Frequently Asked Questions

Washington State Health Care Authority

Draft companion guide: encounter files

Note: If the Pharmacy Benefit Manager (PBM) is reporting, it is on behalf of the Managed Care Organization (MCO), so the PBM and/or MCO are the same in these instances.

General

Question: Will there be a testing process and period for MCOs to submit test files containing the new data?

Yes, there will be a testing period for the plans to submit files with the new and updated fields. Stay tuned for exact dates.

** Please see the draft encounter file companion guide for changes to what MCOs send to Health Care Authority (HCA) and the questions below that apply to that draft companion guide.

Question: Confirming that none of the new data elements identified in Segment 23 need to be reported for a B2 – ***Reversal transaction***

Answer: The new fields will need to be reported on B2 transactions.

Encounter file field questions

*****Segment Identifier 11 (Pricing)*****

430-DU	Gross Amount Due	8	s9(6)v99	D	O	Must use

Definition: Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Other Amount Claimed' (480-H9).

ProviderOne Companion Guide Rules D.0:

Total amount remitted to the pharmacy entered as '$$$$$$cc'.

Question: For this field, is state expecting the total that the PBM sends to the pharmacy on behalf of the MCO? Or the total of (PBM portion paid to the pharmacy+ patient portion paid to the pharmacy + other payer(s) portion paid to the pharmacy)?

Answer: This should include all sources.

*****Segment Identifier 23 (Response Pricing) *****

501-F1	Header Response Status	1	x(1)	A/N	M	Must use

Definition: Code indicating the status of the transmission.

ProviderOne Companion Guide Rules D.0:

Code indicating the status of the transmission.
A = Accepted - Code indicating the receipt and approval of the transmission.
R = Rejected - Code indicating the rejection or refusal to accept the transmission.

Question: Since this is normally a field used on a response file sent back to an outbound encounter file submission to indicate if the transmission of that file was accepted or not, what is the expectation for us to populate this at a record level on an individual outbound encounter record? Would the expectation be that this would always be populated with an "A" for each record since we wouldn't be rejecting the transmission of our outbound encounter record that we are sending to you? Need clarification on what would account for a code of 'R' (rejected) in this field?

Answer: This is the Transmission response at header level from the MCO to the pharmacy. When the transmission is accepted or rejected in the response back to the pharmacy, you would send that information on the National Council for Prescription Drug Programs (NCPDP) file to HCA.

Question: What is the expected usage of this data element? Are we to identify if the PBM approved or denied the incoming claim that is now being reported as an encounter? How is this different from 399-Z3?

Answer: For usage, please see the answer on the above question. The 501-F2 is transmission level and the 399-Z3 is transaction level.

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409-Z8	Allowed Ingredient Amount	8	s9(6)v99	N	M	Must use

Definition: The Allowed Ingredient Amount cost calculated by the MCO

ProviderOne Companion Guide Rules D.0:

The Allowed Ingredient Amount cost calculated by the MCO or PBM, Enter as $$$$cc.

Question: Is the expectation that this field be populated with the Ingredient Cost portion of the claim that is paid to the pharmacy by the PBM? For example, if PBM is paying the pharmacy $12.00 of which $10.00 is the ingredient cost and $2.00 is the dispending fee, are you looking for this field to be populated with $10.00?

Answer: It should be populated with amount the PBMs will pay the Pharmacy for the ingredient. In your example above yes, we would expect $10.
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Question: Field 409-Z8 was added, "Allowed Ingredient Amount" to the file, with the definition "The Allowed Ingredient Amount cost calculated by the MCO or PBM, Enter as $$$$cc." We're not able to find an NCPDP definition for this field. Please clarify who's cost should be reported here.

Answer: Maximum amount (contracted rate) the PBM would pay to the pharmacy for the ingredient on the claim.

Question: Due to the addition of this new element, is there any impact to reporting the Total Paid Amount? Is this element specifically included or excluded from the Total Paid Amount calculation?

Answer: The allowed amount and paid amount are separate from one another.

Question: For this field are they looking for the total amount that the pharmacy is paid by PBM?

Answer: No, this should be the maximum amount (contracted rate) the PBM would pay to the pharmacy for the ingredient on the claim.

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509-F9	Total Amount Paid	8	s9(6)v99	D	O	Must use

Definition: Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (506-F6),'Dispensing Fee Paid' (507-F7),'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL),'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4),less 'Patient Pay Amount' (505-F5) and 'Other Payer Amount Recognized' (566-J5).

ProviderOne Companion Guide Rules D.0:

Comments: Format=$$$$$$cc Examples: Ingredient Cost Paid (506-F6)=$20.00+ Dispensing Fee Paid (507-F7)=2.00+ Flat Sales Tax Amount Paid (558-AW)=1.00+ Percentage Sales Tax Amount Paid (559-AX)=.00+ Incentive Amount Paid (521-FL)=00+ Other Amount Paid (565-J4)=.00+ Professional Service Fee Paid (562-J1)=.00-Patient Pay Amount (505-F5)=5.00- Other Payer Amount Recognized (566-J5)=3.00 = Total Amount Paid (509-F9) =$15.00 This field would reflect: 150{

Question (CCW, AMG, and MHC): For this field is state looking for the total amount that the pharmacy is paid by PBM?

Answer: Yes.

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399-Z3	Record Status Code	1	x(1)	A/N	O	Used

Definition: Identifies the transaction status as assigned by the processor.

ProviderOne Companion Guide Rules D.0:

Identifies the transaction status as assigned by the processor.

1 - Paid
2 - Rejected
3 - Reversed
4 - Adjusted
5 - Captured
6 - Reverse

Question (MHC): What is the difference between 3-Reversed and 6-Reverse?

Answer: We are getting further clarification on how these are expected to be used and the requirements. The standard definitions are:

3 – Reversed - Code indicating that the paid transaction was cancelled

6 – Reverse - Captured- Code indicating that the captured transaction was cancelled.

Question (MHC): Does the value '2-Rejected' identify an incoming claim that was denied by the PBM? If not, please clarify

Answer: Yes.

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510-FA	Reject Count					O	Used
510-FA	Reject Count	2	9(2)	N		M	Must use
	Definition: Count of 'Reject Code' (511-FB) occurrences. **ProviderOne Companion Guide Rules D.0:** *Count of Reject Code (511-FB) occurrences.*						
510-FA	Reject Count				5	O	Used
511-FB	Reject Code	3	x(3)	A/N		O	Used
	Definition: Code indicating the error encountered. **ProviderOne Companion Guide Rules D.0:** *The MCO reject codes. This code indicates the error encountered. - Occurs up to 5 times*						

Question (CCW, AMG and MHC): Is the expectation that we start encountering Point of Sale (POS) rejections, as we currently do not?

Answer: Yes, you will now be reporting all paid and rejected claims (federal requirement).

Question (MHC): Confirming that this data element is identifying the number of denial reasons that were applied by the PBM for the incoming claim. If not, please clarify.

Answer: Yes.

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257-Z9	Formulary Status	1	x(1)	A/N	O	Used
	ProviderOne Companion Guide Rules D.0: *Please Use* *I - Non Preferred* *P - Preferred*					

Question (MHC): Confirming this data element is reporting whether the reported National Drug Code (NDC) is identified as preferred in the WA-HCA formulary (not the Kaiser Permanente (KP) formulary). If not, please clarify.

Answer: Washington Preferred Drug List (PDL).