FFS
0461	Units/Visits/Studies Not Equal Days

ESC	Error Description
0464	Invalid Drug Code; Not a Compound
0482	Unable to Validate Enrollee in HMO
0493	Prescribing Physician Not on File
0706	Invalid Third Diagnosis
0707	Invalid Fourth Diagnosis
0708	Invalid Fifth Diagnosis
0709	Invalid Sixth Diagnosis
0710	Invalid Seventh Diagnosis
0711	Invalid Eighth Diagnosis
0712	Invalid Ninth Diagnosis
0713	Second Other Procedure Invalid
0714	Third Other Procedure Code Invalid
0715	Fourth Other Procedure Code Invalid
0716	Fifth Other Procedure Code Invalid
0717	First Other Procedure Date Is Missing or Invalid
0718	Second Other Procedure Date is Missing or Invalid
0719	Third Other Procedure Date is Missing or Invalid
0724	Admit Type is Missing or Invalid
0729	Servicing Provider Not on File
0731	Servicing Provider Not Eligible on DOS
0732	Servicing Provider Invalid
0733	Admitting Diagnosis Missing or Invalid
0734	Covered Days Entered Exceed Statement Period
0735	Invalid Procedure for Anesthesia
0736	Invalid Surface Code/Procedure
0739	Personal Care Begin Date > From DOS
0740	Same Procedure, Same Day, Different Modifiers
0747	Duplicate Payment Request - Different Provider, Overlap DOS
0748	Duplicate of History File Record - Different Provider, Overlapping DOS
0752	Missing HMO Claim Number
0753	Fourth Other Procedure Date is Missing or Invalid
0754	Fifth Other Procedure Date is Missing or Invalid
0756	Billing Provider is Not a Group Provider
0757	Servicing Provider Cannot Be a Group Provider
0758	Provider Cannot Bill as an Individual
0759	Inpatient Hospital Payment > $500,000
0820	Review Enrollee Birth Date
0821	Outpatient Days Billed Exceeds 1
0825	Limitation Audit - Once in a Lifetime, Any Provider - Deny
0826	Limitation Audit - Three in a Lifetime, Any Provider - Deny
0827	Unable to Assign Object Code
0828	Inpatient versus Outpatient, Possible Duplicate
0829	Inpatient versus Title 18, Possible Duplicate
0830	Outpatient versus Title 18, Possible Duplicate
0831	SNF versus Title 18, Possible Duplicate
0833	Transportation versus Title 18, Possible Duplicate
0838	Missing/Invalid PA Tran Request End Date

ESC	Error Description
0840	Quantity Dispensed > Intended Quantity
0841	Multiple Partial Fill Prescriptions Not Allowed
0842	Different NDC Between Partial & Completion Fill
0843	Intended Quantity Exceeds Maximum
0844	Missing/Invalid Associated Rx Number on Completion Transaction
0845	Missing/Invalid Associated DOS on Completion Transaction
0846	Associated Partial Fill Transaction Not On File
0847	Partial Fill Transaction Not Supported for Compounds
0848	Completion Transaction not Permitted with Same DOS as Partial
0849	Intended Days Supply Exceeds Maximum Allowed
0850	Intended Days Supply Missing or Invalid
0852	Intended Quantity Missing or Invalid
0853	Dispensing Status Missing or Invalid
0856	Missing/Invalid Basis of Request
0857	Missing/Invalid PA Tran Request Begin Date
0858	Bill Type 111/112 Admit Date Not = From Date
0866	Duplicate Provider, Rx #, and Date of Service
0871	Invalid Secondary Diagnosis
0874	Drug Daily Dose Exceeded
0875	Drug Total Dose Quantity Exceeded
0877	Same Cycle Reversal with Diff Media Not Allowed
0878	Early Refill Override Due to Increase in Dosage
0893	Days Supply for Partial Fill Components Exceeds Intended Days
0894	Quantity for Partial Fill Components Exceeds Intended Quantity
0902	Assistant Surgeon Modifier & Co-Surgeon Modifier Not Allowed On Same
0919	Inpatient versus Nursing Home - Possible Duplicate
0932	Related Component Radiology Procs Not Payable when Global Paid
0933	Components of Surgical Care Not Payable when Global Surgery Paid
0934	Umbrella Audit - Postpartum Visits, Same Provider
0936	Tooth/Procedure - Invalid Combination
0937	Limitation Audit - Twice in a Lifetime, Any Provider - Deny
0938	Limitation Audit - Four in a Lifetime, Any Provider - Deny
0939	Limitation Audit - Six in a Lifetime, Any Provider - Deny
0940	Limit Audit - Only One New Patient Medical Visit per Lifetime
0954	Inpatient versus Outpatient, Same Provider
0970	Enrollee Not Enrolled in a Covered Plan for This Service on the DOS
0970	Enrollee Not Enrolled in a Covered Plan for This Service on the DOS
0971	Enrollee in Plan that Provider is Not
0979	Duplicate Ingredient(s) on Compound Claim Not Paid
0983	Enrollee not on File
0986	DRG Rate Not On File
0990	Revenue Code Not on File
0991	Revenue Code Not Valid for Dates of Service
0992	Revenue Code Not Valid for Enrollee's Age
0993	Revenue Code Not Valid for Enrollee's Sex
0994	Revenue Code Not Valid for Provider Type, Specialty
0995	Revenue HCPCS Not on File

ESC	Error Description
0996	Revenue HCPCS Not Valid for Dates of Service
1008	Wheelchair Van Passenger Limit Exceeded
1009	Mileage Limit or Charge Exceeded
1470	More than 30 Errors
1503	Negative PA on File/Physician Must Approve for PA
1505	Angiotensin Receptor Blockers - Non PDL, PA Required
1506	ACE Inhibitor - Non PDL, PA Required
1507	ACE Inhibitor/Calcium Channel Blocker Combo - Non PDL, PA Required
1509	Nondihydropryidine Calcium Channel Blockers - Non PDL, PA Required
1510	Proton Pump Inhibitor Non PDL
1511	Sedative Hypnotics - Non PDL, PA Required
1512	Beta Adrenergic Agent - Non PDL, PA Required
1515	Beta Blockers - Non PDL, PA Required
1516	Cholesterol Lowering Drugs (Statins) - Non PDL, PA Required
1517	Inhaled Corticosteroids - Non PDL, PA Required
1518	Nasal Steroids - Non PDL, PA Required
1519	COX-II Inhibitors - Non PDL, PA Required
1520	Low Sedating Antihistamines - Non PDL, PA Required
1521	Histamine 2 Receptor Antagonist - Non PDL, PA Required
1522	Oral Hypoglecemics - PDL PA Required
1523	Leukotriene Modifiers - PDL PA Required
1524	NSAID - PDL PA Required
1525	Bisphosphonates - PDL PA Required
1526	Oral Antifungals for Onychomysis - PDL PA Required
1527	Serotonin Receptor Agonists - PDL PA Required
1528	Cephalosporins - PDL PA Required
1529	Macrolides - PDL PA Required
1530	Quinolones - PDL PA Required
1531	Glaucoma Agents - PDL PA Required
1532	CNS Stimulant/ADHD Medications - PDL PA Required
3500	Dummy Edit for Newborn Encounters

1.4.5 Encounter Exception Error Code List

This section has been eliminated effective 07/01/2015.

Error (ESC) codes that were previously listed here have now been transferred to the new 'Encounter Data Quality' (EDQ) process (MCTM 1.5).

Effective 07/01/2015, all encounter data quality issues will be tracked via the new EDQ process.

1.5 Encounter Data Quality (EDQ) Process

The DMAS Encounter Data Quality (EDQ) process described in this section is effective for all encounters submitted July 1, 2015 and after. EDQ supersedes the encounter requirements and reporting used in prior contract cycles.

The goals of EDQ are as follows:

- Define and document each critical encounter data quality issue
- Identify and report encounter data issues when they occur
- Prioritize each MCOs' efforts to resolve and correct encounter issues
- Ensure that each encounter that has a critical data quality issue is corrected in a timely manner
- Integrate encounter processing requirements with DMAS' Compliance Monitoring Process (CMP)

Two categories of issues are identified and reported to the MCOs. Each issue represents a specific measurable encounter data requirement:

- Critical Issues – MCOs must correct each Critical Issue that is identified by DMAS on an encounter. All Critical Issues are subject to CMP penalties.
- Emerging Errors – MCOs should attempt to correct these issues, but DMAS will not be tracking these corrections. Emerging Issues are not subject to CMP penalties.

DMAS monitors and evaluates the Emerging Issues on an ongoing basis for volume and impact to operations. The Emerging Issues are used as a staging area for Critical Issues. DMAS will evaluate new issues as Emerging Issues prior to designating them as a Critical Issue. For each Emerging Issue, DMAS will provide an anticipated 'Implementation Date' indicating when the issue will be moved to the Critical Issue category. This allows the MCO to evaluate potential impacts and to prioritize their remedial efforts.

Component	Critical Issue	Emerging Issue
Compliance	Subject to CMP assessment	Not subject to CMP
Correction	Must be corrected by MCO	MCO should attempt to correct
DMAS Tracking	Issues are reported until corrected by MCO	Reported for current month only DMAS does not track corrections
Disposition	Issues remain on the Critical list indefinitely and are continuously evaluated	May eventually be promoted to 'Critical' or may be removed from list altogether
Report Level	Reported at Issue level (i.e. multiple ESC may be rolled up to a single Critical Issue)	Reported individually by ESC/ error condition to provide more granularity for evaluation

1.5.1 DMAS Reporting

DMAS will generate several EDQ deliverables for each MCO. Reports are generated weekly on Mondays and reflect month to date encounter processing. The calendar monthly reporting period is based on the date each file was submitted by the MCO and received by the State's fiscal agent processor (as confirmed by MCN assignment).

- Critical Issue Report – A summary exception report showing any current month Critical Issues. This report also shows any Critical Issues submitted in prior months that have yet to be corrected by the MCO.

- Critical Issue Detail File – A data file that lists every encounter with one or more Critical Issues. Each issue is reported as a separate record. The detail file matches what is reported on the Critical Issue Report. This file includes all data elements required for the MCO to identify the specific issue and the type of issue.

- Emerging Issue Report – A summary exception report showing any Emerging Issues that occurred for the current month. This report does not include any prior month issues.

- Emerging Issue Detail File – A data file that lists every encounter with one or more Emerging Issues. Each issue is reported as a separate record. The detail file matches what is reported on the Emerging Issue Report. This file includes all data elements required for the MCO to identify the specific issue and the type of issue. Encounters may appear on the Critical and Emerging detail files if the encounter contains errors from both categories.

Refer to sections 1.5.2 through 1.5.4 of this document for detailed specifications for each of these deliverables.

In order to be included in the EDQ reporting process, an encounter must meet all of the following criteria:

- Must represent a 'paid' claim as identified by the MCO*.
- Must be an original, replacement, or failed void.
- Must be fully adjudicated by the MMIS as of the report date (including extraction to the DMAS data warehouse).

*An institutional encounter containing one or more paid revenue lines will be identified as a 'paid' claim even if the claim contains one or more denied revenue lines. EDQ revenue line edits will not be applied when the revenue line billed amount is equal to the revenue line non-covered amount or the revenue line billed amount is equal to zero.

1.5.2 Compliance and Corrections

Each month, DMAS will use the final end of month (EOM) EDQ Critical Error Report to determine if there are any outstanding compliance violations for the MCO for the month. The EOM Critical Issue report reflects all encounters submitted for the current calendar month.

Each issue (report line) on the EDQ Critical Issue Report represents a compliance violation. Refer to the Medallion 3.0 contract 'Compliance Monitoring Process' section (13.2) for further details about assessment and tracking of compliance penalties.

Compliance violation penalties will be assessed only once per month based on the content of the final EOM report. Note that each unique issue is counted only once per calendar month, even if the same issue occurs in multiple weeks and /or files.

The MCO must correct all Critical Issues that are listed on the EDQ Critical Issue Report, unless otherwise instructed by DMAS. DMAS will track and report every encounter with a Critical Issue until it has been corrected.

In order for a Critical Issue to be considered 'corrected', the MCO must submit a void or replacement transaction that causes that encounter record to be successfully voided (or credited) in the MMIS encounter history. DMAS prefers for MCOs to use replacement transactions for corrections instead of voids whenever possible. If the MCO chooses to use void transactions, then the MCO must also submit a corrected original encounter after the void has been successfully applied in the MMIS.

1.5.2.1 EDQ Critical Issue Correction in the MMIS

<u>To correct a Critical Issue on 837 transactions</u>

- The MCO must submit an 837 replacement or void transaction that causes the erroneous encounter to be successfully voided in the MMIS encounter history. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
- Replacement/void transactions must be successfully processed by the MMIS for the EDQ error to be considered corrected. To verify success of the replacement or void transaction, see below "EDQ – Encounter Correction Tips".
- If using a void transaction, the corrected encounter must be submitted after the void transaction is deemed successful. Do not submit the corrected encounter in the same adjudication cycle as the void transaction.
- Note: 837 transactions are adjudicated weekly (Sat/Sun) in the MMIS.

<u>To correct a Critical issue on NCPDP transactions</u>

- The MCO must submit a reversal (B2) transaction that causes the erroneous encounter to be successfully voided in the MMIS encounter history. Rebills (B3) are not accepted by DMAS.
- Replacement/void transactions must be successfully processed by the MMIS for the EDQ error to be considered corrected. To verify success of the replacement/void transaction, see below "EDQ – Encounter Correction Tips".

- The corrected encounter (B1) must be submitted after the reversal (B2) transaction is deemed successful. Do not submit the corrected (B1) encounter in the same adjudication cycle as the reversal (B2) transaction.
- Note: NCPDP transactions are adjudicated daily in the MMIS.

<u>EDQ – Encounter Correction Tips</u>

- To verify success of replacement/void transactions, the following MMIS adjudication reports should be reviewed.
    - CP-O-507 (Summary) – see Section 1.2.5.9
    - CP-O-506-01 (Error-Detail) – see Section 1.2.5.10
    - CP-O-506-02 (All-Detail) – see Section 1.2.5.11
- The MMIS must find the associated original for a replacement/void transaction to be successful. If not found, error 0396 will be set on the replacement transaction and error 0397 will be set on the void transaction.
- The primary data elements in the NCPDP reversal (B2) transaction are listed below. These data elements are used as a key in the MMIS to locate the matching original (B1) transaction so that it may be voided.
    - Pharmacy NPI
    - Date of Service
    - Prescription Number
    - NDC

  If a NCPDP void receives error 0397, verify that the reversal (B2) key values match the corresponding values on the original (B1) transaction.
- If an 837 replacement/void transaction receives error 0396/0397, verify that the "pointer" on the replacement/void transaction contains the correct value to point back to the original transaction (EDI pointer: loop 2300, REF*F8 value). Also, verify that the original encounter has been sent to DMAS and was successfully processed past the top tier edits (described below).
- The MMIS validates encounters in a "tiered" approach. Some of the top tier edits relate to member and provider enrollment. When a top tier edit is set, in some cases no further editing occurs on the encounter. When an original encounter fails a top-tier edit, an associated replacement/void transaction may be at risk for failure or may need special handling to be successful.
    - Below is an initial list of MMIS top-tier edits that will cause a replacement/void transaction to be unsuccessful. This is a recent discovery and we will build this list as errors are uncovered.
        - ESC 0130 – Billing Provider Number not on file
        - ESC 1357 - NPI Servicing Provider not on file
    - If replacing or voiding an original encounter that received MMIS ESC 0004 (Invalid or missing enrollee id), the replacement or void transaction must contain the correct enrollee id or an enrollee id that is set up in the MMIS to be successful.
- If you have attempted to replace/void an original encounter that received a top-tier edit and the replacement/void fails, please send an email to the HCSEncounters mailbox. In the situation where the MCO cannot successfully replace or void an encounter because of the MMIS tiered-edits, the MCO will not be held accountable for the EDQ corrections.
- The MCO should request special submission dates for large EDQ corrections (> 10,000 encounters).

1.5.3 Critical Issues

This section provides a detailed description of each current Critical Issue. The Managed Care Technical Manual will be updated throughout the year as new Critical Issues are implemented.

Issues may represent ESC codes, data fields, Internal edits (edits outside of the MMIS), or other contractual requirements. A single Critical Issue may represent multiple ESC codes or Internal error codes.

The chart below shows an implementation schedule for Critical Issues and anticipated Critical Issues (Emerging Issues that will be promoted to the Critical Issue list).

IMPLEMENTATION SCHEDULE Critical Issues				
Scheduled Implementation Date	**Implementation Date**	**EDQ Category**	**ESC/Internal Error**	**Section Reference**
07/01/2015	07/01/2015	Lag Days	Not applicable	1.5.3.1
12/01/2015	12/01/2015	Date	I011, I014, I024	1.5.3.2
12/01/2015	12/01/2015	M/I Value	I012, I015, I022, I102, I103, I105, I106	1.5.3.3
12/01/2015	12/01/2015	Provider	I020	1.5.3.4
09/01/2016	09/01/2016	M/I Value	I025	1.5.3.3
02/01/2017	02/01/2017	Pharmacy Rebate	I201, I202, I203, I204, I205, I206, I207, I208, I209, I210	1.5.3.5
Anticipated Critical Issues				

1.5.3.1 Lag Days

Description	Failure to meet the contractual requirement for timely reporting of encounter data to DMAS
Implementation Date	**07/01/2015**
Contract	Medallion 3.0, Section 11.5.C
Criteria	For each encounter, the lag days are calculated as the difference between the MCO's payment date (provided by the MCO on each encounter record) and the date that the

	file was submitted to DMAS (based on the Julian date from the MCN number assigned by Xerox when the EDI file is received). Calculation of the percentage = Encounters that met the timeliness threshold divided by total encounters submitted for the month. Encounters with missing or invalid MCO payment dates are assigned a default lag days value of 9999 and included in the 'Fail' count for reporting purposes. The timeliness requirement is applied only to original encounters. It is not applied to voids or adjustments. This requirement is assessed as a whole for all encounters and not by individual transaction type.
Correction	MCO is not required to correct encounter records for this issue.
Updates	N/A

1.5.3.2 Date

Description	Error in a date field on a 'paid' encounter
Implementation Date	**12/01/2015**
Contract	Medallion 3.0, Section 11.5
Criteria	One or more 'paid' encounters receiving one or more of the following Internal error codes: **I011 From DOS is greater than Thru DOS** **I014 From DOS is greater than MCO Payment Date** **I024 MCO Payment Date is more than 3 years old** MCO Payment Date <= (MCN file submission date - 1095)
Correction	MCO must correct all encounters identified as having one or more of these errors. See Section 1.5.2.1 – EDQ Critical Issue Correction in the MMIS.
Updates	02/01/2017

1.5.3.3 M/I Value

Description	Missing or invalid value in required field on a 'paid' encounter
Implementation Date	**12/01/2015 – I012, I015, I022, I102, I103, I105, I106** **09/01/2016 – I025**
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following Internal error codes: **I012 From DOS is missing** **I015 MCO Payment Date is missing** **I022 Procedure Code is missing - 837P**

	I102 NDC is missing – NCPDP (not applicable to compound drugs) **I103 Bill Type is missing – UB92** **I105 Units are zero – 837P/837I** This edit will be set if a transportation encounter (837P) contains fractional mileage (units) that are less than 1. See section 1.3.11. **I106 Units are zero – NCPDP** (not applicable to compound drugs) **I025 Diagnosis code, Revenue code, and/or Procedure code contains a value of all X's.**
Correction	MCO must correct all encounters identified as having one or more of these errors. See Section 1.5.2.1 – EDQ Critical Issue Correction in the MMIS.
Updates	09/01/2016

1.5.3.4 Provider

Description	Servicing provider-related error on a 'paid' encounter
Implementation Date	**12/01/2015**
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following Internal error codes: **I020 MCO NPI has been submitted as Servicing Provider NPI** This edit will be set if the MCO's NPI is used as the Servicing Provider NPI on the encounter.
Correction	MCO must correct all encounters identified as having one or more of these errors. See Section 1.5.2.1 – EDQ Critical Issue Correction in the MMIS.
Updates	08/01/2016

1.5.3.5 Pharmacy Rebates

Description	Encounter data quality errors that affect DMAS' ability to collect pharmacy rebates. Edits are applied to PAID claims only.
Anticipated Implementation Date	**02/01/2017**
Contract	Medallion 3.0, Section 7.2.S.I
Criteria	One or more encounters receiving one or more of the following errors:
	The Outpatient Physician-Administered Drug edits listed below will be applied when Encounter submission date (MCN) and MCO Payment date is >= 02/01/2017.

OUTPATIENT PHYSICIAN-ADMINISTERED DRUG EDITS

Some edits below will require the current version of the *DMAS REBATE PROC CODE FILE*. This file can be downloaded from the Virginia Medicaid Web Portal at http://www.dmas.virginia.gov/Content_pgs/mc-rpt.aspx .

See table at bottom for missing/invalid values.
See instructions at bottom for drugs that do not have a Procedure Code.

I201 Rebate Proc Code – NDC M/I – 837P/837I
This edit will set when:
837P/837I (Bill Type 13x and 83x only) and
Procedure Code is in *DMAS REBATE PROC CODE FILE* and
NDC is missing/invalid

I202 Rebate Proc Code – Qty M/I – 837P/837I
This edit will set when:
837P/837I (Bill Type 13x and 83x only) and
Procedure Code is in *DMAS REBATE PROC CODE FILE* and
NDC Quantity is missing/invalid

I203 Rebate Proc Code – UOM M/I – 837P/837I
This edit will set when:
837P/837I (Bill Type 13x and 83x only) and
Procedure Code is in *DMAS REBATE PROC CODE FILE* and
Unit of Measure is missing/invalid

I204 NDC Present – Qty or UOM M/I – 837P/837I
This edit will set when:
837P/837I (Bill Type 13x and 83x only) and
Procedure Code is <u>not</u> in *DMAS REBATE PROC CODE FILE* and
NDC is <u>not</u> missing/invalid and
NDC Quantity is missing/invalid or
Unit of Measure is missing/invalid

I205 Qty Present – NDC or UOM M/I – 837P/837I
This edit will set when:
837P/837I (Bill Type 13x and 83x only) and
Procedure Code is <u>not</u> in *DMAS REBATE PROC CODE FILE* and
NDC Quantity is <u>not</u> missing/invalid and
NDC is missing/invalid or
Unit of Measure is missing/invalid

I206 UOM Present – NDC or Qty M/I – 837P/837I
This edit will set when:
837P/837I (Bill Type 13x and 83x only) and
Procedure Code is <u>not</u> in *DMAS REBATE PROC CODE FILE* and
Unit of Measure is <u>not</u> missing/invalid and
NDC is missing/invalid or
NDC Quantity is missing/invalid

I207 Pharmacy Rev Code – NDC M/I – 837I
This edit will set when:
837I (Bill Type 13x and 83x only) and
Revenue Code is 25x or 63x and

NDC is missing/invalid

I208 Pharmacy Rev Code – Qty M/I – 837I
This edit will set when:
837I (Bill Type 13x and 83x only) and
Revenue Code is 25x or 63x and
NDC Quantity is missing/invalid

I209 Pharmacy Rev Code – UOM M/I – 837I
This edit will set when:
837I (Bill Type 13x and 83x only) and
Revenue Code is 25x or 63x and
Unit of Measure is missing/invalid

I210 Pharmacy Rev Code – Proc Code M/I – 837I
This edit will set when:
837I (Bill Type 13x and 83x only) and
Revenue Code is 25x or 63x and
Procedure Code is missing/invalid

Field	Missing	Invalid	EDI
NDC	Spaces, nulls, EDI field omission	Zeros, nines, Xs, not 11-digits	Loop 2410, LIN03
*NDC Quantity	Spaces, nulls, EDI field omission	Zeros, nines, 88888, 88888.888, 888888.888, 88888.88, 88888.8, 888888, 8888888, 88888888, 888888888, 888888888.9, 88888888.89, 99999, 99999.999, 999999.999, 99999.99, 99999.9, 999999, 9999999, 99999999, 999999999, 999999999.9, 99999999.99	Loop 2410, CTP04
UOM	Spaces, nulls, EDI field omission	Any character(s) other than F2, GR, ML, UN, or ME	Loop 2410, CTP05
Procedure Code	Spaces, nulls, EDI field omission	Zeros, nines, Xs, not 5-digits	Loop 2400, SV101-2 (837P) SV202-2 (837I)

***NOTE: The smallest NDC Quantity that the MMIS can accept is .0005**

Drugs that do not have a Procedure Code
In the case where the NDC/drug does not have an associated procedure code (e.g. oral dosage drugs), please use Procedure Code **J3490**.

Correction	MCO must correct all encounters identified as having one or more of these errors. See Section 1.5.2.1 – EDQ Critical Issue Correction in the MMIS.
Updates	03/01/2016

1.5.4 Emerging Issues

1.5.4.1 Adj/ Void

Description	Successful processing of adjustment and void transaction submitted by the MCO in MMIS
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following ESC codes: **0396 Adjust Denied - Orig Pmt Req Not On File** **0397 Void Denied - Orig Pmt Req Not On File**
Correction	DMAS recommends research and analysis of these errors. If possible, the MCO should attempt to correct all encounters identified as having one or more of these errors.
Updates	08/01/2016

1.5.4.2 Date

Description	Error in a date field on a 'paid' encounter
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more 'paid' encounters receiving one or more of the following Internal error codes: **I023 From DOS is more than 3 years old** From DOS <= (MCN file submission date - 1095)
Correction	DMAS recommends research and analysis of these errors. If possible, the MCO should attempt to correct all encounters identified as having one or more of these errors.
Updates	02/01/2017

1.5.4.3 Duplicate

Description	Error in a date field on a 'paid' encounter
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more 'paid' encounters receiving one or more of the following Internal error codes: Future edits TBD.
Correction	DMAS recommends research and analysis of these errors. If possible, the MCO should attempt to correct all encounters identified as having one or more of these errors.
Updates	08/01/2016

1.5.4.4 Enrollment

Description	Error related to member's enrollment / eligibility
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more 'paid' encounters receiving one or more of the following Internal error codes: Future edits TBD.
Correction	DMAS recommends research and analysis of these errors. If possible, the MCO should attempt to correct all encounters identified as having one or more of these errors.
Updates	08/01/2016

1.5.4.5 M/I Value

Description	Missing or invalid value in required field on a 'paid' encounter
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following Internal error codes: **I017 Billed Charge Amount is missing** **I104 Diagnosis Code missing – 837P/837I**

	1735 An encounter for a newborn baby that has a temporary Medicaid Id (as defined in section 1.3.9) has one or more of the following issues: **1) Baby's date of birth is missing or is an invalid date** **2) Baby's gender is missing or is set to a value other than "M", "F" or "U".**
Correction	DMAS recommends research and analysis of these errors. If possible, the MCO should attempt to correct all encounters identified as having one or more of these errors.
Updates	08/01/2016

1.5.4.6 Provider

Description	Servicing provider-related error on a 'paid' encounter
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following Internal error codes: **I018 Servicing Provider zip code is Invalid** • Servicing Provider is "000000000" or "00000 " or "999999999" or "99999 " • Not applicable to Pharmacy (NCPDP) encounters
Correction	DMAS recommends research and analysis of these errors. If possible, the MCO should attempt to correct all encounters identified as having one or more of these errors.
Updates	08/01/2016

1.5.4.7 340B Providers

Description	Pharmacy encounters submitted by 340 Providers
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 7.2.S.I
Criteria	MMIS ESC associated edits for 340B drugs: • **1620: Missing/invalid Submission Clarification Code** • **1621: Pharmacy is not authorized for 340B pricing** • **1622: Invalid combination of Basis of Cost and Submission Clarification Code**
Correction	TBD
Updates	N/A

2 Enrollment Roster & Payment Files

2.1 Enrollment Roster (834)

For each month of coverage throughout the term of the Contract, the Department shall post an Enrollment Roster to DMAS' secure FTP EDI server using the 834 electronic data interchange (EDI) transaction set to the Contractor. Unless otherwise notified by the Department, these files will be available on the 20th (mid-month) and 2nd (end of month) of each calendar month. The 834 Enrollment Roster shall provide the Contractor with ongoing information about its active and disenrolled members.

The 834 Mid-Month and End of the Month rosters will list all of the Contractor's members for the prospective enrollment month as of the report generation date. The Mid-Month 834 will be provided to the Contractor on the twentieth (20th) day of the month prior to member enrollment. The End of the Month Enrollment Report will be provided to the Contractor on the second (2nd) day of the current member enrollment month.

ELIGIBILITY CUT-OFF	MID-MONTH 834 RUN	MID-MONTH 834 AVAILABILITY	END OF MONTH 834 RUN	END OF MONTH 834 AVAILABILITY
06/16/2017 Fri	06/18/2017 Sun	06/20/2017 Tue	06/30/2017 Fri	07/02/2017 Sun
07/16/2017 Sun	07/18/2017 Tue	07/20/2017 Thu	07/31/2017 Mon	08/02/2017 Wed
08/16/2017 Wed	08/18/2017 Fri	08/20/2017 Sun	08/31/2017 Thu	09/02/2017 Sat
09/16/2017 Sat	09/18/2017 Mon	09/20/2017 Wed	09/30/2017 Sat	10/02/2017 Mon
10/16/2017 Mon	10/18/2017 Wed	10/20/2017 Fri	10/31/2017 Tue	11/02/2017 Thu
11/16/2017 Thu	11/18/2017 Sat	11/20/2017 Mon	11/30/2017 Thu	12/02/2017 Sat
12/16/2017 Sat	12/18/2017 Mon	12/20/2017 Wed	12/31/2017 Sun	01/02/2018 Tue
01/16/2018 Tue	01/18/2018 Thu	01/20/2018 Sat	01/31/2018 Wed	02/02/2018 Fri
02/16/2018 Fri	02/18/2018 Sun	02/20/2018 Tue	02/28/2018 Wed	03/02/2018 Fri
03/16/2018 Fri	03/18/2018 Sun	03/20/2018 Tue	03/31/2018 Sat	04/02/2018 Mon
04/16/2018 Mon	04/18/2018 Wed	04/20/2018 Fri	04/30/2018 Mon	05/02/2018 Wed
05/16/2018 Wed	05/18/2018 Fri	05/20/2018 Sun	05/31/2018 Thu	06/02/2018 Sat
06/16/2018 Sat	06/18/2018 Mon	06/20/2018 Wed	06/30/2018 Sat	07/02/2018 Mon

2.2 Capitation Payment Remittance (820)

The 820 Capitation Payment file will list all of the members for whom the Contractor is being reimbursed in the current weekly payment cycle. For current month enrollments, the 820 is processed on the last Friday of the calendar month, and is available to the Contractor on the following Monday. The file includes individual member month detail. The 820 includes current and retroactive capitation payment adjustments.

2.2.1 Capitation Payment Remittance (820) Schedule

CAPITATION 820 RUN	CAPITATION 820 AVAILABILITY	CAPITATION CHECK DATE
06/30/2017 Fri	07/03/2017 Mon	07/07/2017 Fri
07/28/2017 Fri	07/31/2017 Mon	08/04/2017 Fri
08/25/2017 Fri	08/28/2017 Mon	09/01/2017 Fri
09/29/2017 Fri	10/02/2017 Mon	10/06/2017 Fri
10/27/2017 Fri	10/30/2017 Mon	11/03/2017 Fri
11/24/2017 Fri	11/27/2017 Mon	12/01/2017 Fri
12/29/2017 Fri	01/01/2018 Mon	01/05/2018 Fri
01/26/2018 Fri	01/29/2018 Mon	02/02/2018 Fri
02/23/2018 Fri	02/26/2018 Mon	03/02/2018 Fri
03/30/2018 Fri	04/02/2018 Mon	04/06/2018 Fri
04/27/2018 Fri	04/30/2018 Mon	05/04/2018 Fri
05/25/2018 Fri	05/28/2018 Mon	06/01/2018 Fri
06/29/2018 Fri	07/02/2018 Mon	07/06/2018 Fri

2.2.2 Capitation Payment Remittance (820) – "Best Practices" in Reconciliation

- If the MCO receives payment on the 820 file for a member that was not listed on the previous 834 enrollment file, the member is retroactively enrolled to the MCO for the dates listed.

- If the MCO receives a retraction of payment on the 820 file, the member is retroactively terminated for the dates listed.

- If a member is listed on the 834 enrollment file but no payment is received for the member on the 820 file, the member should not be terminated. The MCO must research the member on the DMAS eligibility website. If the member is no longer eligible on the website, the MCO will terminate the member. However, if the member still is shown as active on the website, the member will not be terminated.