# Table of Contents

**Chapter Six – How to…**


| | | |
|---|---|---|
| I. | Introduction | 1 |
| II. | Check Status of Encounter File Submission | 1 |
| III. | Reporting Inpatient Covered Days | 2 |
| IV. | Reporting of Non-Covered Charges/Partial Denials | 3 |
| V. | Benefit Service Limitations and Timing of Encounter Submission | 4 |
| VI. | Encounter/Reference Table Update Communication | 5 |
| VII. | Contractor Reference Table Review Update (RTRU) Requests | 7 |
| VIII. | Contractor On-line Voids and Reinsurance Payment Cycle | 8 |
| IX. | Encounters for Medicare Part B Only and Medicare Part A Exhausted Claims | 8 |
| X. | Record Status Code and Clearing H290 Pends | 10 |
| XI. | Same Day Admit Discharge Encounter Reporting | 11 |
| XII. | Keystrokes for Online Encounter Overrides | 11 |
| XIII. | Encounters Submitted for “Unidentified” Individuals | 11 |
| XIV. | Encounters Edit Status H140 and H141 | 12 |

# Chapter 6 – "How to…"

## I. INTRODUCTION

The purpose of this chapter is to provide additional clarification for common questions presented to the Arizona Health Care Cost Containment System (AHCCCS) from Contractors regarding encounter processing. This section covers a variety of topics and is updated annually and is further supplemented by the AHCCCS encounter keys newsletter.

It is important to note that the AHCCCS contract requires that Contractors follow claims processing guidelines, applicable to managed care, that are maintained within the AHCCCS Fee-for-Service Provider Manual posted on the AHCCCS website at  unless otherwise specified (where allowable) in a written contract between the Contractor and the provider. Therefore, the billing requirements, coding standards, and instructions reflected in that manual are the general guidelines for editing encounters.

## II. CHECK STATUS OF ENCOUNTER FILE SUBMISSION

Mainframe availability for the inquiry of encounter files status is listed in the Pre-paid Medicaid Management Information System (PMMIS) on the EC552 HIPAA TRANSMISSION SUMMARY screen. To get to the next screen to view the file, type an "s" to select the file and hit "enter". The HIPAA TRANSMISSION DETAIL screen will come up.

```
 TR: EC552  ACT: I            AHCCCS - ENCOUNTERS                  08/30/12
NTR: _____________        HIPAA TRANSMISSION SUMMARY               12:19:13
                                                                   EC31L552
  SHOW TI FILES: N      START _________
  110007           (OPT) END _________ ____________________________ _ _
  HP-ID  DESCRIPTION          PROCESS DTE    ORIGINAL FILE NAME          STATUS
                                                                      FIL STG
s 110007 LTC DD DES           08/23/2012  110007.20120822.001.837P       L  W
  110007 LTC DD DES           08/23/2012  110007.20120822.001.837I       L  W
_ 110007 LTC DD DES           08/16/2012  110007.20120815.001.837P       L  L
_ 110007 LTC DD DES           08/16/2012  110007.20120815.001.837I       L  L
_ 110007 LTC DD DES           08/16/2012  110007.20120815.001.837D       L  L
_ 110007 LTC DD DES           08/16/2012  AZ837P007040080912.019         L  L
_ 110007 LTC DD DES           08/16/2012  AZ837P007040080912.018.DENY    L  L
_ 110007 LTC DD DES           08/16/2012  AZ837I007040080912.017         L  L
_ 110007 LTC DD DES           08/16/2012  AZ837I007040080912.016         L  L
_ 110007 LTC DD DES           08/16/2012  AZ37P_00740_80912_.005.DENY    L  L
_ 110007 LTC DD DES           08/16/2012  AZ37P_00740_80912_.004         L  L
_ 110007 LTC DD DES           08/16/2012  AZ37I_00740_80912_.007.DENY    L  L
_ 110007 LTC DD DES           08/16/2012  AZ37I_00740_80912_.006.DENY    L  L
_ 110007 LTC DD DES           08/16/2012  AZ37I_00740_80912_.002         L  L

PF:       2=RTN 3=CLR 4=MSG            7=UP  8=DWN       10=TOP 11=BOT 12=ESC
MA+  a                                                            10/002
```

STG = Staging Load Status:

"STG" on EC552 HIPAA TRANSMISSION SUMMARY screen is the same as "FILE STATUS: L" on EC552 HIPPA TRANSMISSION DETAIL screen.

(Staging) Load Status: W = Waiting, H = Hold, L = Loaded, E = Exclude. Fil – File Processing Status: U = Unprocessed, L = Loaded, F = Failed.

## III. REPORTING INPATIENT COVERED DAYS

General reminders related to the reporting of covered days:

- This data element is critical to tracking the Inpatient Days actually covered and paid by each Contractor and is required to be submitted on all inpatient encounters. If this required data is not submitted, encounters may be rejected at validation.
- Covered days should only be reported on Inpatient Encounters.
- Contractors should report the number of days they covered for that encounter. If the stay is 20 days, but the Contractor only reimburses 15 days the covered days reported should be 15.
- Covered days cannot exceed the actual length of stay on the encounter. If the stay is four (4) days, contractors cannot report covered days greater than four (4) days.
- Covered days cannot be zero (0) unless the encounter is submitted as Contractor Administrative Denial or Zero Paid. On an inpatient claim, other than a same day admission discharge/transfer, Contractors must report covered days greater than zero, unless reporting the encounter as Contractor Administrative Denial or Zero Paid.
- For Inpatient claims, all allowed/covered days should be reflected only in the Covered Days reported by the Contractor; do not also include in non-covered related accommodation revenue code charges, as it will result in edit failures for out of balance conditions.
- If Covered Days are required by the outlined criteria and are not submitted on the encounter, a Covered Days Validation error 32006 will result: "2300 HI Value Information – Value code '80' Covered days required for Inpatient encounters."
- Please refer to the guidance found in the current version of the UB04 Manual to report the following value codes:
    - '80' Covered Days,
    - '82' Co-insurance Days, and
    - '83' Lifetime Reserve Days.

To report the above value codes, please reference the following 2-digit Bill types that are assigned as an inpatient designation for the AHCCCS Encounters process and considered for the Covered Days validation edit mentioned above:

| | | |
|---|---|---|
| • 11 | Hospital Inpatient (Including Medicare Part A) | IP |
| • 12 | Hospital Inpatient (Medicare Part B Only) | OP (AHCCCS uses as IP) |
| • 65 | Intermediate care – Level I | IP/3 |
| • 66 | Intermediate care – Level II | IP/3 |
| • 86 | Residential Facility | IP/3 |
| • 89 | Special Facility - Other | IP/OP |

| Sample 837I |
|---|
| CLM*128000052*1505.1***11:A:7**A*Y* |
| DTP*434*RD8*20111001-20111002 |
| DTP*435*DT*201110010600 |
| CL1*4*5*01 |
| REF*F8*113200010117 |
| REF*EA*1892807 03-66-741 |
| HI*BK:V3000 |
| HI*BJ:V3000 |
| HI*BF:V053 |
| **HI*BE:80:::5*BE:82:::10*BE:83:::30** |
| NM1*71*1*ATTENDING*PROVIDERNAME****XX*1799742047 |
| SBR*P*18*******MC |
| AMT*D*487.77 |
| OI***Y***Y |
| NM1*IL*1*LASTNAME*FIRSTNAME****MI*A99999999 |
| N3*801 E JEFFERSON ST |
| N4*PHOENIX*AZ*85034 |
| NM1*PR*2* HEALTH PLAN OF ARIZONA*****PI*0101010782 |
| REF*F8*128000052 |
| LX*1 |

## IV. REPORTING OF NON-COVERED CHARGES/PARTIAL DENIALS

Reporting Non-Covered Charges:

- Contractors must report applicable non-covered charges on encounters as outlined in the TR3 and AHCCCS Companion Guides.
- Non-covered charges should not be subtracted from the total billed charge as, the provider-submitted billed charge should not be altered.

Administrative Denials/Zero Paid Encounters:

- If all charges are non-covered on an encounter, it is an applicable Administrative Denial or Zero Medicaid Payment Claim. It should be reported as Administratively Denied/Zero Medicaid Paid per the instructions in Chapter 3 of this manual.

Disallowed Lines:

- Inpatient or outpatient facility encounters may have both paid and disallowed lines.
- To ensure that such encounters pass validation, do not split the encounter between covered and disallowed lines but submit as AHCCCS Partial Disallowed per instructions below and in Chapter 3.

Professional Paid versus Denied Lines:

- Only zero paid lines that meet the criteria for inclusion as outlined in this manual should be submitted in the denied/zero paid file; all others should be submitted in the paid file.
- Denied lines should only be submitted if they meet the criteria for inclusion as outlined in this manual, otherwise, it is not expected for MCOs to submit their denied Encounters even if a claim has mixed status of lines (i.e., some paid, some denied not meeting administrative denial criteria).

FQHC Claims Paid versus Denied:

- If the T1015 is paid greater than zero and has an approved ancillary code paid at zero, all lines write to the paid file.
- If the T1015 is denied, do not write to either file. Unless the reason for denial meets the criteria for inclusion as an administrative denial.

| Sample of Claims Scenario: |
|---|
| 3-line claim<br>line 1 approved<br>line 2 approved<br>line 3 denied (non-administrative reason)<br>**NOTE:** In this scenario, AHCCCS expects that lines 1 and 2 are submitted in the paid claims/new day file and that we would not receive line 3. |
| 3-line claim<br>line 1 approved<br>line 2 denied for an administrative reason<br>line 3 paid zero due to, for example, bundling with another service or under a capitation arrangement.<br>**NOTE:** In this scenario, AHCCCS expects that lines 1 and 3 are submitted in the paid claims/new day file and line 2 submitted in the denied file. |

## V. BENEFIT SERVICE LIMITATIONS AND TIMING OF ENCOUNTER SUBMISSION

Benefit Limits "first in basis":

Certain AHCCCS Medicaid benefits have annual contract year service unit or per diem limits. Contractors' staff working encounter pends must be aware of these benefit limitations. These benefit restrictions are listed in AHCCCS contract Section D and delineated in AMPM Chapter 300. Contractors are notified of any changes to these benefit limitations. For example:

Effective January 1, 2014, outpatient physical therapy for adults (age 21 years and older) is limited to the following 15 visits per contract year to:

- Restore a particular skill or function the recipient previously had but lost due to injury or disease and maintain that function once restored, and
- Attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

When such a service limitation applies, AHCCCS combines AHCCCS Fee-for-Service (AFFS) paid claims, and all Contractor approved encounters on a" first-in basis" to calculate services applied during the contract year.

Contractors may receive Z295 pended encounters (A and O) indicating that the adult PT service units have been exceeded. Contractors may have prior authorized services and paid for services, but due to payment or encounter submission delays, another Contractor or AFFS (having an enrollment period within the same plan year) may have already submitted and had approved encounters exhausting the benefit. In such cases, the pended claims must be recouped and encounters voided. Other similar benefit-exhausted pend codes include Z297 (Inpatient limits exhausted) and Z298 (Respite Care Limits Exceeded).

It is imperative that Contractors have clear language in provider contracts and/or their provider manuals indicating that no payment may be made when the benefit is exhausted, even if the contractor issued a Prior Authorization (PA). PA is not a guarantee of payment; all claims must be for AHCCCS-covered benefits and be medically necessary at the time of service.

Duplicate or Near Duplicate Service Encounters from Different Contractors:

There are a series of encounter edits that indicate that Contractors have submitted an encounter that is either an exact or near duplicate of service for a member for which another Contractor has already reached AHCCCS adjudicated/approved status.

## VI. ENCOUNTER/REFERENCE TABLE UPDATE COMMUNICATION

AHCCCS endeavors to keep all reference/code tables in PMMIS up to date by issuing regular agency revisions and AHCCCS-specific coding requirements. Contractors receive and have Web access to multiple communication tools to alert them of table and code updates. Several of these website locations also provide updates electronically by Listserv. To subscribe, go to https://www.azahcccs.gov/PlansProviders/AHCCCSlistserve.html and follow the directions.

"PMMIS System/Table Update E-mails":

AHCCCS Division of Analysis and Research (DAR) staff send out regular e-mails informing Contractor encounter staff and Contract Compliance Officers about significant AHCCCS program changes, including policy, scheduling, required reporting, benefits, PMMIS table updates, and encounter editing. These e-mails provide first notice of items and issues, including Encounter Manual changes, which may require remediation of Contractor system and encounter reporting. If you want to be added to e-mail distribution related to encounters, contact your Contractor's assigned encounter liaison or request through your Contract Compliance Officer.

Encounter Keys Newsletter:
Encounter Keys is a periodic supplement to the Encounter Manual containing updates and system changes. Published quarterly by DAR, this newsletter provides a recap, summarized by code type, of the table changes and other information that Contractors received by e-mail since the last newsletter issue. Current and historical issues are available on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/HealthPlans/encounterkeysnewsletter.html.
Provided as current encounter requirements; Contractors are responsible for incorporating the information into their encounter processes. It is important to note that some table values and relationships are retroactively dated and may affect previously adjudicated claims and encounter submissions. You will also find SFTP file layout changes, EDI technical interface changes, and other clarifications that need to be shared with the Contractors' IT staff.

AHCCCS Fee-for-Service Provider Manual:
AHCCCS contract requires that Contractors follow claims processing guidelines applicable to managed care, which are maintained within the AHCCCS FFS provider manual, unless otherwise specified (where allowable) in the provider subcontract. Therefore, the billing requirements, coding standards, and instructions reflected in that manual are the general guidelines for editing encounters. This manual is located on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html.

Claims Clues Newsletter:
Claims Clues is produced periodically by the AHCCCS Claims Department for Fee-For-Service (FFS) providers as an adjunct to the AHCCCS FFS Provider manual. As such, it is also beneficial for Contractors to keep up with changes in the AHCCCS FFS provider Manual. Issues can be accessed at the link https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html.
It provides useful information including, but not limited to, the following:

- Changes to the program,
- System changes and updates,
- Billing policies and requirements, and
- Provider Training opportunities.

AHCCCS Contractor's Operations Manual (ACOM):
This Manual provides AHCCCS policy specific to operations and reporting for Contractors. It is divided into chapters for Administrative, Claims, Financial, and Operational Policies of the AHCCCS Administration. The AHCCCS staff issues monthly updated Memo to Contract Compliance Officers for internal distribution. ACOM updated memos are also available by Listserv. These memos are intended to alert Contractors to a summary of changes. It is the Contractors' responsibility to review all policy changes and assess the impact on claims processing and encounter reporting. The ACOM manual is located on the AHCCCS website at https://www.azahcccs.gov/shared/ACOM/.

AHCCCS Medical Policy Manual (AMPM):
This Manual contains information regarding services covered within the AHCCCS program. The AMPM applies to both Managed Care and Fee-for-Service members. This manual defines covered services and their limitations, including special maternal and child health programs and services relevant to encounter reporting. Chapter 600 designates provider qualifications and licensing requirements. The AMPM should be referenced in conjunction with state and federal regulations, other Agency manuals (AHCCCS Contractors' Operations Manual [ACOM], and the AHCCCS Fee-for-Service Manual), and applicable contracts.
It is available online https://www.azahcccs.gov/shared/MedicalPolicyManual/
"What's New" memos (summaries of policy revisions), issued as needed and sequentially numbered by contract year, are distributed to AMPM holders and Contract Compliance Officers. Revision history is available at the bottom of the manual webpage.

## VII. CONTRACTOR REFERENCE TABLE REVIEW UPDATE (RTRU) REQUESTS

AHCCCS makes every effort to keep the PMMIS reference table sub-system properly updated to reflect nationally recognized and AHCCCS-specific coding standards and requirements. Even so, Contractors may discover apparent inconsistencies or missing values, driving encounter edits that they believe are inappropriate.
**IMPORTANT NOTE:** Encounter pends related to provider registration issues; for example, P353-Provider type not eligible for service billed, must be directed to AHCCCS Provider Registration Unit. Contractors should be working with the provider in question, assisting them in contacting AHCCCS provider registration to have the provider's profile modified.
For questions regarding the provider registration process, please contact the AHCCCS Provider Registration Unit.

- In Maricopa County: 602-417-7670 and select option five (5),
- Outside Maricopa County: 1-800-794-6862, and
- Out-of-State: 1-800-523-0231.

Reference Table Review Update (RTRU) issues appropriate for review usually revolve around reference table values and relationships, for example, units, modifiers, POS, coverage, effective dates, etc. For example, a Contractor may have multiple claims from various providers, pending for POS invalid for service procedure code. If, after researching, Contractors determine that it is industry standard to provide that service in that POS and an RTRU is submitted and approved, the table maintenance will allow all the related pends to clear the next encounter cycle. It is important to indicate what effective DOS is needed in the tables to clear the related pends so that the table maintenance may cover all pended encounters.

Contractors must research their issues before submitting an RTRU e-mail request to AHCCCS for reference table revisions or updates. Contractors are provided PMMIS training to assist in this research effort. And it is important to review any communications (see section VII above) related to the specific issue. Contractor staff can also contact their assigned encounter representative to review the issue. Contractor staff may submit clearly labeled RTRU requests by e-mail to: AHCCCSEncounters@azahcccs.gov.

The subject line should indicate that this is a reference table review update request. If larger files are required as supporting documentation, they can be placed on the SFTP server and indicated in the e-mail. These e-mails should explain the issue and document the Contractor's research findings and any reference or authority supporting the update request. If a retroactive effective date is being requested, AHCCCS will evaluate and determine the appropriate start date for the table maintenance.

In many instances, update requests must be deferred to the office of the AHCCCS Chief Medical Officer (CMO) for medical review and determination. Whether approved or not, Contractors will receive feedback on submitted requests. Because of the multiple unit review process, turnaround time on these RTRU requests may take up to 30 days.

## VIII. CONTRACTOR ON-LINE VOIDS AND REINSURANCE PAYMENT CYCLE

The timing of Contractor entered PMMIS pend corrections/voids can adversely affect the Reinsurance (RI) payment cycle. Therefore, Contractors are prohibited from performing online encounter voids during the monthly Reinsurance payment cycle. The Reinsurance Payment/Pricing Cycle runs on the first Wednesday of every month. It takes two days for files to pass back and forth between systems. The Reinsurance Databases will be closed for online updates from the first Wednesday of the month, from 5:00 p.m. until the following Wednesday morning. Online voids cannot be performed during this time. Contractor compliance with this policy will ensure accurate disbursement of RI funds and prevent misallocation to closed RI years and RI payment recoupments.

## IX. ENCOUNTERS FOR MEDICARE PART B ONLY AND MEDICARE PART A EXHAUSTED CLAIMS

AHCCCS has reviewed the encounter processing logic for members with Medicare Part B Only coverage and for members who have exhausted all their Medicare Part coverage. AHCCCS has subsequently revised the encounter instructions to ensure the Contractors receive full Reinsurance reimbursement when these encounters are associated with a reinsurance case.

Institutional Inpatient encounters being submitted by the Contractors for a member who effectively has only Medicare Part B Coverage (either Medicare Part B Only or the member has exhausted all their Medicare Part A coverage) should have the Medicare Part B payment reported using the following segments:

- 2320/SBR - Other Subscriber Information
- 2320/CAS - Claim Level Adjustments
- 2320/AMT – COB Payer Paid Amount

| Loop | Element | Description | 837 Note | AHCCCS Usage/Expected Value |
|---|---|---|---|---|
| 2320 | **SBR** | **OTHER SUBSCRIBER INFORMATION** | | |
| 2320 | SBR01 | Payer Responsibility Sequence Number Code | | Expect any value |
| 2320 | SBR02 | Individual Relationship Code | | Expect any value |
| 2320 | SBR03 | Insured Group or Policy Number | | NOT USED BY AHCCCS |
| 2320 | SBR04 | Other Insured Group Name | | NOT USED BY AHCCCS |
| 2320 | SBR05 | Insurance Type Code | | NOT USED |
| 2320 | SBR06 | Coordination of Benefits Code | | NOT USED |
| 2320 | SBR07 | Yes/No Condition or Response Code | | NOT USED |
| 2320 | SBR08 | Employment Status Code | | NOT USED |
| 2320 | SBR09 | Claim Filing Indicator Code | | Expect any value |
| **2320** | **CAS** | **CLAIM LEVEL ADJUSTMENTS** | | 01/08/13: AHCCCS expects Co-pay amounts to be reported at the 2430/CAS segment for Institutional files. |
| 2320 | CAS01 | Claim Adjustment Group Code | | Expect any value |
| 2320 | CAS02 | Adjustment Reason Code | Occurrence 1 | Expect Adjustment Reason Code |
| 2320 | CAS03 | Adjustment Amount | | Net Allowed Amount (Approved Amount):<br>Final value of the encounter if paid as FFS after all other payments have been considered<br>Capitated = Amount Paid $0, use CAS*CO*24 segment.<br>FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported.<br>Per section 1.4.5 Allowed/Approved Amount is determined as:<br>Prior payer's payment (2320, AMT*D*$) + Total of all patient responsibility adjustment amounts (CAS*PR*RSN CD*$*, CAS03, 06, 09, 12, 15, 18)<br>= Allowed Amount |
| 2320 | CAS04 | Adjustment Quantity | | Expect Adjustment Qty |

| Loop | Element | Description | 837 Note | AHCCCS Usage/Expected Value |
|---|---|---|---|---|
| 2320 | CAS05 | Adjustment Reason Code | Occurrence 2 | Expect Adjustment Reason Code |
| 2320 | CAS06 | Adjustment Amount | | Expect Adjustment Amount |
| 2320 | CAS07 | Adjustment Quantity | | Expect Adjustment Qty |
| 2320 | CAS08 | Adjustment Reason Code | Occurrence 3 | Expect Adjustment Reason Code |
| 2320 | CAS09 | Adjustment Amount | | Expect Adjustment Amount |
| 2320 | CAS10 | Adjustment Quantity | | Expect Adjustment Qty |
| 2320 | CAS11 | Adjustment Reason Code | Occurrence 4 | Expect Adjustment Reason Code |
| 2320 | CAS12 | Adjustment Amount | | Expect Adjustment Amount |
| 2320 | CAS13 | Adjustment Quantity | | Expect Adjustment Qty |
| 2320 | CAS14 | Adjustment Reason Code | Occurrence 5 | Expect Adjustment Reason Code |
| 2320 | CAS15 | Adjustment Amount | | Expect Adjustment Amount |
| 2320 | CAS16 | Adjustment Quantity | | Expect Adjustment Qty |
| 2320 | CAS17 | Adjustment Reason Code | Occurrence 6 | Expect Adjustment Reason Code |
| 2320 | CAS18 | Adjustment Amount | | Expect Adjustment Amount |
| 2320 | CAS19 | Adjustment Quantity | | Expect Adjustment Qty |
| **2320** | **AMT** | **COB PAYER PAID AMOUNT** | | |
| 2320 | AMT01 | Amount Qualifier Code | | Expect 'D' |
| 2320 | AMT02 | Payer Paid Amount | | Expect COB Payer Paid Amount |
| 2320 | AMT03 | Credit/Debit Flag Code | | NOT USED |

## X. RECORD STATUS CODE AND CLEARING H290 PENDS

Contractors receiving pend error code H290 “Adjustment/ Void Code Invalid” are advised to check the Record Status Code (Element 399). That value must be accurate for the type of transaction being submitted. A mismatch on this code will fire this pend. The edit status code values are for transactions as follows:

- 1 Paid: Code indicating that the transaction was adjudicated using plan rules and was payable. **(New encounter submission)**.
- 2 Rejected: Code indicating that the transaction was denied/rejected. **(HP Denied)**.
- 3 Reversed: Code indicating that the paid transaction was canceled. **(Voided)**.
- 4 Adjusted: Code indicating that the previous transaction was changed. **(Replaced)**.

## XI. SAME DAY ADMIT DISCHARGE ENCOUNTER REPORTING

AHCCCS utilizes the APR-DRG inpatient claims payment methodology. Inpatient claims with an admission date equal to the discharge date will be paid using the AHCCCS outpatient fee schedule methodology, including same-day admission and discharge claims for maternity and nursery. There is one exception to this methodology. Claims with the same admission date and death date will be reimbursed with a full DRG payment. The DRG edit A956 DRG - DOES NOT MEET CRITERIA FOR ANY DRG will apply if financial fields do not match AHCCCS DRG calculation. For detailed information on DRG billing requirements, see the AHCCCS Fee for Service Provider Manual addendum at www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap11_Addendum.pdf. This payment methodology differs from the Tiered Per Diem methodology for claims with discharge dates before October 1, 2014. Billing information for that methodology is available in the FFS Provider Manual.

## XII. KEYSTROKES FOR ONLINE ENCOUNTER OVERRIDES

PMMIS screen (EC780) provides an override summary of edit encounter errors that Contractors can override online. Each encounter overrides performed online must include a numeric override reason on the PMMIS screen (RF747) and a notation explaining why the override is appropriate. Below are the available keystrokes by form type utilized to perform an online override and where the overriding reason (F4) and notation (F5) are entered in the record.

| 1500 – EC205C and Dental – EC203C | Pharmacy – EC215C | UB – EC810C |
|---|---|---|
| Enter CRN | Enter CRN | Enter CRN |
| F4 and enter override reason code. | F4 and enter override reason code. | F4 and enter override reason code. |
| F2 | F2<br>Move from panel 2 to panel 3 | F2<br>Move from panel 3 to panel 4 |
| F3 | F8 | F11 |
| F8 | F5 Enter error code and override comment | F8 |
| F5 Enter error code and override comment. | F9 | F5 Enter error code and override comment |
| F9 | F2 | F9 |
| F2 | F2 | F2 |
| F2 | F9 | F2 |
| F9 | | F9 |

## XIII. ENCOUNTERS SUBMITTED FOR "UNIDENTIFIED" INDIVIDUALS

When encounters are submitted for "unidentified" individuals (such as in crisis when a person's eligibility or enrollment status is unknown), Contractors shall require the provider to use the applicable pseudo-ID numbers that are assigned to each RBHA. For assistance, contact the DHCM/DAR Encounters Unit. Pseudo-ID numbers are not assigned to TRBHAs. Encounters are not submitted for prevention services.

## XIV. ENCOUNTERS EDIT STATUS H140 AND H141

Effective 11/1/2022, Encounter edit H140 (pick up information ) and H141 (drop off information) will be set to 'hard' to gain compliance with gathering this information from non-emergency medical transportation (NEMT) providers. These edits validate that the pick-up and drop-off information are included in the encounter. For NEMT Providers, the information will be submitted through the 837P for HCFA 1500 files loop 2310E (Pick Up) and 2310F (Drop Off).

| | | |
|---|---|---|
| **2310E** | **NM1** | AMBULANCE PICK-UP LOCATION |
| **2310F** | **NM1** | AMBULANCE DROP-OFF LOCATION |

This will be accomplished when the EDI 837 Professional file is loaded into the Encounter subsystem, looking at loop 2310E/2310F to ensure it contains pickup/drop-off address data. The correct address data needs to include Address line 1; Address line 2 if provided; City, State, and Zip Code. If the encounter does not have this information populated on the 837P, the encounter will pend for H140 and/or H141. Correct any encounter that pends for H140 or H141, this will be accomplished through a Replacement Record.