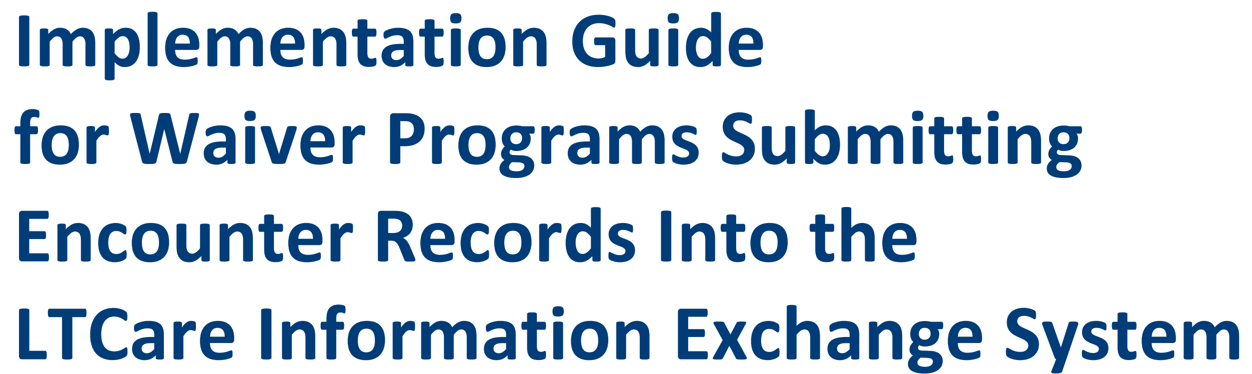
Implementation Guide for Waiver Programs Submitting Encounter Records Into the LTCare Information Exchange System



WISCONSIN DEPARTMENT of HEALTH SERVICES

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Introduction

Purpose of This Guide

The Implementation Guide for Waiver Programs Submitting Encounter Records into the LTCare Information Exchange System (IES) provides information about submitting regularly scheduled (often monthly) encounter batch submissions for waiver programs, adjusting encounters, and reporting fraud, abuse, and waste to meet Wisconsin Department of Health Services (DHS) and Centers for Medicare and Medicaid (CMS) reporting requirements.

Encounters are detailed records of services provided to members under the responsibility of a managed care organization (MCO), IRIS (Include, Respect, I Self-Direct), or a county agency. (These are collectively referred to as MCO/agency in this implementation guide.)

The waiver programs for which encounters are reported include the following:

- Family Care
- Family Care Partnership
- Program of All-Inclusive Care for the Elderly (PACE)
- IRIS
- Children's Long-Term Support Services (CLTS)

Note: A separate document describing the reporting functions for non-waiver programs, including incident reporting, approval of restrictive measures, and contacts made to the Aging and Disability Resource Centers (ADRCs), is available on the DHS website at www.dhs.wisconsin.gov/ies/index.htm

This implementation guide is divided into three sections:

- Introduction—Provides general information about the LTCare IES application.
- Submitting encounter data—Gives step-by-step instructions on how to perform the tasks necessary to submit and validate a submission.
- Appendix—Provides support information and a change log.

If you have questions about using the LTCare IES application, email dhsltcareencounterhelp@dhs.wisconsin.gov.

Overview of the LTCare IES Application

The LTCare IES application accepts regularly scheduled data transfers from each MCO/agency to the state. These data transfers yield timely information for reporting and analysis. All file submissions, report viewing, and administration activities may be done from a standard web browser.

The LTCare IES reporting application provides a consistent data collection and validation utility to gather data to do the following.

Purposes of Collecting the Data:

- Updates and evaluates service costs for business or operations management
- Calculates capitation payment rates
- Provides a source of data for federal reporting
- Monitors program integrity (i.e., service utilization, access to care)
- Assesses quality of care
- Monitors contract
- Conducts research

Summary of the LTCare IES Functionality:

- Accepts claims, spenddown, and cost share data directly from business systems
- Allows for transfer of compressed files via SSL website for secure transmission
- Provides information to MCOs/agencies about incorrectly formatted or invalid data
- Assists MCOs/agencies in achieving and maintaining Health Insurance Portability and Accountability Act of 1996 (HIPAA) data compliance
- Moves certified data from the IES application into the data warehouse to be queried and analyzed
- Allows MCOs/agencies to correct data anomalies either by resubmission or through adjustment transactions
- Requires quality assurance (QA) reports to be submitted for summary verification to ensure local and state databases remain synchronized

Description of Encounter Transactions

Encounter records are detailed records of services provided to members and payments made under the responsibility of the MCO/agency. Encounter reporting requires a separate and unique record for each service.

Encounter data must be specific (unique to a person, provider, treatment or assistance, and service date). Service quantities must be reasonable with respect to the service code unit of measure; fractional quantities are not reasonable for unit values of "each" or "visit." Quantities must also be reasonable with respect to the dates of service (e.g., 348 visits in a month is generally not reasonable). When dates of service span a range, the service must be provided continuously throughout the period by the same provider at the same quantity each day. If there is any deviation, the encounter record must be end dated and a new encounter started.

Example 1: A member receives 10 home-delivered meals during the month of May. Ten units in May is not a specific transaction because the specific date those 10 meals were actually provided to the member cannot be determined. A quantity of 10 meals that spans 10 days is determined to be one meal per day and is an acceptable data record.

Example 2: A person receives one hour of counseling each weekday. This example can be expressed as one encounter record that spans five days with a quantity of five.

Example 3: A person receives one hour of counseling each weekday and two hours of counseling on Wednesday. This example becomes three encounter records.

QTY 2 UNIT HR Service Date From 2016-10-05 Service Date To 2016-10-06
QTY 2 UNIT HR Service Date From 2016-10-07 Service Date To 2016-10-07
QTY 2 UNIT HR Service Date From 2016-10-08 Service Date To 2016-10-09

Example 4: A person received a one-hour counseling once a day on Monday, Wednesday, and Friday. This example becomes three encounter records:

QTY 1 UNIT HR Service Date From 2016-10-05 Service Date To 2016-10-05
QTY 1 UNIT HR Service Date From 2016-10-07 Service Date To 2016-10-07
QTY 1 UNIT HR Service Date From 2016-10-09 Service Date To 2016-10-09

Overview of Transaction Types, Record Types, Claims Types, and Adjustment Types

Encounter transactions are detailed records of services provided to members under the responsibility of the MCO/agency. The source of most of the data is the MCO/agency claims systems, but encounter data can have other sources, such as accounts receivables. In addition to reporting service encounters, MCOs/agencies are required to report collections of member share and voluntary contributions. For waiver programs, the two types of transactions are encounter transactions and member share transactions.

Transaction Types

- Encounter transactions are claim transactions: a service or item provided to a member through the case management plan. Some examples include durable medical equipment, case management, and personal care services.
- Member share transactions are non-claim transactions: the service or transaction is not directly provided by the MCO/agency, but the MCO/agency holds professional or administrative responsibility. Some examples include:
    - A cost share amount due to the MCO.
    - A voluntary contribution.
    - Room and board payments.

Note: The terms “service” and “item” may also include services or items that are not in the waiver’s benefit plan but that the MCO/agency has chosen to include as part of their treatment plan.

Record Types

All transactions have a record type of either “original” (O) or “change” (C). The record type identifies if the record is an original record or a change of a previous record.

Adjustment Types

A record type that identifies a change must further identify the adjustment type as a “reversal” (R) or as a “new” (N) record. Adjustments to existing records are usually made in two steps: the first reverses the previous transaction, and the second replaces the record with a new record.

Adjustment Type Detail

The adjustment type detail explains why the adjustment was needed.

Claim Status

The claim status identifies whether the claim is “paid” (P) or “denied” (D).

Claim Types

The claim type is determined by the claim form used to report the service:

- IN equals institutional for the Uniform Billing (UB-04) claim form.
- PH equals pharmacy for the Prescription Drug Reimbursement Claim Form.
- PR equals professional for the CMS 1500 claim form.
- DE equals dental for the American Dental Association Claim Form.

Summary of the LTCare IES Reporting Process

In summary, this data collection and verification utility does the following:

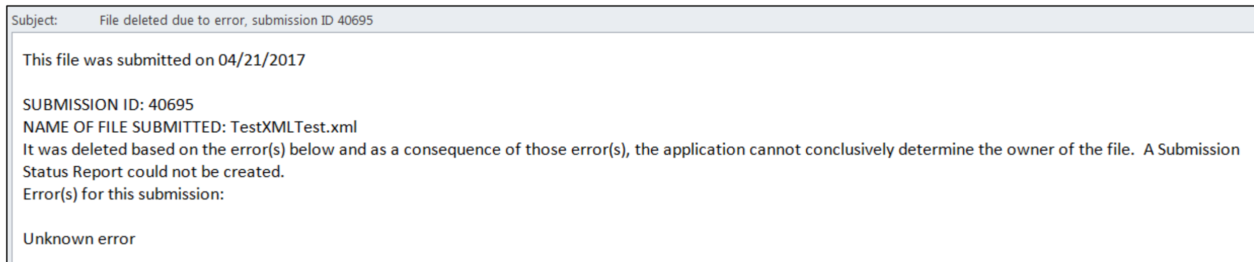
- Accepts claims and non-claims data from MCO/agency or contracted entity via our batch upload process
- Allows for the transfer of compressed zip files via an SSL website for secure transmission
- Provides information to MCOs/agencies about incorrectly formatted or invalid data
- Allows resubmission of data when necessary due to data corrections
- Allows for adjustments to data to be submitted

Each MCO/agency initiates a data transfer submission file in an XML format according to the required schedule per the contract with the Wisconsin Department of Health Services (DHS). Template XML files are available on the Documentation page of the IES Application for waiver and non-waiver programs. Select the template for the program for which you are submitting

data. The Documentation page also has instructions about how to convert Microsoft Excel-like files into an XML format.

Once submitted, the data transfer files are processed through a series of parser and content edits based on the business rules. Differing levels of error checking occur within the application to verify the submission. Content edits are delayed until parser edits are passed.

It is possible that an entire submission will be deleted due to an unknown error. If a submission was deleted due to an unknown error, you will be sent an email.


Subject: File deleted due to error, submission ID 40695

This file was submitted on 04/21/2017

SUBMISSION ID: 40695
NAME OF FILE SUBMITTED: TestXMLTest.xml
It was deleted based on the error(s) below and as a consequence of those error(s), the application cannot conclusively determine the owner of the file. A Submission Status Report could not be created.
Error(s) for this submission:

Unknown error

Figure 1 File Deleted Email

Files may often be deleted because information in the header or some other section of the file was not "well-formed." Review the file for formatting errors, correct any errors, and resubmit.

An entire submission is rejected when a critical error is found. This is referred to as a batch reject error. The error(s) must be corrected before the file can be accepted.

A batch is considered accepted when no batch reject errors occur. After the file processing is completed, feedback is viewable on the Submission Status List. These feedback reports outline specific details of any edits that may have triggered. After a file is accepted, it must be certified in order to be loaded into the data warehouse.

Certified data is loaded into the data warehouse on a weekly basis.

For more information about using the encounter application, refer to the LTCare Information Exchange System (IES) User Guide for Reporting of Encounters, which is available on the DHS website at www.dhs.wisconsin.gov/ies/index.htm.

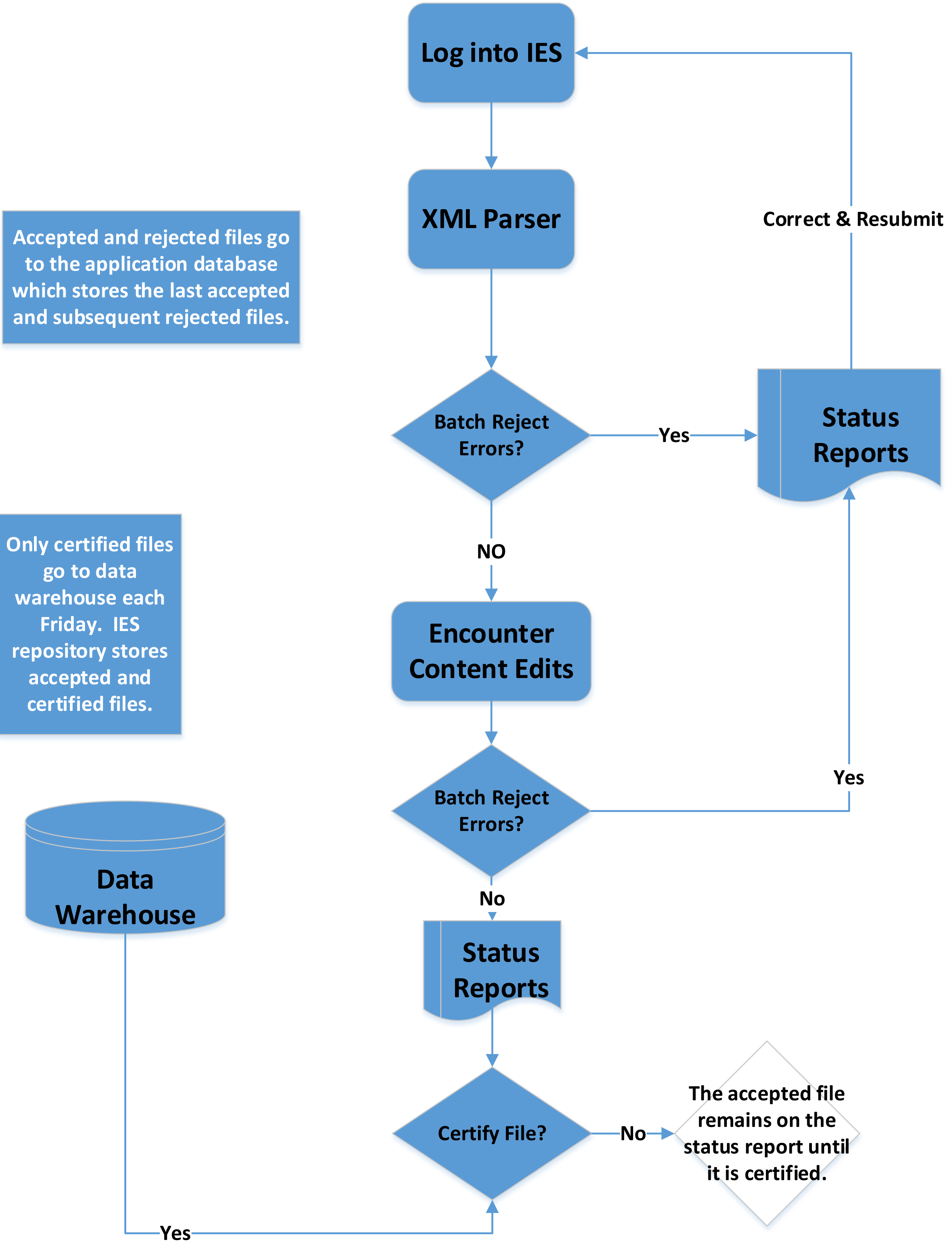


Figure 2 LTCare IES Process Flow

Defining an Encounter

Encounter records are detailed records of events or services provided to members of the MCO/agency. Encounter claims transactions include a service or item provided to a member through the case management plan, including direct and/or indirect services. Examples are durable medical equipment, case management, personal care services, personal emergency response system (PERS), transportation services, or Meals on Wheels.

Encounter non-claim transactions are transactions for which the MCO/agency holds professional or administrative responsibility, such as collection of the following:

- A cost share amount due to the MCO.
- A voluntary contribution.
- Room and board payments.

Multiple encounters may occur between a provider and a member during a single day. For example, if supportive home care, personal care service, and chore services are all provided on a given day, the MCO/agency will report three encounter records because the services are described by different procedure codes. If the same service (same procedure code) was provided on the same day by different rendering providers, the MCO/agency will report two encounters. If the same service (same procedure code) is provided by the same rendering provider on a single day, the MCO/agency can submit one encounter record with the total number of units for that procedure. You can also submit separate encounter records.

The source of most of the encounter data is the MCO/agency claims systems, but encounter data can have other sources, such as accounts receivable. In addition to reporting service encounters, MCOs/agencies are required to report collections of cost share, room and board payments, and voluntary contributions.

Local Business System Requirements

General Claims Processing Requirements of the Submitting Organization

MCOs/Agencies must have a claim processing system that is robust enough to meet LTCare IES reporting data requirements. The system must have the ability to supply required encounter data elements, and the required elements must pass data edits for encounter business rules.

The system must be able to generate original record transactions and adjustment records so that to the MCO/agency submits accurate data that reflects the transactions from the source system. The claims system must adhere to generally accepted accounting principles. Adjustments are expressed as debit or credit transaction pairs.

The claims system must be able to receive claims and claims-related data in paper and electronic formats from various sources, including service providers, billing services, Medicare carriers, and intermediaries.

The MCO/agency claims system must be able to reconcile, coordinate, and pay claims. The system must be able to process special claims, including late billing, recipient retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal or fair hearing, class action suit, and any other state-defined situation in accordance with state instructions.

To manage the claims processing function, the MCO/agency system must be able to identify existing and potential coordination of benefits (COB) opportunities (including Medicare). This includes the ability to deny a claim when it is for a service covered under another member benefit resource, and deduct COB amounts, as appropriate, when adjudicating claims. The system must be able to identify the allowable reimbursement according to date-specific pricing data and reimbursement methodologies for the date of service on the claim, including Medicare coinsurance and/or deductible crossover claims and adjustments (i.e., pay the Medicare deductible in full, pay Medicare coinsurance so as not to exceed the Medicaid maximum allowable fee, deduct Medicaid copayment where appropriate). Any claim payments involving subrogation need to be credited back to the original claim (with the exception of reinsurance).

The MCO/agency must also be able to manage member contributions for services according to member share policies set by the state. Management includes collections and coordination of claim payments, tracking remaining balances, and invoicing members for the remaining monthly amount due.

Effective claims adjudication requires the MCO/agency to perform adjustments to original and adjusted claim records. The process must ensure successive adjustments are applied to the most current version of the claim record. The MCO/agency must have the ability to identify a claim's disposition of paid or denied, including the ability to track all claim records from receipt to final disposition and to track (update) the claims inventory (e.g., to be processed, suspense) after each claim processing cycle.

The MCO/agency must report room and board separately according to §1915(c)(1) of the Social Security Act, 42 U.S.C. 1396n(c)(1).

LTCare IES reporting of encounters allows the ability to track and report on the original calculated claim amount allowed, any manually priced amount, and the actual payment amount in the claim history, including current and historical cost share data.

Each claim submitted to IES for processing is classified as either paid or denied.

- **Paid status:** Covered person or service for which payment is generated or an internal service paid amount is posted. Zero pay is part of paid. Zero pay is a covered or valid service for which the MCO/agency liability was paid in full by other coverage and is considered a paid claim for encounter reporting purposes.
- **Denied status:** Valid claim (covered person or service) but nothing is paid (i.e., denied) because no amount is payable under these circumstances (e.g., exceeds authorized units, no authorization, duplicate). A claim adjustment reason code must be given for denied claims to give the reason for the denial.

The suspended/pending status must also be tracked within the MCO/agency system.
Suspended/pending status: Claims that are not yet finalized. Further processing is required to determine the final status of these claims.

Only paid or denied (after final adjudication) should be sent to the IES application.

Interest payments should not be included in paid amounts nor reported in the IES application as a separate item.

Balancing Considerations

As with any reversal process, it is important to accurately balance cash accounts with claims history. The following are recommendations to consider when implementing a reversal process:

- Claims history records must always balance against financial ledger (accounts payable or accounts receivable) records. All cash transactions should have a corresponding record within claims history to allow for accurate reporting, research, and auditing.
- Non-cash debits must always equal non-cash credits. Any claims payments involving subrogation need to be credited back to the original claim (with the exception of re-insurance).

- Statistical information should not be inflated. For example, Provider X submitted a claim for $1,000 for services rendered for 10 units of procedure ABC. This same provider now requires an additional $200 due to incorrect billing. The parent record of the original record with $1,000 billed should be adjusted, and a new corrected record should be submitted. The last record should always show the correct procedure, units, date of service, and amount billed and paid.

Ad Hoc Reporting

Each MCO/agency must have the ability to generate ad hoc reports from the source data used to generate scheduled encounter data extracts. Various tools are available in the marketplace.

MCOs/Agencies are required to generate ad hoc reports to ensure the source data is synchronized with the data stored in the DSS data warehouse. This process is called the reconciliation process.

Implementation Planning

To take advantage of the features of the data collection and validation utility, organizations must consider the current requirements of the encounter reporting process and evaluate these requirements against their own current systems capability. This implementation guide provides an overview of the encounter reporting process and instructions for reversing records when an incorrect payment is made or the record contains incorrect information (e.g., incorrect date of service, number of units, procedure code). The MCO/agency can contact the LTCare Encounter Reporting Team at DHSLTCareEncounterHelp@dhs.wisconsin.gov to discuss questions or unique challenges.

Planning Guidelines

In addition to the business system requirements listed above, the following fundamental principles must be considered when planning for the implementation of encounter reporting:

- Organizations must be able to generate encounter records for both provider-based and internally provided services. Encounter data must conform to claims and service reporting requirements for HIPAA.
- Organizations must have sufficient resources available to analyze and correct problems with data submitted to the encounter application.
- Organizations must be able to extract encounter level data in XML file format for transmission.
- Organizations must be able to generate summary reports to verify that the source data matches the data submitted.

Encounter reporting requirements are program-specific and the MCO/agency agrees to accommodate the specific requirements.

Organizations must evaluate the capability of their existing business system and determine any functional gaps between their system and the requirements of encounter reporting. Additionally, MCOs/agencies must consider each of the following items and develop an implementation plan to address any conflicts that may relate to them:

- Data dictionary elements
- Definitions of paid and denied claims
- Definitions of full cash, partial cash, and noncash transactions
- COB processes
- Adjustment processes
- XML file reports
- Test data sets
- Processes for tie out or to reconcile the financial data

Encounter Reporting Transaction Information

Required Data Elements for MCOs/Agencies

Refer to the DHS website at www.dhs.wisconsin.gov/ies/index.htm for the most recent versions of LTC encounter documents.

Record Edits

Each record within a submission is validated by a series of edits or business rules. Some of these rules require a field to contain correct values. Edits validate a variety of circumstances from a well-formed submission file and its data elements to specific content edits.

All populated fields must have correct values. Reference tables validate populated fields in accordance with national code sets (e.g., procedure codes, diagnosis codes).

All relationships between associated or related fields that contain data are validated. Encounter records require a Medicaid billing provider number or billing provider ID. If a billing provider ID is given, a billing provider ID qualifier must also be given and must be within the defined set of values (24 [EIN], 34 [SSN], XX [NPI], CO [MCO specific]). This validation does not check the correctness of the values in the fields but does confirm the existence and data type based on the qualifier and/or the definition field(s). For example, if the billing provider ID qualifier is set to XX, then there must be an associated National Provider Identifier (NPI) value in the Billing Provider ID field.

Each MCO/agency should implement a set of edits for each encounter record in their own business system or process prior to extracting data to minimize errors in their file submissions. Errors identified through the edit process contain the unique record identifier supplied by the MCO/agency. This identifier helps evaluate the errors and correct the appropriate transactions. The functionality of the status report download also helps with error evaluation. The

MCO/agency is required to correct the errors and resubmit the complete file or the corrected transactions, as appropriate, in the next submission depending on the type of errors.

Edits may change over time as business rules or requirements from federal or state entities change.

Error Messages

The following are the three types of edit error messages:

- Batch Reject Error: This message indicates that a critical error(s) exists, and the entire submission is rejected. The batch reject errors must be corrected, and the file resubmitted in its entirety.
- Warning: This message identifies potential errors, such as paid more than billed. These records are processed; corrections should be made where possible in future submissions. These messages are provided to assist the MCO/agency in managing their information systems and data. Warning messages are sometimes used to assist in the implementation and "at a later date," may become batch reject error messages.
- Batch Accept Error: This error message is rarely used but it indicates that a serious error(s) exists in individual records within the file. The error records are flagged and listed in the Submission Status Report.

Requirements for Encounter and Member Share Transaction

There are two types of transactions, as previously defined: encounter transactions and member share transactions. Both transactions result in a record. Records follow the same rules for reporting, correcting and adjusting. These rules are:

- The first appearance of an encounter or a member share transaction is called the original record (record type O).
- If an adjustment is needed, the record being adjusted is the parent record. The record ID of this adjusted record must be in the parent record ID field of the adjusting record. Adjustments must link to the original (has the same original ID) and to the record being adjusted.
- Adjustments must follow a credit/debit methodology. (See the Requirements for Reversals and Adjustments section for details.)

Requirements for Member Share Transaction Types (MCOs, IRIS Agencies, and Adult Waiver Programs)

Member share transactions track cost share, voluntary contributions, room and board, and spenddown payments with the Member Share Values shown in the following table:

Cost Share	C
Voluntary Contribution	V
Room and Board	R
Spenddown	S

These transactions provide a record of the amount received from the member or on behalf of the member.

In general, all of these member share transaction types must follow these rules:

- Changes to any of these transaction types must use the standard rules for adjustments. Do not apply any member share amounts to any particular service.
- Report the amount for these transaction types regardless of whether the MCO/agency or the provider collects the member share.
- Member share transactions report a negative dollar amount because the MCO is receiving money.
- The Paid Amount is the amount paid by the member or on behalf of the member.
- The Support Indicator must equal N for Non-Services.
- The Charges and Allowed Amount fields are NULL. Allowed Amount is also an optional field.
- The Quantity and Unit or Basis for Measurement Code fields are NULL.
- All third-party liability fields including Medicare Paid Amount and Other Payer Amount Paid fields must equal zero.
- The Claim Status must be paid.
- The MA Billing Provider ID and the MA Rendering Provider ID fields must contain the Submitter Organization ID.
- The From Dates of Service and To Dates of Service are relevant to the date for which the specific member share transaction applies.
- When room and board transactions are provided, the corresponding facility transactions must be the gross cost.

Record Type Business Rules

Record type is a required field and is either O or C:

- O equals the unadjusted transaction/original record

C equals the adjusting transaction/change record.
The characteristics of an original record are as follows:

- Quantities and amounts are positive, except member share transaction quantities and amounts which are negative.
- Adjustment type must be null.
- Original ID must equal the Record ID.
- The Parent Record ID must be NULL.

The characteristics of a change record follows:

- The Parent Record ID is required and is the record ID of the record being adjusted. Adjustment type is required.

- The reversal record amounts must be the inverse of the record being adjusted.
- Reversal record non-amount fields must equal the values of the record being adjusted.

Adjustment Type Values

R=a reversal record
N=the replacement or new record

Adjustment Type Detail (reason for the adjustment)

This field explains why an adjustment made to a record because of a cash or noncash adjustment.

Characteristics of Paid Encounter Records

Data Dictionary provides the field requirements for paid and denied records

Paid encounter records are claim records and have no member share component. The following rules apply to paid encounter transactions:

- Adjustments must follow a credit debit methodology. (See the Requirements for Reversals and Adjustments section for details.)
- The data dictionary lists the required and situational fields.
- The sign (positive/negative) for the Quantity, Charges, Allowed Amount, Medicare Paid Amount, and other Payer Amount Paid fields must be the same when they exist on the same encounter record. Allowed amount is an optional field.
- Self-directed support services transactions must have a support indicator of S.
- MCO-directed support services transactions must have a support indicator of C.
- Claim adjustment reason codes are required when the paid amount is not equal to the billed amount.

Characteristics of Denied Encounter Records

Denied records have a claim status of D. The paid Amount must equal zero and have a claim adjustment reason code

Claims that have a status of D (denied) may not be adjusted.

Basic Assumption Regarding Null and Blank Fields

When only spaces (blank fields) or NULL appear in any field, it is considered NULL (avoid sending empty tags).

Requirements for Record/Data Adjustments

Reversal records completely reverse a parent record ID. (A parent record ID equals the original record ID.) Adjustments are made using a credit debit pair of records to reverse a record and replace it with a new record of the correct data, effectively adjusting the record. Reversal records may be submitted alone or as the first of a pair of adjusting records. Adjustment type is required when submitting an adjustment record. Note the adjustment type detail issue.

In addition, all non-numeric fields must exactly match the corresponding field of the record being adjusted, as indicated by the value in the Parent ID. All numeric fields must be the exact negative amount of the corresponding field of the record being adjusted.

When a reversal occurs, it may only be followed by a new record. Once a record has been adjusted by a reversal record, it may not be reversed again. If a replacement record was submitted and needs adjustment, it follows the same adjustment rules. This is an example of an adjustment (minimal detail shown).

ID	Record Type	Adjustment Type	Parent ID	Quantity	Amount
5	O			200	5
7	C	R	5	-200	-5
9	C	N	5	300	8

The Parent Record ID in a reversal record is the reversed original record. The following are acceptable reversal transaction sequences:

1) Original encounter record
   Reversal record

2) Original encounter record
   Reversal record
   New record (situational)

3) Original encounter record
   Reversal record
   New record
   Reversal record
   New record (situational)

The following is an **invalid** reversal transaction sequences:

4) Original encounter record
   Reversal record
   Reversal record
   New record

When an MCO/agency provides data that is inconsistent with these rules, the IES Application flags these inconsistencies as batch reject errors and rejects the file submission.

Cash Adjustment

A partial cash adjustment is actually an adjustment that results in a change to a portion of the cash amounts on the record. Record 123 was correctly billed but incorrectly paid. The copay ($10.00) was not applied. The MCO/agency creates a record (127) that reverses the parent record. Finally, the MCO/agency creates a new record (134) to correctly pay the claim.

Record ID	Record Type	Adjustment Type	Adjustment Type Detail	Quant ity	Procedure Code	Charges	Paid Amount	Adjustment Reason Code	Parent Record ID	Original ID
123	O			1	XYZ	50	50			123
127	C	R	PC	-1	XYZ	-50	-50		123	123
134	C	N	PC	1	XYZ	50	40	22	123	123

Noncash Adjustment

A noncash adjustment adjusts the components of the record that are not related to cash amounts. Record 123 was billed with an incorrect procedure code. There is no pricing difference; therefore, there is no financial impact. The MCO/agency creates a record (127) that reverses the parent record. Then the MCO/agency creates a new record (134) with the correct procedure code on the paid claim.

Record ID	Record Type	Adjustme nt Type	Adjustment Type Detail	Quantity	Procedure Code	Charges	Paid Amount	Parent Record ID	Original ID
123	O			1	XYZ	50	50		123
127	C	R	NC	-1	XYZ	-50	-50	123	123
134	C	N	NC	1	ABC	50	50	123	123

Multiple Adjustments type detail

Record 123 is the original encounter. Record 127 is an adjustment that completely reverses the parent record. Record 134 is the new record that replaces the parent record. Record 168 is an adjustment that completely reverses the parent record, record 134. Record 199 is the new record that replaces the parent record 134.

Record ID	Record Type	Adjustment Type	Adjustment Type Detail	Quantity	Procedure Code	Charges	Paid Amount	Adjustment Reason Code	Parent Record ID	Original ID
123	O			1	XYZ	50	50			123
127	C	R	NC	-1	XYZ	-50	-50		123	123
134	C	N	NC	1	ABC	50	40	22	123	123
168	C	R	NC	-1	ABC	-50	-40		134	123
199	C	N	NC	1	CDE	50	40	25	134	123

CMS Requirement for Reporting Recoveries Made for Fraud, Abuse and Waste, Effective January 1, 2018

CMS issued managed care rules that require MCOs to obtain and report recoveries and overpayments due to fraud, waste and/or abuse. The rule is applicable and treated like any other recovery that an MCO/agency gets from the provider. MCOs will follow the adjustment process to indicate recoveries and use the applicable adjustment reason code listed here.

CMS defines fraud as, "The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s)."

CMS defines abuse as, "A range of the following improper behaviors or billing practices including, but not limited to: billing for a non-covered service; misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or inappropriately allocating costs on a cost report."

Waste means "over-utilization of services, or practices that result in unnecessary costs." Waste also refers to useless consumption or expenditure(s) without adequate return, or an act or instance of wasting." As an example, waste is providing services that are not medically necessary.

Magellan Health Services developed a training program on fraud, waste, and abuse for Medicare and Medicaid providers. It can be found at www.magellanprovider.com/MHS/MGL/about/handbooks/supplements/fwa_training.pdf.

The following are detail adjustment code values to indicate type of recovery:

- FA=Full reversal abuse
- FF=Full reversal fraud
- FW=Full reversal waste
- PA=Partial reversal abuse
- PF=Partial reversal fraud
- PW=Partial reversal waste

An Example of Reporting Partial Waste

In March, an MCO submitted a paid encounter record for $500 for 10 units of medical supplies given to a member. Care management staff worked with the member, saw the 10 units, and questioned the amount of medical supplies given to the member. Staff reviewed the care plan, the needs of the member, and determined that five units were necessary for the member and five units were not needed and was wasteful.

Record ID	Record Type	Adjustment Type	Adjustment Type Detail	Quantity	Procedure Code	Charges	Paid Amount	Adj Reason Code	Parent Record ID	Original ID
150	O			1	XYZ	500	500			150
175	C	R	PW	-1	XYZ	-500	-500		150	150
200	C	N	PW	1	ZYZ	500	250	57	150	150

Correcting Submission Errors

Each MCO/agency initiates a regularly scheduled (often monthly) data transfer submission file. Once submitted, the data transfer files are processed through a series of parser and content edits based on the business rules. Differing levels of error checking are used within the application to verify the submission. Content edits are delayed until parser edits pass the parsing editing. A submission may be deleted if it is not well-formed.

An entire submission is rejected when critical errors are found. This is referred to as a batch reject error.

When an error is classified as a batch reject, the complete batch is rejected and the MCO/agency is expected to correct the error(s) and resubmit the file.

A batch is considered accepted when no batch reject errors occur.

The Centers for Medicare and Medicaid Services (CMS) statute 42 C.F.R. § 438.600 requires that the Chief Executive Officer (CEO) or Chief Financial Officer (CFO), or a person delegated by the CEO or CFO must certify the MCO/agency file. Once the file is certified it is loaded into the data warehouse. The file must be certified by the date specified by the program area.

During the submission and edit process, status reports that provide feedback on the data transfer are available to the submitter on the Reports page in the IES application. These status reports outline specific details of any errors triggered during processing with drill-down capability and submission specific information.

Making Changes and Maintaining Integrity of Data

One of the business goals of encounter reporting through the IES application is to maintain a database of information that matches the source data. Note the following requirements:

- All changes to certified data must be made using the encounter adjustment process exclusively. This is the only way the MCO/agency source claims data and the LTCARE IES data repository will remain synchronized.
- The MCO/agency claims history records must be a snapshot of the data at a point in time, so it matches the encounter data that has been reported through LTCARE IES.
- The reconciliation process (QA reports) allows verification between the source data and the DHS database. When discrepancies are found, the IES team works with the MCO/agency to identify the discrepancy and resolve the issue(s).

Submitting Encounter Data

Submission Process

Encounter reporting has designed submission periods for each line of business. Encounters posted are events that are finalized (paid or denied with a corresponding EOB). Once certified, there are no changes to these records, although you may alter an encounter through an adjustment process. Adjustments are treated as an encounter record with similar rules as the original.

Encounter submissions are required to be certified by the established due date following the posting period and contain complete data posted in that period. Partial submissions are not acceptable. The begin posting date must always be the beginning of the submission period and the end posting date is the last day of the period. The previous period's submission must be accepted before any new submission is accepted. (**Note:** This does not apply to the initial data submission as a prior submission does not exist.)

Certified encounter reporting submissions are due no later than the assigned date or on the first business day following the due date.

Organizations should send the encounter submissions prior to the assigned due date to allow time to make corrections should the submission fail any edits. To meet the assigned deadline, the encounter submission must pass all critical edits in the LTCare IES validation program. When the MCO/agency is satisfied that the data transmitted is representative of the business transacted in the previous month, the MCO/agency must certify each submission attesting to its accuracy.

Extracting Data and the XML File Format

An XML file layout template is provided on the [DHS website]() for the different waiver programs. A Data Dictionary that contains specific details of each data element, including the maximum length of these fields, is also available.

The following are issues to consider when creating the XML file:

- Comments use the following syntax: <!—This is a comment □
- Do not generate XML tags for fields that do not contain data. For example, if there is no cmo_reason_code, then omit this line from the XML file for that record.
- There is currently no support for the NULL attribute.
- It is very important that the first line of the XML file is exactly as provided here. There must not be any characters before this line in the file.

  <? Xml version="1.0" encoding="UTF-8" ?>

- The last line of the XML file must be a proper end of file. Do not end the file with a single Line Feed (LF) without a Carriage Return (CR). Do not end the file with any extraneous characters.
- Issue a line break after each line of XML code, otherwise the file is read as one (very long) line. A very long line is difficult to parse, and causes difficulty in issuing meaningful error references.
- A few special characters (<, >, &, ‘, or “) confuse the XML parser. The XML parser strips the data from the XML file. Each occurrence of these special characters must be issued with a specific escape sequence (or character string). These characters are often found in provider names, but they may exist in other fields as well. The following table illustrates the escape sequence mapping:

Character	Escape Sequence
< (less than)	<
> (greater than)	>
& (ampersand)	&
‘ (apostrophe)	'
“ (quotation mark)	"

For example:
<billing_provider_last_name>Jones & Smith</billing_provider_last_name>

Becomes:
<billing_provider_last_name>Jones & Smith</billing_provider_last_name>

Or send:
<billing_provider_last_name>Jones and Smith</billing_provider_last_name>

Note: The semicolon is part of the sequence.

Submission File Edits for Header and Details

Edits are imposed at the parser and content levels. Parser editing is for length, type and requirement (if field is always required or situational.) Content editing is generally for valid values and dependencies. Content editing does not take place if a parser edit is triggered. A submission file may contain only header information and not contain any detail records. For example, various business circumstances may force claims payment to be suspended for a given month where this type of file submission may be needed to maintain a proper reporting sequence.

Accessing Online Documentation

Current documentation on encounter reporting is available on the DHS website at www.dhs.wisconsin.gov/ies/index.htm.

Application Support

The LTCare Information Exchange System application is available 24/7. Encounter reporting application support is available, Monday through Friday, from 8:00 a.m. to 4:00 p.m. excluding holidays.

If you have any questions or problems, email IES Support at dhsltcareencounterhelp@dhs.wisconsin.gov.

Change Log

Date	Changes	Changed By	Remarks/Reason
3/24/2017	Updated text and figures to represent changes and enhancements made since the last update.	Nancy Crawford	We are moving away from Encounter Reporting because many of the programs we serve do not have encounters.
3/24/2017	The User Implementation Guide will be separated into a User Guide (for nontechnical staff) and an Implementation Guide for the technical staff.		
3/24/2017	Moved the instruction section for XML construction to the Implementation Guide.	Nancy Crawford	Technical staff will build the XML file.
4/21/2017	Moved the considerations that MCOs/agencies should think about before planning for the implementation guide.	Nancy Crawford	Technical staff more likely to review these considerations.
5/31/17	FAQ moved to its own document so that Implementation Guide does not need to be changed as often.	Nancy Crawford	
5/31/17	The User and Implementation Guides will be written in a broader fashion by waiver and nonwaiver programs.	Nancy Crawford	

Date	Changes	Changed By	Remarks/Reason
6/1/2017	User and Implementation Guides are listed by waiver and non-waiver programs to be applicable to organizations that report incidences, contacts, etc.	Nancy Crawford	