

Encounter Data FAQs

Companion Guide

Q: In the companion guide for the 837P and the 837I, the claim filing indicator is HM for the Health Maintenance Organization, what value do we use in the CAS segments for commercial insurance? What is the claim filing indicator for worker's compensation? Is there a place to reference all the valid entries for the claim filing indicator?

A: There are other values that can be used in the claim filing indicator. For example claim filing indicator CI is for Commercial Insurance and AM is for Automobile Medical. Refer to the implementation guide for a complete listing of the codes/values that can be used in the claim filing indicator field.

Q. Are there any plans to update DHS 835E remittance advice (DHS response file to the 837 submission file)? The last version we have is dated 2008.

A. The ASC X12/005010X221A1 Health Care Claim Payment Advice (835) Implementation Guide is published by the Washington Publishing Company. The Minnesota Department of Health publishes a Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment Advice (835) to be used in conjunction with the 835 Implementation Guide. The MN Companion Guide can be found at Minnesota Statutes 62J.536 Rulemaking - Minnesota Dept. of Health.

As there were no changes to the 835 specific to encounters, no 5010 companion guide was developed by DHS.

Third Party Liability Claims (TPL)

Q: What is the difference between 'Certification of Revision Date', 'Date Claim Paid' and 'MCO Paid Date' for 837P claims in the draft 837 companion guide?

A: Certification of Revision Date is specifically for physician-administered drugs and is found only on 837 P and I claims. Date Claim Paid on the other hand is equivalent to the date that the claim is run through the payment system. Similarly, MCO Paid Date is equivalent to the date that a check is cut or that the payment happens, and this is required for pharmacy rebate.

Q: Are MCOs that provide coverage for dual specialized products (MSHO/SNBC) considered a single payer?

A: Yes, they are considered a single payer and the payer is reported in Loop 2330B.

Consolidated Provider Identification

Q: Do the service facility and billing addresses have to match the address information in the provider file exactly?

A: An exact match of the address is not required. However, it is important to enter the complete address. For example: Spelling out "NORTH" or just using "N" are both acceptable. Similarly, a 5 digit zip code is sufficient.

Provider Help Desk

Q: How do I contact the Help Desk if I am having some issues related to encounter claims?

A: Any time you have problems with file or claim submissions; you can contact the Provider Help Desk by following the steps listed below. If you are missing a response to a file, or claims are missing from your RA, for example, call:

- 651-431-2700
- 1-800-366-5411 (Toll Free)
- Press Option 6
- Tell the Customer Service Representative which MCO you are calling for
- Have the EXACT name of the input file

Remark Codes

Q: Is W449 still used?

A: W449 is no longer considered a remark code for implementation. In the past it was a code related to duplicate claims on a project we have postponed due to multiple system issues. D448 is the code that will check for specific duplicate fields on pharmacy claims and has started to appear on your remittance advice since 6/18/2013.

Q: Is W423 moving to D423? In other words W423 is currently a warning code indicating "The PCA treating provider is not affiliated with the Pay-to Provider on the date of service." Will this become a denial code?

A: At this time W423 remains a warning and will not change to a denial.

Q: Why are pharmacy claims with different fill numbers duplicating and then being denied?

A: Fill numbers are not used to determine duplicate records at this time. Fill date must be the date the pharmacy sent more medication - not the original prescription date. By using this definition, a duplicate would not occur since pharmacy would not fill identical prescriptions for the same recipient on the same day.

General

Q: Is there a difference between Pay to Provider and Billing Provider?

A: No, they are both treated as the same.

Q: How does DHS want pharmacies to indicate 340B pricing to the Claim Processors?

A: Field 423-DN, Basis of Cost Determination is a mandatory field. This field indicates whether the product dispensed or administered was purchased under the Federal 340B program. Enter 08 (Other) for "Yes, this is a 340B product" or 00 for "No or Unspecified".

Q: How does DHS define "bi-weekly"? Is it every two weeks, or twice per month?

A: DHS defines bi-weekly as every 2 weeks while dealing with encounter processes.

Q: While sending CAS segments are claims required to be balanced according to the HIPAA implementation guide's rules pertaining to those CAS segments?

A: DHS does not require claim balancing at this time.

Q: Do drug quantities need to be converted from ME (ME value= milligrams) to grams still?

A: No, DHS no longer requires drug quantities to be reported in grams. They can be sent in as milligrams.

Q: Are CAS segments at the header only required when adjustments are at the header?

A: Yes, they are not required if CAS segments are on the line.

*Q: Is 2330B, REF*F8 (Medicare ICN) required to be populated on all occurrences of 2330B or in just those where Medicare information is provided?*

A. Medicare ICN is required only when Medicare is the payer.

Q. Since Medicare ICN is not a HIPAA standard is it okay to send claims where Medicare is the primary payer without ICNs?

A. Providing Medicare ICN when it is present is a HIPAA standard and providers should deny claims where Medicare is the primary payer and ICN is not sent on the claim.

Denials

Q: Do we need to include NDC drug codes while submitting pharmacy claims?

A: Yes, if NDC drug codes are not entered the claim will deny unless they are Medicare Part D or if the pharmacy is 340B. This is a federal legislation requirement. The NDC drug codes:

- Should be 11 digits
- Should not contain an alpha character
- Should not be of the same value (77777777777, 44444444444, etc.)
- Should not have 5 leading zeros on pharmacy encounters and 837I and P encounters submitting physician administered drugs. The line item must have a procedure code requiring an NDC code.

Q: Will claim deny if Physician Administered Drug claims are missing NDC?

A: Yes, they will post EC152 on professional and institutional encounter claims if they are missing the NDC. However, NDC is not required if the claim is Medicare Part D or if the pharmacy is 340B.

Q. What does the 'D899' edit mean?

A. The 'D899' edit sets when there are 200 or more edits on the encounter in the MMIS claim system. These edits may be a mix of True Denial and DHS internal editing. In order to get the encounter claim past the 'D899' edit the MCO should correct the edits shown on the Remittance Advice.

Q. Why would a claim receive an EC101 when the REV CODE is different but the procedure code, modifier, provider, PMI and the date of service are all the same?

A. MCOs are advised to confirm that there is a distinct modifier with a procedure code if they are billing for the same procedure code on the same date of service.

Warnings

Q: What will happen if drug quantity is zero or missing on outpatient and physician claims?

A: An EC288 warning will post if drug quantity is zero or missing on an outpatient or physician claim.

Q. For M86 warnings in 2013, was the subsequent submission with its inherent identifier, associated diagnosis codes, and other data elements loaded to DHS' database in a fully functional (risk adjustment, etc.) way?

A: Yes.

Rejections

Q: NCPDP claims with values 6 to 7 in the 429-DT data file are being rejected. Why?

A: DHS only accepts values 0 to 5 at present. In order to prevent claims from being rejected do not use values 6 through 7 or leave it blank as populating this field is optional.

Q: Why are NCPDP files being rejected when missing the 354-NX which is not a required loop and segment?

A: The 354-NX is not required unless the 420-DK segment is sent.

Claim Adjustments

Q. Is there a particular order in which voided claims and paid encounter claims should be submitted?

A. Voided claims and paid encounter claims should be submitted in the following order:

- **Day 1: Files containing voided claims should be submitted.**
- **Day 2: Files containing paid claims should be submitted.**

Q. Would submitting a claim as a replacement be better than submitting a void when adjusting a claim?

A. EDQ does not have a preference on that. Either a replacement or a void is acceptable as long as the instructions are followed. For voided claims, MCOs are asked to wait a day before resubmission.