Claim vs. Encounter

Fee-For-Service Claim:

• A healthcare claim reports a service has been provided and requests payment for services rendered.

• Claims are analyzed for information such as costs of a specific disease or condition, or utilization rates for a particular service.

• FFS claims are adjudicated in WellCare’s claims platform, Xcelys.

Encounter:

• Services provided by WellCare, or its providers, are required to be reported to state/federal entities as encounters.

• WellCare does not adjudicate encounters.

• Encounters are paid either via capitated or ASO (Admin Services Only) agreement.

• Encounters are used by government entities for quality assessments and calculation of the capitated rates.
What does WellCare do with FFS claims and Encounters?

- WellCare receives both FFS claims and encounters depending on the type of reimbursement agreement with service providers.
- WellCare reports the information to contracted state and/or federal agencies.
  - All data is electronically submitted to state/federal entities as “encounters” regardless of how that data was submitted to WellCare, whether via FFS claim or encounter.

Challenges

- Historically, WellCare data edits have been more relaxed than State edits.
- Paying claims has taken a higher priority than getting encounters accepted with the State.
# Claim/Encounter Types

<table>
<thead>
<tr>
<th>Institutional</th>
<th>Professional</th>
<th>Dental (837D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AKA: 837I, UB92, UB 04, Hospital</td>
<td>• AKA: 837P, HCFA 1500, CMS 1500, Physician</td>
<td>• X12 837 Version Code: 005010X224A2</td>
</tr>
<tr>
<td>• X12 837 Version Code: 005010X223A2</td>
<td>• X12 837 Version Code: 005010X222A2</td>
<td></td>
</tr>
</tbody>
</table>

**Definition:**

**Institutional**

Claims which are billed with revenue codes and ICD9 procedure codes that describe room accommodations and services rendered in either an inpatient or outpatient setting;

Submitted by facilities such as hospitals, ambulatory surgical centers, home health agencies, skilled nursing facilities, or residential treatment centers;

These claims typically include charges for use of rooms, supplies, drugs, and equipment.

**Professional**

Claims which are filed by providers such as doctors, health care professionals etc.;

These claims typically include charges for services such as: mental health, DME, lab, primary care visits, specialty care visits, etc.

**Dental (837D)**

Claims which are filed by dental providers including charges for dental services.
Why Are Encounters Important?

Visibility

• Encounters provide AHCA visibility into services provided to members.
• They also offer the State details regarding those services (i.e. dates, diagnosis, procedures, provider information, member information, etc.)

Rate Setting

• AHCA uses encounters to determine the Per Member Per Month (PMPM) rates for a given period of time.
• AHCA sets rates based on the completeness and accuracy in which the encounters are submitted *and* accepted.
• This means that rates are adjusted each year (either increase or decrease) based on the previous year’s encounters submissions and acceptance.
Risk Adjustment

• Encounters offer visibility into the high risk members served by the plan and the services provided to them.

• In addition to completeness and accuracy, AHCA may adjust rates based on risk level.

Kick Claims

• Some encounters result in specific kick payments from AHCA. Examples of kick payments include transplants, maternity, newborn, etc.

Risk of Fines and Penalties

• Under the FL MMA contract, AHCA has outlined very stringent penalties and fines for any plans not meeting the required Service Level Agreements (SLAs).
Encounters Pre-MMA

Service Level Agreement

• Timeliness: Health plan must submit encounter data for all services rendered to its enrollees within 60 days (15 days for Pharmacy) following the end of service month.

• Completeness: Submit 95% of covered services

• Accuracy: 95% of encounter lines must pass State edits

Manual Intervention

• Pre-MMA, WellCare allowed data to process through the system that did not pass AHCA validation.

• Intensive manual interventions were required in order to submit encounter data to AHCA within the then-60 day timeframe.
Encounters Post-MMA

Service Level Agreement

• Timeliness: Health plan must submit encounter data for all services rendered to its enrollees within 7 days following the adjudication date.
• Completeness: Submit 95% of covered services
• Accuracy: 95% of encounter lines must pass NCPDP edits

Front-End Edits

• WellCare is required to replicate AHCA’s validation for all front-end claim/encounter submissions.
• This removes the risk of allowing claims or encounters into the system that would otherwise require manual intervention before submission to AHCA.

Automated Processes

• WellCare will automate as much of the process as possible to avoid delays in adjudication and/or submission to AHCA.
• With AHCA’s newly tightened timeframes of SLAs, manual intervention is not an option.
Submission Methods and Naming Conventions
Encounter Data Submission

**Encounter Data Definition:**

The primary record of service containing detailed information derived from claims, whether paper or electronic, regarding the services provided to enrolled members.

**5010 Implementation**

- AHCA mandated encounter submission in the CMS 5010 version.
  - As a result, WellCare created and launched a new system to adhere to the mandated CMS 5010 version.
• WellCare is required to ensure that data received from providers are accurate and complete.

• The health information system collects data on plan beneficiaries, provider characteristics, and services used for the purpose of generating encounter data.

• Reporting requirements that dictate format, frequency, and/or validation expectations for encounter data are influenced by CMS and/or state guidelines.

• Our state and federal government partners substantiate every single service provided to every WellCare member by utilizing the reported encounter data.

• Financial sanctions can be imposed on WellCare if encounter data submissions do not meet the service level agreements for timeliness of submission, completeness, and/or accuracy.
Encounter Data Submission - continued

Encounters must be submitted electronically via:

- WellCare’s preferred clearinghouse RelayHealth
- WellCare’s Secure FTP (SFTP) process
- Direct Data Entry (DDE)

For more information regarding Encounter Data submission requirements and methods, please refer to the Provider Manual.

Acceptable Encounters formats:

- 837I (Institutional)
- 837P (Professional)
- 837D (Dental)
- NCPDP (Pharmacy)
Encounter Production for 837 I, P, or D:

- After the Provider or Trading Partners are able to submit ANSI ASC X12N 837 files with the correct naming convention, the plan will accept production files.

- Files must have the appropriate PRODUCTION identifiers as listed in the 837 mapping documents.

Encounter Naming Standards:

- The plan uses the file name to help track each batch file from the drop off site through the end processing into the Plan’s data warehouse.
Naming Convention Example

First 3 letters of the Provider/Vendor name
Provider State
File Format
PROD or TEST
Year, Month, Day, Hours, Minutes
YYYYMMDDHHMM
Type of file:
P-Professional
I-Institutional
D-Dental

ATAFL_837PROD_201312181117P
File Syntax, SNIP and Business Edits
WEDI SNIP Edit Types

Definition:

• **WEDI (Workgroup for Electronic Data Interchange):**
  
  A healthcare industry group that lobbied for HIPAA Administrative Simplification, and that has a formal consultative role under the HIPAA legislation.

• **SNIP (Strategic National Implementation Process):**
  
  A WEDI program for helping the healthcare industry identify and resolve HIPAA implementation issues.

• **SNIP Edits:**
  
  Standard rules that define the proper format and syntax of an X12 file. These rules are defined by the corresponding HIPAA Implementation Guide for each transaction type.
The WEDI SNIP program defines seven levels of edits for X12 transactions:

- **SNIP Type 1:** EDI Syntax Integrity
  Validates the file and record structure for each type of transaction

- **SNIP Type 2:** HIPAA Syntax Specific Requirements
  Validates that the transaction sets adhere to the HIPAA Implementation Guide

- **SNIP Type 3:** Balancing
  Validates if claim summary totals balance to the line level details

- **SNIP Type 4:** Situational Warning
  The testing of specific inter-segment situations described in the HIPAA Implementation Guide such that: If A occurs, then B must be populated.
• **SNIP Type 5**: External Code Set Testing
  
  Testing for valid Implementation Guide specific code set values and other code sets adopted as HIPAA standards

• **SNIP Type 6**: Product Types/Types of Service Testing
  
  Also known as line-of-business testing, is specialized testing required by certain healthcare specialties, such as chiropractic, ambulance, durable medical equipment, etc.

• **SNIP Type 7**: Trading Partner-Specific Testing
  
  Edits in the HIPAA Implementation Guide that are unique and specific to a payer; Examples are edits for Medicare, Medicaid, or Indian Health Services
WEDI SNIP Level 1: EDI Syntax Integrity Validation

• Syntax errors, also referred to as *Integrity Testing*, will verify that a valid EDI syntax for each transaction has been submitted.

• Errors can occur at the file level, batch level within a file or individual Encounter level.

• It is therefore possible that when these errors are received an entire file or part of a file, depending on where the error occurred, could be rejected and sent back to the submitter when one of these errors is encountered.
Common Errors:

- Invalid date or time
- Invalid telephone number
- The data element is too long (i.e. the Encounter form field expects a numerical figure 9 characters long but reads 10 or more characters)
- Field ‘Name’ is required on the Reject Response Transaction (i.e. Field ‘ID’ is missing. It is required when Reject Response is “R”)
- The sign is not allowed as a value (i.e. date of service is expected to a numerical only format of MM/DD/CCYY and is entered improperly)
WEDI SNIP Level 2: HIPAA Syntactical Requirement Validation

• Also known as Requirement Testing

• Verifies submission of a valid HIPAA syntax for each type of transaction

• This level will verify that the transaction sets adhere to HIPAA Implementation guides.
Common Errors:

- Invalid Social Security Number
- Procedure Date required when ICD Codes are reported
- Encounter number limit per transaction has been exceeded
- ‘Name’ is required when ID is not sent
- Revenue Code should not be used when it is already used as a Procedure Code
- NPI number is invalid for ‘Name’
- State code is required for an auto accident
- Employer Identification Number (EIN) is invalid
- Missing/invalid patient information
Common Errors - continued:

- Member identification missing or invalid.
- Patient’s city, state, or zip is missing or invalid
- Invalid character or data element. The data element size is invalid or has invalid character limits
- Missing NPI. As of May 23, 2008 WellCare requires NPIs to be populated on all Encounters, unless the provider is atypical, in accordance with HIPAA guidelines. An NPI must be a valid 10 digit number.
- Legacy ID still on Encounter. Legacy numbers include Provider IDs, Medicaid and Medicare IDs, UPIN and State License numbers. All legacy numbers need to be removed from Encounters
WEDI SNIP Level 3: Balancing Validation

• This level is for balancing of the encounter.
• It is used to validate the transactions submitted for balanced field totals and financial balancing of encounters.

Common Errors:
• Total charge amount for services do not equal sum of lines charges; and,
• Service line payment amount failed to balance against adjusted line amount.
WEDI SNIP Level 4: Situational Requirements

• This level will test specific inter-segment situations as defined in the implementation guide; where if “A” occurs, then “B” must be populated.

Common Errors:

• If the Encounter is for an auto accident, the accident date must be present.
• Patient Reason for Visit is required on unscheduled outpatient visits.
• Effective date of coverage is required when adding new coverage for a member.
• Physical address of service location is required for all places of service billed.
• Referral number is required when a referral is involved.
• Subscriber Primary ID is required when Subscriber is the Patient.
• Payer ID should match to the previously defined Primary Identifier of Other Payer.
WEDI SNIP Level 5: External Code Set Validation

- This level validates the code sets.
- It ensures that the usage is appropriate for any particular transaction and in adherence to the coding guidelines applicable to its corresponding code set.

Common Errors:

- Validates CPT code
- ICD Codes
- Zip code
- National Drug Code (NDC)
- Taxonomy Code validation
- State code
- Point of Origin for Admission or Status codes Box 15 (UB-04)
- Adjustment Reason Codes and their appropriate use within the transaction
WEDI SNIP Level 6: Product Types/Types of Service Testing

• This level is intended for specialized testing required by certain health care specialties.

Common Errors:
• Service Facility Location Name is required.
• Ambulance Transport Information is required on ambulance claims.
• Attending Provider Name is required.
WEDI SNIP Level 7: Custom Health Plan Edits

• This level is intended for specific WellCare business requirements, which are not covered in the WEDI SNIP and the Implementation Guide.

Common Errors:

• Service Location Address contains a PO Box Address

• POA indicator missing or invalid.
  ➢ Valid indicators are y, n, u, w (POA indicator of "u" not allowed with primary diagnosis)
Resubmission, Cancel, Void and Replace
Void and Replace

Void:

- A provider-initiated electronic void (formerly called claim reversal) is a cancellation of an entire claim.
- A void can be completed on the same day or in the same week that the original claim was submitted, as well as after the original claim payment is finalized.
- A region code of 63 is assigned to post-financial claims for electronic voids that are initiated by the provider.

Replace:

- A provider-initiated electronic replacement (formerly called an adjustment request) is submitted with a claims frequency code of 7 and becomes a new claim (including attachments and claim notes).
- A replacement can be completed on the same day or in the same week that the original claim was submitted, as well as after the payment is finalized.
- New region codes are assigned to post-financial claims for electronic replacements that are initiated by the provider.
Submitting Corrected or Voided Claim Electronically (EDI)

For Institutional and Professional claims:

• Providers must include the original WellCare claim number in Loop 2300 segment REF*F8
  ➢ Include claim’s Frequency Code (CLM053) of 7 (Replacement of prior claim) or 8 (Void/cancel of prior claim)

• Please refer to the 5010 Implementation Guides or WellCare’s Companion Guides for complete details.
Submitting Corrected or Voided Claim Electronically (EDI) - continued

Electronic replacement (frequency code 7) and void (frequency code 8) requests MUST meet the following requirements for processing:

- Replacement/Void claims must include the original WellCare Control Number in Loop 2300’s Payer Claim Control Number REF segment, with an “F8” in Position 01.

- The original WellCare Control Number referenced by that ID number MUST be in a finalized status.

- The Member ID and provider NPI/Tax ID on the replacement/void claims must be the same as what was submitted in the original claim.

- Electronic replacement claims for original claims that the plan has split cannot be accepted.

Any replacement/void claims that do not meet ALL of these requirements will be rejected and reported accordingly in the plan’s initial claims status reports.
Submitting a Corrected or Voided Claim on Paper

For **Institutional** claims, the provider must include the original WellCare claim number and bill frequency code per industry standards.

**Example:**

Box 4 – Type of Bill: the third character represents the “Frequency Code”

<table>
<thead>
<tr>
<th>3a PAT. CNTL. #</th>
<th>4 TYPE OF BILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. MED. REC. #</td>
<td>117</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5 FED. TAX NO.</th>
<th>6 STATEMENT COVERS PERIOD FROM</th>
<th>7 THROUGH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Box 64 – Place the Claim number of the Prior Claim in Box 64

```
298370064
```
Submitting a Corrected or Voided Claim on Paper - continued

For **Professional** claims, the provider must include the original WellCare claim number and bill frequency code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left hand side of Box 22.

Electronic replacement (frequency code 7):

```
Example:

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567890A33456</td>
</tr>
</tbody>
</table>
```

**Or:**

Void (frequency code 8):

```
Example:

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567890A33456</td>
</tr>
</tbody>
</table>
```

**Please Note:** Any missing, incomplete or invalid information in any field may cause the claim to be rejected. If you handwriting, stamp, or type “Corrected Claim” on the claim form without entering the appropriate Frequency Code “7” or “8” along with the original claim number as indicated above, the claim will be considered a first time claim submission and will reject as a duplicate affecting adjudication.
The Correction Process involves two transactions:

1. Reversal of the original claim
   - The original claim will be reversed and noted with an adjustment reason code RV059.
   - “Payment Reversal – Payment lost/voided/missed”
     - This process will deduct the prior payment. The Payment Reversal for this process may generate a negative amount, which may be offset from future payments rather than on the EOP that is sent out for the newly submitted corrected claim.

2. Adjudication of corrected claim
   - The corrected claim will be processed with the newly submitted information and noted with an adjustment code CL025.
   - “Adjusted per corrected bill.”
     - This process will pay out the newly calculated amount on a new claim with a new claim number.
Void Process

The Void Process involves the following transaction:

Reversal of the original claim

• The original claim will be reversed

• The subsequent claim submitted with an 8 (Void/cancel of prior claim) will be processed as a zero payment and noted with an adjustment reason code RV059 “Payment Reversal – Payment lost/ voided/ missed.”

• This process will deduct the prior payment or zero net amount if applicable.
Questions and Answers
Resources

Claims & Encounter Materials:
https://florida.wellcare.com/provider/claims_updates

- Companion Guides
- Provider Manuals
- Calendar with important dates and events
- Past Webinars
- “How-to” guides:
  - Additional response file guides
  - Rejection code guides
  - Reading an 837
- Implementation Guides: