

Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES

CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES

Table of Contents

1.	Introduction	2
2.	Guidelines for 837 Files.....	2
A.	Prerequisites	2
B.	Essential Documents.....	2
C.	Level 1 Testing.....	2
D.	999 Response Files.....	3
E.	Remit Response File.....	3
F.	Level 2 Testing.....	3
G.	Guidelines for Submitting 837 Production Files	3
3.	Guidelines for NCPDP Files.....	4
A.	NCPDP 1.2 Input Batch File	4
B.	Required Transmission Header Record.....	5
C.	Transaction Detail Data Record	6
D.	Required Transmission Trailer Record	6
E.	NCPDP File Specifications.....	7
F.	Direction to create NCPDP file.....	7
G.	NCPDP Testing.....	8
4.	Void Submission and processing.....	8
A.	Pharmacy voids	8
B.	Professional voids	8
C.	Institutional voids.....	8
D.	Institutional Voids Technical Workflow	10

Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES

1. Introduction

Illinois Medicaid managed care organizations (MCOs) are required to submit encounter claims to the Illinois Department of Healthcare and Family Services (HFS) in Health Insurance Portability and Accountability Act (HIPAA) compliant formats.

This guide is not intended to replace the ACS X12 Technical Report Type 3 (TR3) documents published by Washington Publishing or the HIPAA Companion Guides published by HFS. Rather, this guide is to be used in conjunction with those documents.

2. Guidelines for 837 Files

A. Prerequisites

The MCO must address the following items in the early stages of preparing to submit 837 files.

1. The plan must have HFS tradelink information to submit test files. Tradelink information is unique to the MCO and is provided by the HFS Bureau of Managed Care (BMC) to the MCO during the enrollment process.
2. The plan should be able to identify each claim by assigning a unique claim ID.
3. The plan must send their MCO paid amount for the HCP02 value. The HCP02 value for institutional is expected to be at claim level. For professional, it is expected to be at the line level.
4. The plan should prepare EDI files for testing by mimicking the production process.
5. File size should not be more than 5 MB for test nor contain more than 5000 claims per SE-ST segment.

B. Essential Documents

The MCO must be familiar with each of the documents below. With few exceptions, HFS expects health plans to submit encounter data using the same business rules that providers use to submit fee-for-service claims. The health plans should become familiar with the following documentation prior to submitting encounter data test files to HFS:

- A ACS X12 TR3 Documents – available from Washington Publishing
- B HFS Companion Guide – available at the following HFS website:
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx>
- C HFS Provider Handbooks – available at the following HFS website:
<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx/>
- D HFS Provider Releases – available at the following HFS website :
<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx>

C. Level 1 Testing

The objective of Level 1 testing is to validate the MCO's ability to submit files successfully to the HFS test environment and the ability to receive 999 responses and remit files.

1. Input file naming convention:
Send filename: xxxxxxxx.Dmmdyy.Thhmmss.MI.EDIyyyy
Where: xxxxxxxx = assigned RACF UserID (upper case)
mmdyy = vendor creation date
hhmmss = vendor creation time

Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES

yyyy = TEST (for test files), PROD (for production files)

2. This File should not contain more than 20 claims.
3. The MCO should be able to submit files with correct trade links.
4. The MCO should be able to receive the 999s response file using their assigned USS port.

D. 999 Response Files

1. AID0XXX.Dmmddy.Thhmmss.MO.EDITEST – Test 999
2. AID0XXX.Dmmddy.Thhmmss.MO.EDIPROD – PROD 999
3. AID0XXX – Your plan profile ID or RACF ID assigned by HFS

There are two compliance checks for 837 files. If the file is accepted by HFS, the MCO will receive one 999 response for each accepted file. If the file clears the first compliance check and fails at the second compliance check, the MCO will receive two 999 responses for each file submitted. It will show the first 999 responses as accepted while the second 999 responses will show as rejected (both 999s generated will have a time difference of not more than 5 minutes in most situations). If the MCO receives two 999 responses, the file or ST-SE segments got rejected at the second compliance check. The MCO is expected to correct the EDI file structure.

4. AID0XXX – MCO plan profile ID or RACF ID assigned by HFS
5. The MCO should be able to retrieve the remit file generated at the end of the process and reconcile internally.

E. Remit Response File.

1. AIDP.P1BPDV03.TC* – Proprietary Test remittance file
AIDP.P1BPDV03.PC* – Proprietary Production remittance file
(*2 byte Source of Data or Submitter ID)
2. HFS will not provide 999 response file names nor remit file names via email when the plan is in production status .The MCO is expected to set up the process to retrieve these files when they set up their USS port with HFS.
3. End to End testing process time is normally 5-7 business days.

F. Level 2 Testing

1. The objective of Level 2 testing is to validate the MCO’s ability to understand the remittance advice and errors listed on the remit file. Errors generated can be based on various business rules related to Providers, Recipients, and structure of the X12 file. The file should contain 150-200 claims. Sending more than 200 claims will make it difficult to reconcile and resolve errors.
2. The MCO should be able to receive the 999 response file using the USS port
3. The MCO should be able to retrieve remit files generated at the end of the testing process.
4. HFS adjudicates claims on the line level for Professional and NCPDP claims, and on the claim level for Institutional claims.
5. The MCO should be able to reconcile claims submitted to HFS and resolve errors that are received on the remittance file before moving to production.
6. The End to End process time is normally 5-7 business days.
7. Throughout the entire testing process, HFS will remain in touch with the MCO and will provide status updates on the files.

G. Guidelines for Submitting 837 Production Files

1. Ensure the file naming convention has a suffix of .PROD instead of .TEST prior to submitting the file to HFS.

Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES

2. Production files will be automatically processed.
3. Each X12 transaction may produce multiple 999 functional acknowledgement transactions. MCOs are expected to retrieve and reconcile 999s and rectify errors wherever applicable. If no functional acknowledgements are available with 24 hours of the file submission, contact the HFS Encounter Team.
4. Production remits are normally generated each Tuesday by end of the day. Please contact HFS Encounter Team if remits are not available by end of the day Wednesday.

3. Guidelines for NCPDP Files

NCPDP Batch 1.2 Pharmacy transactions will be processed by the HFS contractor CHC. Please refer to the MCO Encounter Pharmacy Companion Guide for information on error handling, file size, Payor sheet and other information regarding the NCPDP Batch 1.2 submission and response transactions.

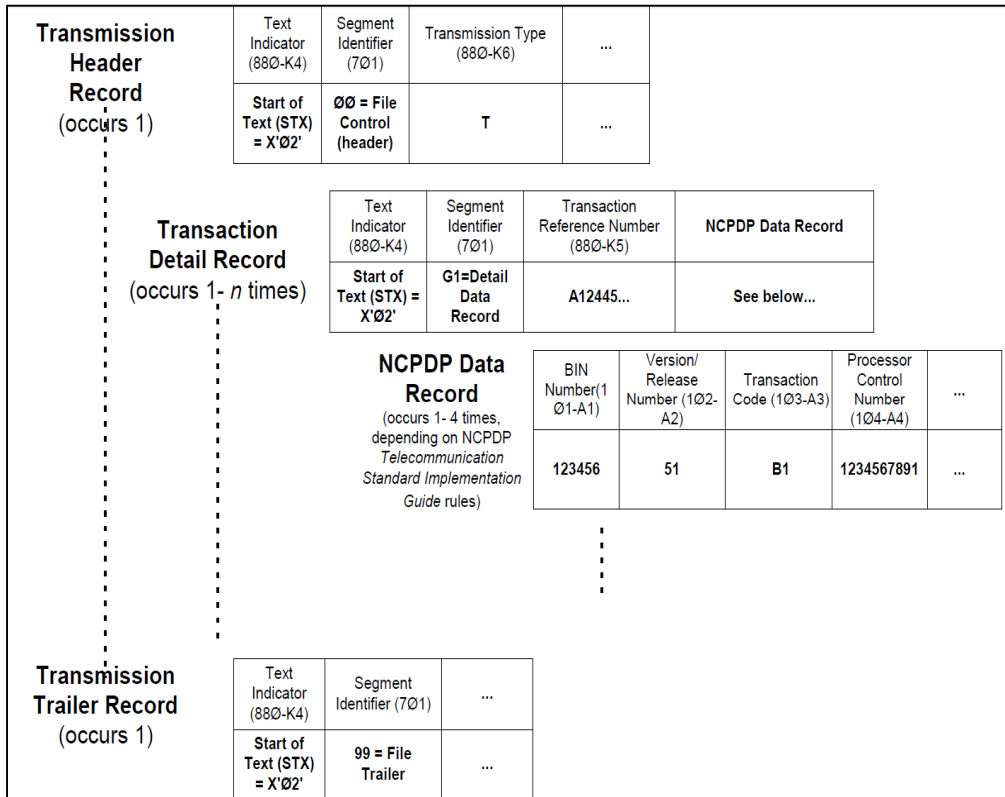
<https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/illinoisrx/Pages/default.aspx>

A. NCPDP 1.2 Input Batch File

NCPDP Input batch file shall meet following criteria.

1. The batch file will consist of 3 sections: the header, data, and trailer. The header and trailer must be present in every transmission.
 - a. Transmission Header 1 per file
 - b. Transaction Detail Data.... up to 20,000 records per file
For test file 20,000 records are the limit. MCO can submit up to 499,999 records per day in production.
 - c. Transmission Trailer 1 per file
2. The maximum number of records in a file is including 1 Transmission Header and 1 Transmission Trailer. Start of Text and End of Text is used to mark the beginning and ending of each record within a file. If a Processor wishes to send the Detail Records to an on-line system, the Start and End of Text fields can be used to feed easily into current real-time processing. The Start and End of Text fields are also used to delimit the records within the file, as variable length Detail Records may be sent in the file.

**Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES**



B. Required Transmission Header Record

FIELD	FIELD NAME	TYPE	LENGTH	START	END	VALUE
880-K4	Text Indicator	A/N	1	1	1	Start of Text (STX) = X'02'
701	Segment Identifier	A/N	2	2	3	00 = File Control (header)
880-K6	Transmission Type	A/N	1	4	4	T = Transaction R = Response E = Error
880-K1	Sender ID	A/N	24	5	28	To be defined by processor/switch.
806-5C	Batch Number	N	7	29	35	Matches Trailer
880-K2	Creation Date	N	8	36	43	Format = CCYYMMDD
880-K3	Creation Time	N	4	44	47	Format = HHMM
702	File Type	A/N	1	48	48	P = production T = test

**Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES**

1Ø2-A2	Version /Release Number	A/N	2	49	5Ø	Version/Release of Header Data
88Ø-K7	Receiver ID	A/N	24	51	74	To be defined by processor/switch.
88Ø-K4	Text Indicator	A/N	1	75	75	End of Text (ETX) = X'Ø3'

C. Transaction Detail Data Record

FIELD	FIELD NAME	TYPE	LENG	STA	END	VALUE
88Ø-	Text Indicator	A/N	1	1	1	Start of Text (STX) = X'Ø2'
7Ø1	Segment Identifier	A/N	2	2	3	G1 = Detail Data Record
88Ø-	Transaction Reference	A/N	1Ø	4	13	To be determined by provider
	NCPDP Data Record		Varies	14	varies	
88Ø-K4	Text Indicator	A/N	1	varie s	varies	End of Text (ETX) = X'Ø3'

NOTES:

The data record to be transmitted in this batch standard will follow the NCPDP *Telecommunication* Standard Version 3.2 or any higher Version/Release of the NCPDP Telecommunication Standard.

<https://www.illinois.gov/hfs/SiteCollectionDocuments/DØPayerSheetILPOP20171127.pdf>

D. Required Transmission Trailer Record

FIELD	FIELD NAME	TYPE	LENGTH	START	END	VALUE
88Ø-K4	Text Indicator	A/N	1	1	1	Start of Text (STX) = X'Ø2'
7Ø1	Segment Identifier	A/N	2	2	3	99 = File Trailer
8Ø6-5C	Batch Number	N	7	4	1Ø	Matches header
751	Record Count	N	1Ø	11	2Ø	
5Ø4-F4	Message	A/N	35	21	55	
88Ø-K4	Text Indicator	A/N	1	56	56	End of Text (ETX) = X'Ø3'

Here is a sample example of a header and trailer: -

Header –

.ØØT30000000ØICP 1431401201411100737 P12ILMEDICAID .

Trailer –

**Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES**

.9914314010000000102 .

The batch number should be same in the header and trailer. The record count should be equal to header + # of detail records + trailer.

E. NCPDP File Specifications

A MCOs should refer to the Payor sheet link below for detailed specifications on how to make NCPDP requests and interpret the NCPDP responses. Specifications for header and trailer records for NCPDP request is attached below.

<https://www.illinois.gov/hfs/SiteCollectionDocuments/D0PayerSheetILPOP20171127.pdf>

B Field IDs example:

G10242603062008259D0B1PCONTROLNO1010120120120
 20140319D012000101-AM01C419590124C52CBXXX-AM04C2012012012-AM07EM1D2000005689112E103D70120120120
 1E70000030000D304D5030D61D80DE20140319DF11DJ4NX1DK09C81E226643006-AM11D90000178EDC0000010{H71H80
 4H90000188EDQ0000188EDU0000188E-AM03EZ01DB2102102102DRANYONPM21752863432E01DL6542361457 4E
 2JYTRERX

We have highlighted the segment separators in pink and the field identifiers in yellow.

See the table below for an example of what some of the field Identifiers are for in the AM07
 e

Field Identifier	Description of field identifier
EM ⁿ	Prescription/Service Reference Number Qualifier
D2 ^e	Prescription/Service Reference Number
E1 ⁿ	Product/Service ID qualifier

F. Direction to create NCPDP file

1. The Sender ID in the Transaction Header must carry the LOB (Line of Business) abbreviation i.e. established in the trading partner configuration guide.
2. Fields must be present in file if defined as REQUIRED and may be in the file is defined as SITUATIONAL.
3. When a field is defined as 'N' (Numeric), it must be Zero Padded to fill all required spaces.
4. When a field is defined as 'N' (Numeric) and 'S' (Signed) it will accept Overpunch values.
5. When a field is defined as 'N' (Numeric) and not 'S' (Signed) it must be a zero padded assumed decimal integer.
6. When a field is defined as an 'A/N' (Alpha Numeric) id does not need to be padded with spaces out to the full field length.
7. The row count value in the Transaction Trailer much matches the Record Count + Header line + Trailer line.
8. Please do not submit E7 with over punch. You can never have negative values for Quantity dispensed.

**Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES**

Signed Overpunch chart
(reference)

Code	}	J	K	L	M	N	O	P	Q	R	{	A	B	C	D	E	F	G	H	I
Digit	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
Sign	-	-	-	-	-	-	-	-	-	-	+	+	+	+	+	+	+	+	+	+

G. NCPDP Testing

MCO will conduct their testing with the CHC. HFS will provide detail guidelines on testing of NCPDP files with CHC. CHC will provide response file for each submitted NCPDP test file.

4. Void Submission and processing

HFS accepts both void and replacement requests for NIPS and Pharmacy encounters. MCO can find instructions on submitting void and replacement transactions in HFS companion guides.

A. Pharmacy voids

HFS accepts and process pharmacy voids electronically. MCO can submit pharmacy voids as per claim reversal guidelines provided in NCPDP Payor sheet.

<https://www.illinois.gov/hfs/SiteCollectionDocuments/D0PayerSheetILPOP20171127.pdf>

B. Professional voids

HFS accepts and process professional voids electronically. MCO can submit professional voids as per guidelines provided in 837 professional companion guide.

<https://www.illinois.gov/hfs/SiteCollectionDocuments/837p.pdf>

C. Institutional voids

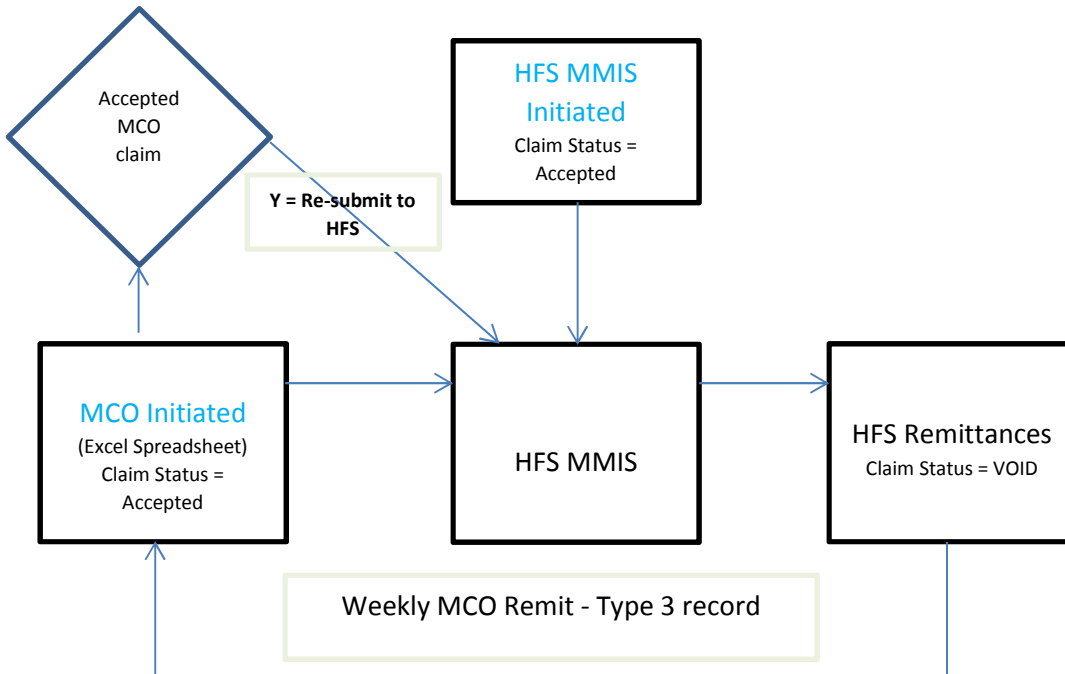
HFS Encounters Team is the primary point of contact for follow-ups and reporting issues related to this process. HFS Institutional void process in listed below.

1. The HFS MMIS system currently cannot process electronic voids for Institutional claims; MCOs must submit void requests by filling out the spreadsheet in the format that is specified in section 6 of Chapter 6 of this manual.
2. Void requests must be sent via secure FTP since PHI is included.
 - HFS Secure FTP link : <https://filet.illinois.gov/filet/PIMupload.asp>
3. Only include HFS accepted 837I Institutional encounters DCN details. Do NOT includes 837P Professional or Pharmacy encounters, as these needs to be submitted electronically to HFS.

Illinois Department of Healthcare and Family Services – Encounter Submission Manual
CHAPTER 3 –ENCOUNTER SUBMISSION GUIDELINES

4. Since the HFS institutional system processes the encounter at the claim level, the voids are also performed at the claim level and NOT at line level.
Therefore,
 - Please verify that only accepted HFS DCN information is included as part of the void request.
 - Wait for the response to the void request, before re-billing, replacing or adjusting the original claim with new 837I submissions.
5. Complete the void request by filling out each and every column of the spreadsheet completely and accurately. Contact the HFS Encounter Team for a complete list of email addresses to whom you are to send this void request.
6. HFS expects that the void request include the below information in the body of the email. Without this information, HFS will not process the request.
[Plan Name:](#)
[Contract:](#)
[Service Period:](#)
[Reason for voids:](#)
[Plan action post voids:](#)
[Member impact, if any:](#)
[Provider impact, if any:](#)
7. Though institutional voids are processed manually, the responses will be received in the HFS proprietary remit file.
Key information for void responses in the HFS proprietary remit file -
 - Process Type at position 568 – If the value is 19C, it is a void credit. Also, in this case of the first byte of the remit record will be 3, which mean credit adjustment – posted.
 - The original DCN or the DCN mentioned in REF*F8 in the X12, will be at position 545 and new DCN at position 103.
 - The provider reference number (CLM01) will not always be populated in position 1383; so plans needs to match the void responses based on key fields present on original DCN i.e. Provider NPI, Recipient ID and service dates
8. If these claims are Dual claims which have a payment component (MPA/DSH) which was made to the rendering facility by HFS, those payment including any interest, will be recouped with a 22C (will recoup from future vouchers) attach to the original claim. But, the health plans will still receive the responses in the remit for the void requests as a 19C.

D. Institutional Voids Technical Workflow



1. An encounter claim void is trigger 2 different ways.
2. HFS MMIS initiated void could be attributed to below that requires **encounter shadow pricing** –
 - a. Member eligibility updates.
 - b. Provider rate updates.
3. Once the voids are processed in HFS MMIS, the weekly remittances will have these responses like any other void responses.
4. If the MCO determines from the void responses, the encounter claim is still eligible for payment, then MCO need to re-submit the claim to HFS electronically as an 837I.

Below are some of the adjustment reason code remitted back to MCOs as applicable to 837I void processing in HFS MMIS -

- 1001 VOLUNTARY REFUND FROM PROV. DUE TO TPL PAYMENT
- 1007 DEPARTMENT INITIATED RECOVERY FROM PROVIDER
- 3202 INCORRECT BILLING INFORMATION
- 3307 REPLACEMENT CLAIM SUBMITTED -VOID/REBILL
- 3308 VOID CLAIM SUBMITTED
- 3561 VOID HOSPITAL ENCOUNTER DATA CLAIM
- 5000 CLAIM VOIDED/DATE CONFLICTS WITH INPATIENT STAY
- 8020 VOID DUE TO MCO COVERAGE CHANGE