

**CHAPTER 1 – OVERVIEW**

**I. INTRODUCTION**

The Encounter Manual is a reference guide for Contractors outlining the methods for submission and correction of encounter data as required by the Arizona Health Care Cost Containment System (AHCCCS). The manual contains chapters addressing encounter submission, file specifications, pending encounter correction requirements, and other encounter-related subjects.

**II. ENCOUNTER DEFINITION**

An encounter is record of a claim as adjudicated by that Contractor for a health care related service rendered by provider(s) registered with AHCCCS to an AHCCCS member enrolled with a capitated Contractor on the date of service.

AHCCCS further defines an encounter as the record of either an inpatient or outpatient claim for service; or each service line on a professional HCFA1500, Dental ADA, or NCPDP Pharmacy claim. AHCCCS encounters are maintained in the Prepaid Medical Management Information System (PMMIS).

**III. ENCOUNTER REPORTING REQUIREMENTS**

The Contractor is required to submit encounters for all valid Medicaid covered services. Including encounters which fall into the following categories:

- Paid
- Contractor denials for administrative reasons (as defined by AHCCCS)
- Zero Medicaid payment due to full reimbursement by another payer or bundling of services

AHCCCS utilizes national industry standards and code sets as published by X12N, NCPDP, and other data standard maintenance organizations for encounter reporting. The 837 and NCPDP technical reports, AHCCCS Companion Documents and the shared provider/reference files specify encounter reporting requirements that Contractors must follow in order to comply with contractual requirements. All of these documents are posted or referenced on the AHCCCS website and may be downloaded at no charge. Additionally, a quick link reference list is provided in Chapter 7, Page 1 of this manual.

**IV. PURPOSE OF ENCOUNTER DATA COLLECTION**

Submission of encounter data to AHCCCS is a mandatory requirement established by CMS and is the responsibility of the Contractor pursuant to its contract with AHCCCS. Complete, accurate, and timely reporting of encounter data is critical to the success of the AHCCCS program. All AHCCCS encounter data is housed in an encounter database that maintains Contractor specific designation. Encounter data is used for a variety of managerial and analytical purposes including but not limited to:

1. Evaluate health care quality

AHCCCS is a Medicaid managed care demonstration project that is partially funded by CMS. The health care service utilization data is analyzed and used by CMS and AHCCCS to evaluate quality of care.

2. Evaluate Contractor performance

The data from encounter records provides AHCCCS with information to evaluate the performance of each Contractor. For example, encounters are used to track specific services provided to members while enrolled with a particular Contractor, such as immunizations administered to children up to 24 months of age, and to calculate whether the Contractor is meeting minimum performance standards required by AHCCCS. Failure to meet these standards will result in corrective action plans and may lead to related sanctions.

3. Develop and evaluate capitation rates

Data used in developing capitation rate assumptions are based on encounter data submitted by Contractors. Encounter data is used by AHCCCS and its actuaries to calculate capitation rate ranges. In addition, encounter data is summarized, compiled and distributed to prospective offerors to assist them in the calculation of their capitation bids.

4. Develop Fee-For-Service (FFS) payment rates

Encounter data is used in conjunction with FFS claims data and other information to establish FFS provider payment rates.

5. Determine Disproportionate Share (DSH) payments to hospitals

Encounter data is used in the calculation of DSH payment allocations to hospitals.

6. Determine Reinsurance risk-sharing payments to Contractors

Encounter data is used as the basis for reinsurance payments.

7. Process reconciliations and risk adjustments

Encounter data is used in the calculation of reconciliations and risk adjustments associated with benefit and program reimbursement. Accurate calculation of these important Contractor revenue sources is solely based on the complete and timely submission of encounter data by the individual Contractors.

**V. GENERAL PRINCIPLES**

AHCCCS utilizes national industry standards and code sets as published by X12N, NCPDP, and other data standard maintenance organizations for encounter reporting; some requirements are specific to the AHCCCS program. The Contractor should ensure that submitted encounters are consistent with the following general principles.

1. Contractor specific identifiers as outlined by AHCCCS are required for all encounter submissions.
2. The reported service must be covered by AHCCCS according to Section D-Program requirements of the Contractor's AHCCCS agreement and as further defined by the AHCCCS Medical Policy Manual (AMPM).
3. The member must be AHCCCS eligible and enrolled with the Contractor on the date of service.
4. The service provider must be actively registered with AHCCCS on the date of service and be approved to provide the specific coded service(s) on that date of service.
5. A service must have been completed, and the provider's claim or encounter must be finalized as paid, administratively denied or zero Medicaid payment by the Contractor, before an encounter is submitted to AHCCCS.
6. The AHCCCS Medicaid program is the payor of last resort. Medicare and other third-party payment must be accounted for prior to submitting the encounter. Medicare and third-party payment amounts must be entered on the encounter in the appropriate fields. In cases where a member has exhausted Medicare or other benefits or the service provided is not covered by another payor, the only fields necessary to populate are the Medicare or other insurance approved and paid amounts using a value of zero.
7. If the Contractor makes a post payment/denial revision to a provider's claim after it has been encountered to AHCCCS, the Contractor must resubmit an appropriate replacement or void encounter to AHCCCS.

The AHCCCS contract year begins on October 1 and is used as the basis for reinsurance payment calculations. For specific Reinsurance requirements refer to the AHCCCS Reinsurance Manual located at <https://azahcccs.gov/PlansProviders/HealthPlans/Reinsurance>.

**VI. ENCOUNTER REPORTING DEADLINES**

The Contractor must submit encounter data within 240 days of the end of the month of service or the date of enrollment, whichever is later. Encounters submitted after this period may be subject to timeliness sanctions, as described in the contract.

AHCCCS defines the receipt date for encounters as the date the encounter is loaded to the mainframe database awaiting mainframe adjudication processing. To reach this point, encounter files must successfully pass the AHCCCS validation and translation process. An encounter that fails validation remains in the validator awaiting correction or resubmission (refer to companion documents for acknowledgement reporting). If an entire file fails this process, notification to the Contractor is placed in the Contractor’s outgoing directory on the AHCCCS FTP server. The encounters with a validator error or contained on failed files are not considered as having been received. In these situations, the receipt date of the encounter data does not begin until the data has been successfully loaded to the mainframe for adjudication processing.

**VII. ENCOUNTER FORMATS AND CLAIM FORM TYPES**

There are four different types of encounter formats accepted by AHCCCS. Each format corresponds to a claim form type standard:

- 837Professional (Form A=1500 claim) Encounters  
Used primarily for professional services, i.e., all HCPCS Level I (0XXXX-99999) and Level II (AXXXX-VXXXX), excluding dental services. These services include but are not limited to: physician visits, nursing visits, surgical services, anesthesia services, free standing ambulatory surgical centers (ASC), laboratory tests, radiology services, home and community based services (HCBS), therapy services, durable medical equipment (DME), medical supplies and transportation services.
  
- 837Dental (Form D=ADA claim) Encounters  
Used for dental services; i.e., HCPCS Level II codes beginning with DXXXX.
  
- 837Institutional (Form B=UB04 claim) Encounters  
Used for institutional facility based services, such as inpatient or outpatient hospital services, dialysis centers, hospice, birthing centers, nursing facility services, and other institutional services.  
  
*NOTE: Institutional encounters are further subdivided into three additional form types for encounter editing purposes:*
  1. Form type “I” for inpatient hospital services
  2. Form type “O” for outpatient hospital services
  3. Form type “L” for long-term care facility service*Form type is determined based upon the reported type of bill (bill type code)*
  
- NCPD (Form C) Encounters  
For retail pharmacy services, such as prescription medicines and medically necessary over-the-counter items.

**VIII. PROVIDER REGISTRATION AND PROVIDER TYPE TO FORM TYPE REQUIREMENTS**

CMS requires that AHCCCS Medicaid funds may only be used to reimburse AHCCCS registered providers. Encounters submitted for dates of service for which the provider is non-active or non-registered will be denied by AHCCCS. The AHCCCS registration requirements are explained on the AHCCCS website at:

<https://azahcccs.gov/PlansProviders/NewProviders/registration.html>

Registered providers are assigned a unique AHCCCS provider registration number in the PMMIS system.

Provider types are AHCCCS-defined categories for providers or facilities based upon the types of services they render. A provider/facility can have only one provider type per AHCCCS provider registration number. Provider types include hospitals, dentists, physical therapists, etc. A listing of provider type codes can be found in the weekly Provider Share Info reference files provided on the Secure File Transfer Protocol (SFTP) server for Contractors. See Chapter 5, Exhibit 5A, Provider Type Code P5 Record and in PMMIS table RF612. The AHCCCS assigned provider type code for a specific provider registration number can be found in provider reference files. See Chapter 5, Exhibit 5B, Demographic P1 Record.

AHCCCS requires the Contractor to use a specific encounter form type depending on the service provider's Provider Type. Services rendered by any registered provider type must be encountered to AHCCCS using the appropriate electronic transaction that corresponds to the required form type.

AHCCCS produces Provider Share Info reference files containing all registered providers including their assigned provider type. Descriptions and formats for these Provider Share Info reference files are included in Chapter 5 of this manual.

**IX. SERVICE UNIT GUIDELINES**

Based on generally accepted and reasonable medical standards of care, AHCCCS employs service unit guidelines for all services. These guidelines assign maximum units for given timeframes, e.g. daily. If encounters are submitted with units that exceed the guidelines then the encounters will pend for validation of medical necessity and, if applicable, override. Refer to Chapter 4-VII for a description of this process.

**X. TRANSPLANT ENCOUNTERS**

The Contractor is required to follow special rules for the submission of encounters for covered transplant services. Refer to the [AHCCCS Medical Policy Manual \(AMPM\)](#) for a list of covered transplant services and to the [Reinsurance Processing Manual](#) for covered services under the Transplant Reinsurance Program. AHCCCS has negotiated specialty contracts with providers for transplant services of which the Contractor may or may not choose to use.

**XI. REINSURANCE FORM TYPES**

Submission requirements by form type are as follows:

▪ 837I (Form B) Encounters

All contracted transplant services provided by the facility, including accommodation days, organ acquisition, and related inpatient or outpatient hospital services as submitted on the UB form using the proper revenue codes, procedure codes, and bill types. Services must be itemized as they would be on any non-transplant encounter and should not include physician or other non-hospital services.

▪ 837P (Form A) Encounters

All physician and other professional services provided as part of the transplant contract, including transportation and medical supplies as submitted on the 1500 form using the proper CPT and HCPCS procedure codes. Services must be itemized as they would be on any non-transplant encounter.

▪ NCPD (Form C) Encounters

Any prescription drugs dispensed by an independent pharmacy covered under the transplant contract as submitted on a Universal Form.

**XI. STANDARDIZED FILE LAYOUTS**

Record layouts for each of the four form type files (837P Form 1500, 837D Dental, 837I Form UB, and NCPDP Pharmacy) and the status files returned by AHCCCS (277U – Unsolicited Status) may be found in the appropriate X12N Technical Report or NCPDP Implementation Guide.

- The X12N technical reports are available from the Washington Publishing Company ([www.wpc-edi.com](http://www.wpc-edi.com)).
- The NCPDP implementation guide is available from the National Council for Prescription Drug Programs ([www.ncpdp.org](http://www.ncpdp.org)).
- Additionally, AHCCCS Companion Documents, which delineate AHCCCS specific and situational requirements, provide supplemental information for encounter reporting and are available from AHCCCS web site at:  
<https://azahcccs.gov/Resources/EDI/EDITEchnicalDocuments.html>

**XII. ACCURATELY REPORTING ENCOUNTER DATA**

1. Coordination of Benefits

One goal of the technical reports is to “develop the capability of handling coordination of benefits (COB) in a totally electronic data interchange (EDI) environment.” AHCCCS utilizes the Provider-to-Payer-to-Payer COB Model identified in the technical reports. AHCCCS is the designated destination payer. Other payers including

AHCCCS Contractors, report payer-specific data in other payer loops as outlined in technical documents.

Information concerning reporting and an explanation of COB are in the technical reports. AHCCCS encounters are edited against AHCCCS PMMIS TPL/COB records. Encounters that should have coordination of benefits, as indicated by the member's TPL records, will deny at AHCCCS and be returned for required COB information. If the Contractor determines that the AHCCCS Member's PMMIS TPL records are in error or need to be updated the Contractor should submit TPL referral information as required by contract. This information may be submitted using either the AHCCCS TPL referral file submission process <https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/>

or online using the AHCCCS contracted TPL vendor's TPL Referral Web Portal. <https://www.azahcccs.gov/PlansProviders/HealthPlans/tpl.html>

2. National Correct Coding Initiative

An explanation of reporting bundled and unbundled services is also in the technical reports. AHCCCS employs the National Correct Coding Initiative (NCCI) in encounter adjudication processing. Inappropriate application of NCCI bundling and unbundling standards may cause resulting encounter pends.

3. Claim to Encounter accuracy

The submitted encounter, i.e., post-adjudicated claim, should be a mirror image of the provider's claim and how the Contractor processed the claim. Data must not be stripped or altered from the provider's submitted claim simply because it is not a necessary data element for AHCCCS encounter processing. Contractors should always submit all relevant and defined adjudicated claims data elements.

Additional data must be reported when situations identified in the technical specifications are met. In addition, reporting of other specified data elements may aid in processing encounter data or in bypassing certain encounter edits, e.g., submission of the Contractor's prior approval/authorization or certification number may bypass certain medical review type edits. Simple encounter examples may be found in the 837 and NCPDP AHCCCS Encounter Companion Documents located at: <https://www.azahcccs.gov/Resources/EDI/>

4. Encounter processing outcomes

The Status File (277U) is produced at the conclusion of the AHCCCS edits and audits to inform the Contractor of the encounter file processing outcome. The 277U file consists of information that indicates

- All encounters that were finalized during processing and
- All pended encounters following processing.