Last updated: May 20, 2024

Frequently Asked Questions

Washington State Health Care Authority

Draft companion guide: encounter files

Health Care Authority (HCA) is in the process of replacing the Pharmacy Point of Sale (POS) system. As a result, there will be changes to encounter submission requirements. Please review the draft Pharmacy encounter companion guide, sent to MCOs July 2022 and updated January 2023, and the related questions below.

Please note: If the Pharmacy Benefit Manager (PBM) is reporting, it is on behalf of the Managed Care Organization (MCO). The PBM and MCO are the same in these instances.

General

Question: How is the quarterly encounter data reconciliation going to work with the new POS system?

Answer: The quarterly encounter data reconciliation process will not change with the new POS system, regardless of the go live date. HCA will need to account for the data coming from two systems, but MCOs shouldn't see an impact.

Question: Will the timeline for the new/changed data elements on the D.0 encounter file submission be the same as the new POS system go-live (6/8/2024)?

Answer: Any encounter files submitted on or after go-live, 6/8/2024, will be expected to include all the new data elements, including denied encounters.

Question: Will there be a post implementation transition period allowing MCOs to continue submitting the "old" file structure or is it a hard cutover?

Answer: The new POS system cutover will be a "hard" cutover, meaning there will be no transition period to continue submitting files with the previous file format.

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

Answer: HCA staff will begin testing May 1. Once HCA staff have completed their testing, MCOs will be invited to test. Exact dates are unknown at this point, but HCA anticipates sometime in late July or August. HCA will share more detailed information once available.

Question: Will the new data elements identified in Segment 23 need to be reported for a B2 – Reversal transactions?

Answer: Yes, the new data elements 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 field 430-DU, is HCA expecting the total the PBM sends to the pharmacy on behalf of the MCO or the total of all of the following: PBM portion paid to the pharmacy, patient portion paid to the pharmacy, and other payer(s) portion paid to the pharmacy?

Answer: Field 430-DU should be the total paid to the pharmacy from all sources noted in the definition.

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: The Header Response Status (501-F1) field is normally 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 MCOs to populate this on an individual outbound encounter record?

Answer: This is the transmission response at header level from the MCO to the pharmacy. The file sent to HCA should have the field populated with an "A" if the transmission from the pharmacy was paid by the MCO's PBM or an "R" if the transmission from the pharmacy was rejected by the MCO's PBM.

Question: How is field 501-F1 different from field 399-Z3?

Answer: Field 501-F1 is *transmission* level and field 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 field 409-Z8 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 dispensing fee, should the field to be populated with $10.00?

Answer: Yes. Field 409-Z8 should be populated with the amount the PBM would pay to the pharmacy for the ingredient on the claim. In the example above, HCA would expect $10.

Question: Who's cost should be reported on field 409-Z8?

Answer: Field 409-Z8 should be populated with the amount the PBM would pay to the pharmacy for the ingredient on the claim.

Question: Due to the addition of field 409-Z8, is there any impact to reporting the total paid amount? Is the amount in field 409-Z8 specifically included or excluded from the total paid amount calculation?

Answer: The total paid amount paid field is not the same field as 409-Z8 and should not reflect the same value. The allowed ingredient amount, field 409-Z8, should be populated with the amount the PBM would pay to the pharmacy for the ingredient on the claim. .

Question: Should field 409-Z8 be submitted with the total amount that the pharmacy is paid by PBM?

Answer: No, this should be the amount the PBM would pay to the pharmacy for the <u>ingredient</u> 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 Should field 509-F9 be submitted with 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 : What is the difference between 3-Reversed and 6-Reverse on field 399-Z3?

Answer: These are standard NCPDP definitions. HCA expects for the MCO to send the encounter reflecting the same status the MCO's PBM sent back to the pharmacy:

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

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

Question: Does the value '2-Rejected' identify an incoming claim that was rejected by the PBM?

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 Is the expectation that MCOs report Point of Sale (POS) rejections?

Answer: Yes, MCOs will be required to report all claims, including rejected claims.

Question: Should field 510-FA be populated with the number of rejection reasons that were applied by the PBM on the incoming claim.

Answer: Yes, field 510-FA should be the count of rejection reasons applied to a claim.

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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: Should field 257-Z9 be populated with the preferred/non-preferred drug status from the WA-HCA formulary?

Answer: Field 257-Z9 should be populated with the preferred/non-preferred drug status from the Apple Health Preferred Drug List (PDL).
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