ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ENCOUNTER MANUAL

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Encounter Manual

The Encounter Manual may be downloaded at no charge from the AHCCCS Website at www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html. Revisions and updates to the manual are posted to this site. Contractors are responsible for providing copies of this manual and any modifications to their staff, Third Party Administrators (TPAs), and other interested parties.

Definitions

Action Modes	The three (3) actions available to contractors to resolve pended encounter errors. The action modes are (C) correct, (A) approve, or (N) no change.
Adjudicated Claim	A claim received and processed by the Contractor, which resulted in a payment or denial of payment.
Administrative Denial	Encounter denied for administrative reasons for claims with valid Medicaid covered services provided to eligible members and denied by Contractors for administrative issues.
AHCCCS	Arizona Health Care Cost Containment System.
AHCCCS Contractor Operations Manual (ACOM)	Provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov.
AHCCCS Medical Policy Manual (AMPM)	Provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov.
Centers For Medicare and Medicaid Services (CMS)	An organization within the Department of Health and Human Services with oversight responsibilities for the AHCCCS program, including encounter reporting.
Children's Rehabilitative Services (CRS)	A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS-related services as specified in 9 A.A.C. 7.
Clean Claims	A claim processed without obtaining additional information from the provider of service or a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
Department of Child Safety Comprehensive Health Plan Program (DCS CHP)	A Contractor responsible for providing covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. § 8-512.
Claims Reference Number (CRN)	A unique 15-digit (12 digits for institutional services) number assigned to each encounter record by AHCCCS for tracking purposes. The first five numbers of the CRN contain the Julian date, which reflects the date of receipt for adjudication processing.
Contractor	An organization or entity with a prepaid capitated contract with the AHCCCS administration pursuant to A.R.S. § 36-2904 to provide goods and services to members directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.
Copayment	A monetary amount the member pays directly to a Contractor or provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.

Cost Avoidance	The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by the Contractor or before payment is made by the Contractor. This assumes the Contractor can avoid costs by not paying until the first or third party has paid what it covers first or having the first or third party render the service so that the Contractor is only liable for coinsurance and/or deductibles.
Covered Services	The health and medical services delivered by the Contractor as described in Section D, Program Requirements of the Contract.
Disenrollment	The discontinuance of a member's ability to receive covered services through a Contractor.
Division of Managed Care Operations (DMCO)	The division responsible for procuring contracts and implementing the ongoing oversight/performance management of AHCCCS' Managed Care Organizations (MCOs)
Division of Managed Care Services (DMCS)	The division responsible for oversight of MCO clinical operations and related compliance, quality management, performance improvement, ALTCS system design/oversight, and provider innovations.
Dual Eligible	A member who is eligible for both Medicare and Medicaid.
Encounter	A record of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a capitated Contractor on the date of service. An encounter is further defined as an inpatient or outpatient claim; or each service line on a professional (HCFA1500), Dental (ADA), or Pharmacy (NCPDP) claim.
Encounter Adjudication Edits and Audits	AHCCCS adjudication system for evaluating submitted encounter data for data quality problems and duplicate records.
Encounter Adjudication Process	The process includes receipt of New Day and Pended Encounter Correction files, encounter processing disposition, and distribution of Status and Pend Correction files and reports to Contractors.
Encounter Form Type	The four (4) encounter types are: • Professional services reported with an 837P (Form A/1500), • Dental services reported with an 837D (Form D/ADA) • Pharmacy services reported with an NCPDP transaction (Form C), and • Institutional services reported with an 837I (Form B/UB04). Institutional encounters are further subdivided into three (3) additional form types: Form type I for inpatient hospital services, form type O for outpatient hospital services, and form type L for long-term care facility services.
Encounter Manual	Reference guide for Contractors required to submit encounter data to AHCCCS.
Enrollee	A Medicaid recipient currently enrolled with a Contractor.
Enrollment	The process by which an eligible person becomes a member of a Contractor's plan.

Explanation of Benefits (EOB)	A form included with a check from the insurance carrier which explains the benefits paid and/or rejected charges.
Fee-For-Service Member	A Title XIX or Title XXI eligible individual not enrolled with an Acute or ALTCS Contractor.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act (P.L. 104-191), also known as the Kennedy-Kassebaum Act, signed August 21, 1996, addresses issues regarding the privacy and security of member confidential information.
Health Plan	See "CONTRACTOR."
Information Services Division (ISD)	The division responsible for processing and protecting data, PC's/laptops, the networking that lets them communicate, and all the systems with which they interact.
Julian Date	A five-digit representation of a date, where the first two digits describe the year, and the next three digits reflect the number of days since the beginning of the calendar year. For example, a January 20, 2008, date is expressed in Julian date format as 08020. The first five digits of an AHCCCS CRN comprise the Julian date that the encounter record was received.
Liable Party	Individual, entity, or program that may be liable to pay all or part of the medical cost of injury, disease, or disability of an AHCCCS applicant or member as defined in R9-22-1001.
Managed Care	Systems that integrate the financing and delivery of health care services to covered individuals utilizing arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management, and the coordination of care.
Management Services Agreement	A type of subcontract with an entity in which the owner of the Contractor delegates some or all the comprehensive management and administrative services necessary for Contractors' operation.
Material Omission	A fact, data, or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following a reasonable review of such report, contract, etc.
Medicaid	A Federal/State program authorized by Title XIX of the Social Security Act, as amended.
Medicare	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
Medical Services	Medical care and treatment provided by a Primary Care Provider (PCP), attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
Medically Necessary Services	Covered services provided by qualified service providers within their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
Member	An eligible person enrolled in AHCCCS, as defined in A.R.S. § 36-2931, 36-2901, 36-2901.01, and A.R.S. § 36-2981.

National Provider Identified (NPI)	A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.
National Council for Prescription Drugs Programs (NCPDP)	An American National Standards Institute (ANSI) accredited group that maintains several standard formats for use by the retail pharmacy industry, some of which are included in the HIPAA mandates.
New Day Encounter File	An encounter file submitted by a Contractor to AHCCCS containing encounter records that have not previously been processed by the adjudication system or are voids or replacements of previously processed encounter records.
Pended Encounter Correction File	An encounter file submitted by a Contractor to AHCCCS containing encounter records previously submitted and had failed the adjudication edit and audit process.
Pended Encounter File	An encounter file produced by AHCCCS for Contractors containing encounter records that have failed AHCCCS' adjudication edit and audit process.
Performance Standards	A set of standardized measures designed to assist AHCCCS in evaluating, comparing, and improving the performance of its Contractors.
Prepaid Medical Management Information System (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities, and reporting requirements.
Post Adjudication History (PAH)	A pharmacy file layout used for encounter submissions.
Provider	Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.
Provider Files	Files produced by AHCCCS for Contractors with information regarding all AHCCCS registered providers.
Provider Group	Two or more health care professionals who practice their profession at a common location (whether they share facilities, supporting staff, or equipment).
Qualified Medicare Beneficiary Dual Eligible (QMB Dual)	A person, eligible under A.R.S. § 36-2971(6), entitled to Medicare Part A insurance and meets certain income and residency requirements of the Qualified Medicare Beneficiary (QMB) program. A QMB, also eligible for Medicaid, is commonly referred to as a QMB dual eligible.
Reference Files	Files produced by AHCCCS for Contractors with information regarding service coverage and fee-for-service payment rates.
Regional Behavioral Health Authority (RBHA)	An organization under contract with the Arizona Department of Health Services (ADHS) to administer covered behavioral health services in a geographically specific area of the state. Refer to A.R.S. §36-3401 and A.R.S. Title 9, Chapter 22, Article 12.

Reinsurance	A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.
Specialty Physician	A physician specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.
Status File	A 277U file produced by AHCCCS includes all finalized encounter records, as well as all pended encounter records, following adjudication processing.
Subcontract	An agreement entered into by the Contractor with any of the following: • a provider of health care services who agrees to furnish covered services to member or • A person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22, Article 1.
Subcontractor	• A provider of health care who agrees to furnish covered services to members. • A person, agency, or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities. • A person, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the AHCCCS agreement.
Technical Coordination Unit (TCU)	The unit responsible for SSR and ticket business-user tracking, User Acceptance Testing review and executions, external trading partner testing development, tracking and coordination, external security facilitation with ISD, member BH data updates and referral coordination within AHCCCS.
Title XIX	The section of the Social Security Act which describes the Medicaid program's coverage for eligible persons (i.e., medically indigent).
Title XXI	The section (or Title) of the Social Security Act that authorizes the State Children's Health Insurance Program known as KidsCare in Arizona.
Transmission Submitter Number (TSN)	A number assigned by AHCCCS for each submitter of encounter data. Contractors must have one TSN and may have multiple TSNs. Multiple TSNs may be used to identify different lines of business, benefits packages, or subcontracts.
Transaction Insight (TI) Encounter Validation/ Translation Process	The AHCCCS front-end editor validates syntax, code sets, and code relationships. Records that successfully pass validation are translated into file formats to be processed by the adjudication system.

Value-Based Purchasing Payment Per Value-Based Purchasing Contract	A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures per the VBP strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment will typically occur after the completion of the contract period but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.

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Chapter One – Overview

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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 REPORTING REQUIREMENTS

Contractors are required to submit encounters for all valid Medicaid-covered services. Including encounters that fall into the following categories:

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

Contractors shall submit all lines of a claim as a single encounter, thereby matching the structure of the claim to its resulting encounter.

AHCCCS utilizes national industry standards and code sets published by the Accredited Standards Committee (X12N), the National Council for Prescription Drug Programs (NCPDP), and other data standard maintenance organizations for encounter reporting. The 837 and NCPDP technical reports, AHCCCS Companion Documents (see XI. Standardized File Layouts), and the shared provider/reference files specify encounter reporting requirements that Contractors must follow to comply with contractual requirements. These documents are posted or referenced on the AHCCCS website and may be downloaded at no charge. A quick link reference list is also provided in Chapter 7 of this manual.

III. PURPOSE OF ENCOUNTER DATA COLLECTION

Submission of encounter data to AHCCCS is a mandatory requirement established by the Centers for Medicare/Medicaid Services (CMS). It is the responsibility of Contractors according to their 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:

- 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.

- Evaluate Contractor performance:
    - Data from encounter records provides AHCCCS with information to evaluate each Contractor's performance. 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 Contractors are meeting the minimum performance standards required by AHCCCS. Failure to meet these standards will result in corrective action plans and may lead to related sanctions.
- 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.
- 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.
- Determine Disproportionate Share (DSH) payments to hospitals:
    - Encounter data is used in the calculation of DSH payment allocations to hospitals.
- Determine Reinsurance risk-sharing payments to Contractors:
    - Encounter data is used as the basis for reinsurance payments.
- 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.

IV. GENERAL PRINCIPLES

Contractors must ensure that submitted encounters are consistent with the following general principles:

- Contractor-specific identifiers as outlined by AHCCCS are required for all encounter submissions.
- AHCCCS must cover the reported service according to Section D, Program Requirements of the Contractor's AHCCCS agreement and as further defined by the AHCCCS Medical Policy Manual (AMPM).
- The member must be AHCCCS eligible and enrolled in a Contractor on the date of service.
- The service provider must be actively registered with AHCCCS on the date of service and be approved to provide the specific coded services on that date of service.
- The service must have been completed. The provider's claim or encounter must be finalized as paid, administratively denied, or zero Medicaid payment by Contractors before submitting an encounter to AHCCCS.

- The AHCCCS Medicaid Program is the payor of last resort. Medicare and other third-party payment must be accounted for before submitting the encounter. Medicare and third-party payment amounts must be entered on the encounter within the appropriate fields. In cases where a member has exhausted Medicare or another payer does not cover other benefits or the service provided, the only fields necessary to populate are the Medicare or other insurance-approved and paid amounts using a value of zero (0).
- If Contractors make a post-payment/denial revision to a provider's claim after it has been encountered to AHCCCS, Contractors must resubmit an appropriate replacement or void the 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.

V. ENCOUNTER REPORTING DEADLINES

Contractors must submit encounter data within 210 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 the Companion Guides for acknowledgment reporting). If an entire file fails this process, notification to the Contractor is placed in the Contractor's outgoing directory on the AHCCCS Managed File Transfer (MFT) server. The encounters with a validator error or contained on failed files are not considered 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.

When a Contractor's contract with AHCCCS ends, the Contractor has 18 months from the end of contract date to clear all pending encounters. AHCCCS will administratively deny any remaining encounters on the 18th month, 1 day following the end of the contract.

VI. ENCOUNTER FORMATS AND CLAIM FORM TYPES

AHCCCS accepts four (4) types of encounter formats. Each format corresponds to a claim form type standard:

- 837Professional (Form A=1500 claim) Encounters:
  - Used primarily for professional services (i.e., all Healthcare Common Procedure Coding System [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.
- NCPD (Form C) Encounters:
  - For retail pharmacy services, such as prescription medicines and medically necessary over-the-counter items.

NOTE: Form type is determined based upon the reported type of bill (bill type code).
Institutional encounters are further subdivided into three (3) additional form types for encounter editing purposes:

- Form type "I" for inpatient hospital services,
- Form type "O" for outpatient hospital services, and
- Form type "L" for long-term care facility service.

VII. PROVIDER REGISTRATION AND PROVIDER TYPE TO FORM TYPE REQUIREMENTS

CMS requires that AHCCCS Medicaid funds 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 www.azahcccs.gov/PlansProviders/NewProviders/registration.html. Registered providers are assigned a unique AHCCCS registration number in the Pre-paid Medicaid Management Information System (PMMIS).
Provider types are AHCCCS-defined categories for providers or facilities based on 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. Provider-type codes are listed in the weekly Provider Share Info reference files provided on the MFT server for Contractors. Provider Type Code P5 Record (RF612) www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ProfileLayoutTable.pdf. The AHCCCS assigned provider type code for a specific provider registration number can be found in provider reference files. See the Demographic P1 Record in the Technical Interface Guide (TIG) at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ProviderLayoutTable.pdf.
AHCCCS requires Contractors 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 corresponding 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.

VIII. 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). Encounters submitted with units that exceed the guidelines, the encounters will pend for validation of medical necessity and, if applicable, override. Refer to Chapter 4 for a description of this process.

IX. TRANSPLANT ENCOUNTERS

Contractors must follow special rules to submit encounters for covered transplant services. Refer to the AHCCCS Medical Policy Manual (AMPM) for a list of covered transplant services and the Reinsurance Processing Manual for covered services under the Transplant Reinsurance Program. AHCCCS has negotiated specialty contracts with providers for transplant services Contractors may or may not choose to use.

X. 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 non-transplant encounters 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.
- NCPDP (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 (4) 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 following X12N Technical Report or NCPDP Implementation Guide:

- The X12N technical reports are available from the Washington Publishing Company at www.wpc-edi.com (subscription required).
- The NCPDP implementation guide is available from the National Council for Prescription Drug Programs at www.ncpdp.org.

- The AHCCCS Companion Documents delineate AHCCCS specific and situational requirements, provide supplemental information for encounter reporting and are available on the AHCCCS website at www.azahcccs.gov/Resources/EDI/EDITechnicalDocuments.html.

XII. ACCURATELY REPORTING ENCOUNTER DATA

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 is in the technical reports AHCCCS encounters and edited against AHCCCS PMMIS Third-Party Liability (TPL)/COB records. Encounters that should have COB, as indicated by the member's TPL records, will be denied at AHCCCS and be returned for required COB information. If a 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 the contract. This information may be submitted by using either the AHCCCS TPL referral file submission process at www.azahcccs.gov/Resources/Contractor/Manuals/TIG/ or online using the AHCCCS contracted TPL vendor's TPL Referral Web Portal at www.azahcccs.gov/PlansProviders/HealthPlans/tpl.html.

National Correct Coding Initiative:

An explanation of reporting bundled and unbundled services is also provided 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 result in encounters pends.

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 other specified data elements may aid in processing encounter data or in bypassing certain encounter edits (e.g., submission of Contractors' prior approval/authorization or certification number may bypass certain medical review type edits). Simple encounter examples can be found in the 837 and NCPDP AHCCCS Encounter Companion Documents at www.azahcccs.gov/Resources/EDI/.

Encounter Processing Outcomes:

The Status File (277U) is produced after the AHCCCS edits and audits to inform Contractors of the encounter file processing outcome. The 277U file consists of information that indicates all:

- Encounters finalized during processing, and
- Pended encounters following processing.

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Chapter Two – Encounter Authorizations and Control Documents

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I. INTRODUCTION

AHCCCS requires the completion of specific agreements, authorizations, and control documents before Contractors can submit encounter data. New Contractors are assigned at least one Transmission Submitter Number (TSN) utilized in encounter submission and processing. The Contractor may elect to obtain additional TSNs based upon processing or tracking needs.

II. PURPOSE OF CONTROL DOCUMENTS

AHCCCS requires control documents for several legal purposes. The documents provide:

- A supplemental, contractual agreement specific to AHCCCS and the Contractor for the submission, acceptance, and processing of encounter and encounter-related data; and
- Authorization for AHCCCS to process the information on encounter data files.

If Contractors intend to subcontract their encounter reporting functions to a vendor, terminate, or change their contract with such vendor, Contractors must notify the Technical Coordination Unit (TCU) 60 days before the change via email at TCURequests@azahcccs.gov. AHCCCS will require the Contractor to provide the necessary control documents authorizing encounter data exchanges.

III. TESTING PROCESS FOR NEW CONTRACTORS OR ENCOUNTER VENDOR CHANGES

To ensure the success of encounter data submissions, new Contractors and those Contractors with a change in vendors must go through a testing phase before submitting production encounter data to AHCCCS. Before beginning the testing phase, Contractors must have provided the necessary control documents to the TCU. Once TCU receives the necessary control documents, AHCCCS will schedule a training session for the Contractor and review the testing process.

When AHCCCS verifies that the Contractor has completed the testing process as defined by AHCCCS, the Contractor will be allowed to begin submitting encounters in production.

IV. CONTRACTOR AGREEMENT

In consideration of AHCCCS acceptance of the Contractor's encounter input data, the Contractor is responsible for any incorrect data, delayed submission, or payment (to the Contractor or its subcontractors), and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by Contractor-submitted data. AHCCCS shall not accept any data that does not meet the standards by AHCCCS. If there are any inconsistencies between the input data and underlying source documents, AHCCCS shall rely on the input data only.

Contractors further agree to indemnify and hold harmless the State of Arizona and AHCCCS from all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings, and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion, or erroneous insert caused by Contractors in the submitted input data. Neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to Contractors' providers (subcontractors) resulting from such error, omission, deletion, or erroneous input data caused by Contractors in the submission of AHCCCS claims.

Contractors are also responsible for immediately identifying any inconsistencies upon receipt of data from AHCCCS. If any unreported inconsistencies are subsequently discovered, Contractors shall

be responsible for the necessary adjustments to correct their records at their own expense. Contractors authorize AHCCCS to:

- Make administrative corrections on submitted encounter data to enable the automated processing of the same; and
- Accept original evidence of services rendered and encounter data in a form appropriate for automated data processing.

V. CONTRACTOR ENCOUNTER ATTESTATION

To comply with 42 Code of Federal Regulations (CFR) Sections 438.604 and 438.608, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or a direct report must certify encounter data before processing. By incorporating the attestation process noted below the CEO, CFO, or the individual who has delegated authority to sign for, and who reports directly to the CEO or CFO, attests that the data and/or documents recorded and submitted as input data or information, based on best knowledge, information, and belief, is in compliance with Subpart H of the Balanced Budget Act (BBA) certification requirements; is complete, accurate, and truthful; and is in accordance with all federal and state laws, regulations, policies, and the AHCCCS/Contractor contract in effect. If any of those procedures, rules, regulations, or statutes are amended hereafter, Contractors agree to conform to those amendments of which they have been notified. Contractors further certify that they will retain and preserve all original documents as required by law, submit all or any part of same, or permit access to same for audit purposes, as required by the State of Arizona, or any agency of the federal government, or their representatives.

The BBA encounter attestation process for:

X12 (837) Files:

The Submitter Name Loop [1000A] allows for two repetitions of the PER segment. For the 837 attestations, add one repetition of the PER Segment within the 1000A Submitter Name Loop. This allows the Contractors to continue to submit a PER segment which indicates who to contact if a file has a problem.

For Example: The additional PER segment should be formatted as follows:
PER*EM*TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM*FX*6025556789*TE*6025555678~

Where:
PER01 = IC – Information Contact
PER03 = EM – Electronic Mail.
PER04 = The attestation followed by the email address of the person who certifies the file, which must be compliant with BBA specifications
PER05 = FX - Fax Number
PER06 = The Fax Number of the person certifying the file
PER07 = TE - Telephone Number
PER08 = Telephone Number of the person certifying the file

NCPDP Files:

An abbreviated attestation message is in the 35-character message field trailer record of the Batch 1.1 or 1.0 [the transport mechanism for the 5.1 and the 3.2 transactions].

For example:
"Attested John Doe CFO" (must be compliant with BBA specifications).

504-F4	Message	A/N	35	21	55	

Pended Encounter Correction Files:
An abbreviated attestation message is in the 35-byte field trailer (T9) record of the Pended Encounter Correction file.
For example:
“Attested John Doe CFO” (must be compliant with BBA specifications).
Please refer to page 4-12 for the BBA Attestation field and positions in the Pended Encounter Correction file layout.

VI. SECURITY AND SYSTEM ACCESS

EDI Solutions Portal is the AHCCCS front-end editor that validates syntax, code sets, and code relationships in submitted encounter files. Records that pass validation are translated into formats for processing and adjudication. Access to EDI Solutions Portal permits the Contractors’ staff to view processing statistics and errors. AHCCCS follows the Health Insurance Portability and Accountability Act (HIPAA) security and privacy rules for Contractors’ security and EDI system access. Users will need to have access to use the EDI Solutions Portal. If you do not have an account, please follow the instructions outlined in the: EDI Portal Provider Signup and Login Guide . If you need assistance, please log your request by going to https://servicedesk.azahcccs.gov/portal or send an email to servicedesk@azahcccs.gov. Please state to assign your ticket to the ISD EDI Team.

VII. CONTRACTOR ENCOUNTER SUBMISSION NOTIFICATION AND TRANSMISSION SUBMITTER NUMBER (TSN) APPLICATION

The application provides notice to the Encounter Unit of the designated person authorized to submit and receive encounter data and related information from AHCCCS. It also estimates monthly encounters to be reported by Contractors. Contractors must complete this notification form before testing and submitting encounter data to AHCCCS. Upon receipt of this application, a TSN is issued. The TSN allows AHCCCS to identify Contractors’ identification number or numbers, county codes, and lines of business for which that transmission submitter is authorized to submit encounters. For each TSN, Contractors must have the Health Plan Contractor Encounter Submission Notification and Transmission Submitter Number Application (Exhibit 2A) form on file with AHCCCS. Contractors must also have completed and submitted the EDI Trading Partner Agreement (Exhibit 2B) to exchange data with AHCCCS. Once the Trading Partner Agreement is completed, the Contractor is given an EDI account for data exchanges.

VIII. PMMIS ACCESS

PMMIS is the AHCCCS integrated information infrastructure that supports AHCCCS operations, administrative activities, and reporting requirements. Contractor access to PMMIS allows staff to view selected members, providers, references, and encounter information helpful in resolving pended and denied encounter issues. Contractors' staff are expected to be trained on the use of PMMIS and use this access to expedite clearing pending and resubmitting denied encounters. Contractors should contact their assigned AHCCCS Encounter Representative to make any requests related to PMMIS training. For Contractors' staff to gain PMMIS mainframe access, a User Affirmation Statement and User Access Request Form must be completed for each user and submitted to the Technical Coordination Unit at mmissecurityrequest@azahcccs.gov for processing. These forms are available online at https://www.azahcccs.gov/PlansProviders/ISDresources.html. Users must sign in at least once every 30 days, change passwords as required, and complete annual recertification to maintain access privileges. Additional information on accessing PMMIS and frequently utilized PMMIS reference screens are available on the AHCCCS website at https://azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/DeskLevelInstructionsForAccessingPMMIS.pdf.

Exhibit 2A

Contractor Encounter Submission Notification and Transmission Submitter Number (TSN) Application

To submit encounter data to AHCCCS; Contractors must be assigned a Transmission Submitter Number (TSN). To apply for a TSN, please complete this application and email to AHCCCSEncounters@azahcccs.gov.

1. Contractor Name:	**2. Contractor ID Number:**

3. As representative for the above Contractor, hereby notify the AHCCCS Administration Encounter Unit that the Contractor's encounter submission will start on __/_/___. The Contractor named above agrees to submit all encounter data and correct any encounter submission errors within the limited time frame prescribed by the AHCCCS Administration.

4. Contractor Address: (Street):

5. (City, State & Zip Code):

6. Contractor Telephone Number:

7. Contact Person's Name:

8. Contact Person's Telephone Number:

Contractor estimates that the monthly average encounter submission volume will be as follows:

9. 837P (Form A) Encounters:	
10. 837D (Form D) Encounters:	
11. 837I (Form B) Encounters:	
12. NCPD (Form C) Encounters:	

13. CEO/Administrator Name:	**14. Date:**

15. CEO/Administrator Signature:

Exhibit 2B

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ELECTRONIC DATA INTERCHANGE TRADING PARTNER AGREEMENT

THIS AGREEMENT is entered into between the Arizona Health Care Cost Containment System Administration (AHCCCS) and _____, a covered entity ("TRADING PARTNER") who transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162.

The TRADING PARTNER agrees to perform functions or activities that are subject to transaction standards, and WHEREAS, the TRADING PARTNER agrees to conduct these transactions according to this agreement.

NOW, THEREFORE, the TRADING PARTNER and AHCCCS agree as follows:

1) Definitions. The following terms shall have the meaning ascribed to them in this section.

   a) Agreement shall refer to this document.

   b) Third Party shall refer to parties authorized to exchange EDI transactions on the provider's behalf.

   c) Trading Partner Agreement shall mean the AHCCCS TRADING PARTNER AGREEMENT.

   d) Covered Entity means a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and162.

   e) AHCCCS shall mean the Medicaid agency of Arizona.

   f) Transactions shall mean the electronic exchange of information between two parties to carry out financial or administrative activities related to health care as defined by 45 CFR Part 160.103.

   g) Individual shall mean the person who has the authority to act on behalf of the TRADING PARTNER to execute this agreement.

h) Information shall mean any “health information” provided and/or made available by AHCCCS to the TRADING PARTNER and has the same meaning as the term “health information,” as defined by 45 CFR Part 160.103.

i) Parties shall mean AHCCCS and the TRADING PARTNER.

2) Term. The term of this Agreement shall commence as of the date it is electronically accepted.

3) TRADING PARTNER Obligations:

a) Third Party Agreement. The TRADING PARTNER understands and agrees that it is responsible for the conduct of a THIRD PARTY in the THIRD PARTY’S performance related to this Agreement. The TRADING PARTNER agrees to inform the THIRD PARTY of the terms of this Agreement. Notwithstanding the lack of specific mention, any obligation or requirement contained in this Agreement that is imposed on the TRADING PARTNER will be construed as an obligation and requirement that is also imposed on its THIRD PARTY.

b) No Changes, Additions, or Unauthorized Uses. The TRADING PARTNER hereby agrees that for the Information, it will not change any definition, data condition, or use of a data element or segment. The TRADING PARTNER also agrees it will not add data elements or segments to the maximum defined data set or use any code or data elements that are either marked “not used” in the Implementation Guide or are not in the specifications.

c) Transfer of Obligations. The TRADING PARTNER must immediately inform AHCCCS of any proposed mergers, acquisitions, or changes in the ownership of the TRADING PARTNER. AHCCCS reserves the right to require the merged entity, the acquiring entity, or the new owners to submit a new TRADING PARTNER Agreement if the merger, acquisition, or change in ownership may reasonably be expected to impact AHCCCS’s or TRADING PARTNER’S ability to comply with the TRADING PARTNER Agreement.

d) Companion Documents. AHCCCS makes available Companion Documents which serve as a supplement to the standard electronic transaction description. They contain specific instructions for conducting each transaction. The TRADING PARTNER agrees to conform and comply with the requirements set forth in these Companion Documents.

4) Adequate Testing. The TRADING PARTNER agrees that it will cooperate with AHCCCS in testing processes. TRADING PARTNER agrees to adequately test business rules appropriate to its types and specialties.

5) Deficiencies. The TRADING PARTNER agrees to be responsible for incorrect data, including errors, omissions, deletions, or erroneous data submitted by the TRADING PARTNER, and that it will correct Transaction errors or deficiencies identified by AHCCCS.

6) Code Set Retention. Both Parties understand and agree to maintain code sets being processed or used in this Agreement for at least the current contract year, state fiscal year, or any appeal period, whichever is longer.

7) Privacy:

   a) Protected Health Information (PHI). AHCCCS and the TRADING PARTNER will comply with all applicable State and Federal privacy statutes and regulations concerning the treatment of PHI.

   b) Notice of Unauthorized Disclosures and Uses. AHCCCS and the TRADING PARTNER will promptly notify the other Party of any unlawful or unauthorized use or disclosure of PHI, which disclosure may have an impact on the other Party that comes to the Party's attention and will cooperate with the other Party in the event that any litigation arises concerning the unlawful or unauthorized disclosure or use of PHI.

   c) Injunctive Relief. AHCCCS retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by TRADING PARTNER, its THIRD PARTY, or any agent or contractor that received PHI from TRADING PARTNER.

8) Security:

   a) Data Security. AHCCCS and the TRADING PARTNER will maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security access codes, backup files, and source documents. Each Party will immediately notify the other Party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions, security access codes, backup files, source documents or the other Party's operating system which attempt may have an impact on the other Party.

   b) Systems Security. AHCCCS and the TRADING PARTNER will develop, implement, and maintain appropriate security measures for its own systems. AHCCCS and the TRADING PARTNER will document and keep current its security measures.

9) Termination of Agreement. The TRADING PARTNER agrees that AHCCCS has the right to immediately terminate this Agreement if AHCCCS determines that the TRADING PARTNER or its THIRD PARTY has violated any terms of this Agreement.

10) Choice of Law. This Agreement shall be governed by the law of the State of Arizona.

11) Liability. AHCCCS shall not be responsible to TRADING PARTNER nor anyone else for any damages caused by delay, rejection, error, omission, deletion, erroneous input, loss, or any misadventure affecting transactions.

12) Binding Nature and Assignment. This Agreement shall be binding on the Parties hereto and their successors and assignees, but neither Party may assign this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

13) Notices. Whenever under this Agreement one Party is required to give notice to the other, such notice shall be deemed given if mailed by First Class United States mail, postage prepaid, and addressed as follows:

AHCCCS
Information Services Division
801 E. Jefferson, MD 2800
Phoenix, AZ 85034

14) Electronic Claims Submission. For each electronic claim submission, the TRADING PARTNER certifies that the claim information is true, accurate, and complete.

I understand that payment of claims (including claims submitted electronically) will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws (42 CFR 455.18).

15) Acceptance of Agreement. By clicking on “I Accept the Terms of the Agreement,” the TRADING PARTNER agrees to the terms and conditions of this TRADING PARTNER Agreement and that the individual accepting the agreement has the authority to act on behalf of the TRADING PARTNER and to bind it to the terms and conditions of this TRADING PARTNER Agreement.

Table of Contents

Chapter Three – Encounter Processing

Chapter 3 – Encounter Processing

I. INTRODUCTION

The purpose of this chapter is to provide Contractors with the sequence of events that occur for encounter processing and to provide the criteria that Arizona Health Care Cost Containment System (AHCCCS) uses to determine when encounter files and/or individual records are acceptable.
Record layouts for each of the four (4) form types (837P – Form A/1500s, 837D/ADA – Form D, 837I – Form B/UB04, and NCPDP – Form C) can be found in the following documents:

- X12N 005010 technical reports at www.azahcccs.gov/Resources/Downloads/HIPAA/5010/2010/May/X12NActual005010TR3ErrataStatusReport.pdf.
- National Council for Prescription Drugs Programs (NCPDP) Post Adjudication History (PAH) Version 2.2 implementation guide at www.azahcccs.gov/Shared/Downloads/EDI/CompanionDocuments/AZ_NCPDP_ENC_CG.pdf
- Health Insurance Portability and Accountability Act (HIPAA) 5010 Consortia and Documentation at www.azahcccs.gov/Resources/EDI/consortium.html.

Record layout for the status file (277U) may be found in the X12N 3070 implementation guide. In addition, the AHCCCS Encounter Companion Documents www.azahcccs.gov/Resources/EDI/ and shared provider/reference files have supplemental information to assist with the submission of encounter data.

II. ENCOUNTER FILE PROCESSING BY AHCCCS

Encounter data is scheduled to be processed in the Pre-paid Medicaid Management Information System (PMMIS) twice a month. The first processing cycle is scheduled to begin on the first Friday after the first Wednesday of the month (see the link below for details on Encounter Processing Schedules). Files placed in the wrong path and/or folder or those which cannot be recognized and validated by AHCCCS will not be processed. AHCCCS will not provide notification of such errors, and additional file processing will not occur.
For the first cycle, newly submitted Encounter (New Day) Files, Pend Correction Files, and all currently pended encounters will be recycled regardless of the action taken by Contractors. All replacement and voided transactions will be processed. The Reinsurance Case Creation cycle will run immediately after the first processing cycle.
The second processing cycle is scheduled to begin on the third Friday following the third Wednesday of the month. For the second cycle, pended corrections submitted since the first cycle will be processed; however, pended encounters with no action will not be recycled.

Replacement and voided transactions for original encounters associated with reinsurance (RI) are NOT PROCESSED IN THE SECOND ENCOUNTER CYCLE. They are left in Staging with a "W" (waiting) status and will be processed in the first cycle of the following month. Online overrides should not be processed during the first or second cycles. Contractors will receive cycle reports and files only for encounters processed only for encounters processed during the submitting period. The Encounter Processing Schedules are available on the AHCCCS website under AHCCCS Encounter Resources section at www.azahcccs.gov/PlansProviders/HealthPlans/encounters.html#Encounter_Processing_Schedules.

III. ENCOUNTER DATA FILES SUBMITTED BY CONTRACTORS

There are two (2) primary types of encounter data files submitted by Contractors:

- New Encounter Submissions (837P, 837I, 837D, NCPDP):
  - New Encounter Files include encounters submitted to AHCCCS for the first time, encounters resubmitted to AHCCCS after being rejected by validation, translation or mainframe edits, replacements (resubmissions), and voids.
- Pended Encounter Corrections:
  - Contractors submit allowed corrections for encounters that failed the edit and audit process and were returned on the Pend File. This file is the accumulation of all current and previously pended encounters. Not all AHCCCS mainframe edits/audits allow this type of correction.

Encounter data must be transmitted electronically to the AHCCCS Secure File Transfer Protocol (SFTP) Server at https://sftp.statemedicaid.us/. Files must be placed in the appropriate Contractor folder on the SFTP server site for processing.

Contractors may submit encounter files as often as desired throughout the month, and multiple files may be submitted on the same day. Duplicate files should not be submitted. Each file is date and time stamped with the date/time the file is uploaded to the AHCCCS server. Contractors are assigned a directory on the SFTP Server for placing plan submitted "incoming" and AHCCCS deposited "outgoing files." When logging in to the AHCCCS SFTP Server Contractors must first choose between Arizona (AZ) and Hawaii (HI) directory paths. After choosing AZ, the next selection "XXX" represents Contractors' three (3) character name abbreviation. Within each Contractor's SFTP Server directory are folders designed for specific data exchange purposes.

Refer to section 4.6 of the Communications/Connectivity Information (CCI) Companion Guide, for file size/length and volume limits (inbound transmissions) and electronic data interchange (EDI) file naming standards.

The following are the directory structure and file naming standards for depositing incoming encounter files:

- New Encounter Submission files 837 and NCPDP PAH (pathsftp/AZ/XXX/prod/edi-in/file name):
    - XXX = the 3-character mnemonic (name abbreviation) assigned to each contractor by AHCCCS.
    - Contractors can use their naming convention if the file name is unique.
    - This path is restricted to 837 and NCPDP PAH version files.
    - These files must not be zipped.
- Pended Encounter Correction path: sftp/AZ/XXX/prod/in/file name:
    - XXX = the 3-character mnemonic (name abbreviation) assigned to each Contractor by AHCCCS.

NOTE: There are two (2) "in" and "out" folders for each Contractor. The "in folder" for pended encounters is **prod/in/**. Incoming 837 New Day encounters are to be placed in the **prod/edi-in/** folder. AHCCCS will place outgoing encounter pend reports in the **prod/out** folder. AHCCCS places response files to New Day file submission in the **prod/edi-out** folder. These files must be zipped. An AHCCCS file naming convention is required for submitting Pended Encounter Corrections: AZSTNDPLANIDTSNXMMDDYY.SEQ. The Proprietary file name standard is:

- AZ = Arizona,
- STND = PEND (Pend Corrections),
- PLANID = Contractor six-byte plan identification number,
- TSN = Contractor Plan ID three-byte transmission submitter number,
- 1 = One-byte code distinguishing denied encounter files from other encounter files.
    - The '1' value indicates all other encounter files, including pend correction files.
- MMDDYY = Current date, and
- SEQ = Sequence number used to identify transmission of multiple same-day files and to distinguish unique file names. Duplicate file names are not accepted.

IV. AHCCCS DATA ACCESS FORMS

Contractors gain access to the SFTP Server by AHCCCS acceptance upon proper completion and submission of the following forms located at https://azahcccs.gov/PlansProviders/ISDresources.html:

- Electronic Data Exchange Request Form
    - The Electronic Data Exchange Request Form is used by providers and vendors who need to request an electronic data exchange account for the AHCCCS Electronic File Transfer (EFT) Server. If requesting a new account, this form must be accompanied by a signed External User Affirmation Statement.

- External User Affirmation Statement
    - The External User Affirmation Statement is an agreement signed by external users who have access to the AHCCCS computer network and data. Users who sign this statement agree to abide by all applicable laws, rules, and AHCCCS directives.

Contractors must submit personal data exchange application forms and affirmation statements for each staff member who requires access to the SFTP Server to place or remove encounter-related files or data. The AHCCCS Information Services Division (ISD) Customer Support Center is the primary contact for all questions related to submitting electronic transactions and data. The preferred method of communication is via email. All inquiries result in Ticket Number assignment and problem tracking. The contact information is:

Email: EDICustomerSupport@azahcccs.gov

Telephone Number: (602) 417-4451

Hours: 7:00 AM – 5:00 PM Arizona Time, Monday through Friday

Information required for initial inquiry:

Customer Name
Organization Name
Customer Email Address
Customer Telephone Number
Health Plan ID/Provider ID/Submitter ID
Transaction ID Inquiring About
Applicable IS/GS Control Numbers
Topic/Nature of Problem (setup, connectivity, etc.)

Information required for follow up inquiry:

Ticket Number assigned by the Customer Support Center

V. CONTRACTOR ADMINISTRATIVE DENIALS/ZERO PAYMENT ENCOUNTER SUBMISSIONS

As previously stated, before an encounter is submitted to AHCCCS, a service must be completed, and the provider's claim or encounter must be finalized Paid, Denied for Administrative reasons, or Zero Medicaid Payment by Contractors. AHCCCS requires Contractor Administratively Denied and Zero Medicaid Payment (except for transplants) 837P, 837I, and 837D encounters to be submitted in separate files from paid encounters. Claims with multiple lines that result in "mixed status" (paid and denied lines) should be split appropriately and submitted in the appropriate files. See Chapter 6, "How To" for additional guidance.

Contractor Administrative Denials encounters are defined as Contractor adjudicated claims that have been denied or non-covered in full for only specific types of administratively related reasons. Denials for administrative reasons represent those claims which are for valid Medicaid covered services provided to eligible members by enrolled and eligible providers that Contractors denied for these administrative reasons:

- Failure of the provider to obtain a required Prior Authorization (PA),
- Untimely submission of the claim to Contractors,

- Provider billed units are more than the Medicaid service benefit limits, and
- Provider's failure to supply required claims supporting documentation for the following scenarios:
    - The provider included primary payer data, the claim would have been paid; because of a lack of coordination of benefits (COB) data, claim was denied.
    - The provider submitted the correct claim form, the claim would have been paid; because of incorrect claim form, claim was denied.
    - The provider submitted supporting documentation, the claim would have been eligible for payment; because of missing documentation, the claim was denied.

Zero Medicaid Payment encounters are encounters for which Contractors did not deny the claim but paid zero due to primary payment and no pass thru or no secondary payment was made under Medicaid, etc. The zero paid designation should not be used for any situations where services are not paid due to bundled payment arrangements such as the Federally Qualified Healthcare Centers (FQHC); services are not paid as they fall under a sub-capitated arrangement of any type (including "Block purchase," "Case Rates," etc.). Denied/Zero Medicaid Payment 837 files must have the input mode of '6' in Loop 1000A NM109, the value of 'AHCCCSDENIED' in GS03 (per current companion document located at https://www.azahcccs.gov/Resources/Downloads/EDIchanges/EDIchangesAZ837ENCCG.pdf) and **add the extension of '.deny' to the file name**.

NCPDP Administratively Denied/Zero Payment encounter reporting file specifications are located within the AHCCSS website at https://www.azahcccs.gov/Shared/Downloads/EDI/CompanionDocuments/AZ_NCPDP_ENC_CG.pdf. These files will undergo limited validator syntax editing and, when they pass validation, will be moved to the mainframe as a denied/zero payment file. These claims will have an encounter status code of 43 = adjudicated/denied by Plan. Files that fail validation must be corrected and resubmitted by the Contractor.

VI. CONTRACTOR ENCOUNTER FILE HOLD REQUESTS

On a limited basis, AHCCCS can support requests to hold submitted encounter files. Contractors needing to hold an encounter file before the encounter processing cycle must submit the request to the DHCM Encounter Manager and Technical Coordination Unit (TCU) via email at TCURequests@azahcccs.gov. All Encounter File Hold Requests must be received no later than noon one (1) day before the scheduled PMMIS encounter processing date. All requests must appropriately identify the location and name of the file the Contractor(s) are requesting to have held.

VII. INSTITUTIONAL SUBMISSIONS WITH NON-COVERED LINES FOR INVALID CODE SET

AHCCCS requires 837I encounters with non-covered lines containing invalid codes to be submitted in separate files from paid or denied encounters. These institutional encounters with an invalid code set at the line must have the line denied or non-covered. While all other data elements are identical to paid files, these files must have 'AHCCCSPARTIAL' in GS03 (per the current companion guide). These files will undergo validation syntax editing and after passing validation, will be moved to the mainframe as a paid file. See Chapter 6, "How To" for additional guidance.

VIII. FILE VALIDATION

All 837 files are subject to AHCCCS's front-end validation edits. When Contractors submit TR3 compliant encounters, the validator reviews the data and its validity. These transactions are then passed for translation onto the mainframe for processing.

For additional information regarding validation reports and error correction, refer to the EDI Portal Users Guide provided electronically to Contractor staff upon obtaining a validation User-ID and password or when validation upgrades are implemented.

The EDI Portal allows a browser to view reports about HIPAA EDI processing. This includes the number and types of transactions processed by date, error rates and types, and success rates. These can be filtered in various ways. In addition, users with the appropriate permissions can view specific transactions at multiple levels of detail.

If you do not have an account, please follow the instructions outlined in the: EDI Portal Provider Signup and Login Guide . If you need assistance, please log your request by going to https://servicedesk.azahcccs.gov/portal or send an email to servicedesk@azahcccs.gov. Please state to assign your ticket to the ISD EDI Team.

IX. VALIDATION FILES PRODUCED BY AHCCCS

Following 837 file validation, applicable TA1, 999, 824, and 277CA files are placed in each Contractor's outgoing directory. These files provide validation results and pass/fail status of each encounter or file.

TA1 Interchange Acknowledgment:

The TA1 Acknowledgment is used by AHCCCS to notify Contractors of errors in the interchange control structure. The TA1 verifies X12 envelopes only.

999 Functional Acknowledgment:

The 999 Functional Acknowledgment is used by AHCCCS to acknowledge each 837 functional group that has passed or failed translator edits.

AZEP_HP010999_2018052416531197_AZ837PXXX052218_001.999

```
ISA*00*          *00*          *ZZ*AHCCCS866004791*ZZ*999337737      *180524*1653*^*00501*000034168*0*T*:~
GS*FA*AHCCCS866004791*0109990Z9*20180524*165327*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*100000321*005010X222A1~
AK2*837*00000001*005010X222A1~
IK5*A~
AK2*837*00000002*005010X222A1~
IK5*A~
AK2*837*00000003*005010X222A1~
IK5*A~
AK2*837*00000004*005010X222A1~
IK5*A~
AK2*837*00000005*005010X222A1~
IK5*A~
AK2*837*00000006*005010X222A1~
IK5*A~
AK2*837*00000007*005010X222A1~
IK5*A~
AK2*837*00000008*005010X222A1~
IK5*A~
AK2*837*00000009*005010X222A1~
IK5*A~
AK2*837*00000010*005010X222A1~
IK5*A~
AK2*837*00000011*005010X222A1~
IK5*A~
AK2*837*00000012*005010X222A1~
IK5*A~
AK2*837*00000013*005010X222A1~
IK5*A~
AK2*837*00000014*005010X222A1~
IK5*A~
AK9*A*14*14*14~
SE*32*0001~
GE*1*1~
IEA*1*000034168~
```

824 Acknowledgment:

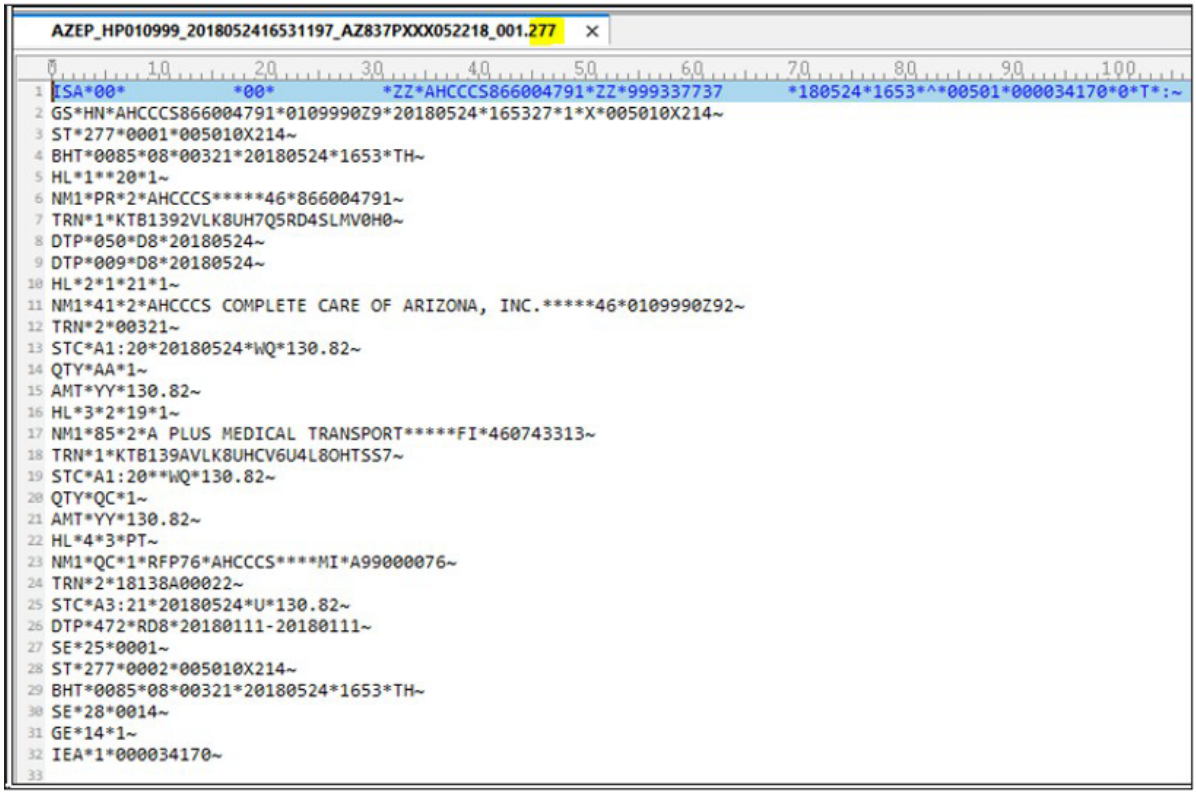
The 824 Acknowledgment is used by AHCCCS to report 837 syntactical problems or data structure errors.

AZEP_HP010999_2018052416531197_AZ837PXXX052218_001.824

```
ISA*00*          *00*          *ZZ*AHCCCS866004791*ZZ*999337737      *180524*1653*^*00501*000034169*0*T*:~
GS*AG*AHCCCS866004791*0109990Z9*20180524*165327*1*X*005010~
ST*824*0001*005010~
BGN*11*00000001*20180524*1653~
OTI*TR*F8*00000001*0109990Z9*AHCCCS866004791*20180524*1457*100000321*00000001*837*005010X222A1~
TED*024*X2 E 41152 2010BB The Billing Provider Secondary Identificat*REF*18~
NTE*DEP*ion (2010BB REF) is required when the Billing Provider Identification Code Quali~
NTE*DEP*fier (2010AA NM108/NM109) is not present.~
RED*Not Claim Specific*AI~
SE*8*0001~
GE*1*1~
IEA*1*000034169~
```

277CA Claims Acknowledgment:

The 277CA is an acknowledgment of an 837 transaction at the pre-adjudication stage. This transaction identifies claims that are accepted or rejected for adjudication. A summary level and an individual claim level pre-adjudication status is included in the 277CA.



For outgoing acknowledgment files, the encounter SFTP directory structure and file naming convention is **837 Acknowledgment path: SFTP/XXX/prod/edi-out/filename.**

XXX = the 3-character mnemonic (name abbreviation) assigned to each contractor by AHCCCS.

File Name Convention for Acknowledgment Files:

AZEt_HPPLANID_ccyymmddhhmmssss_originalfilename. (TA1, 999, or 824).

Following NCPDP and Pend Correction File validation, the file pass/fail information is placed in the Contractors' outgoing SFTP directory-Pend=prod/out and NCPDP=prod/edi-out.

NOTE: NCPDP PAH files with a validation error will be placed in the outgoing directory with a **.bad** extension.

NCPDP PAH 2.2 Acknowledgments:

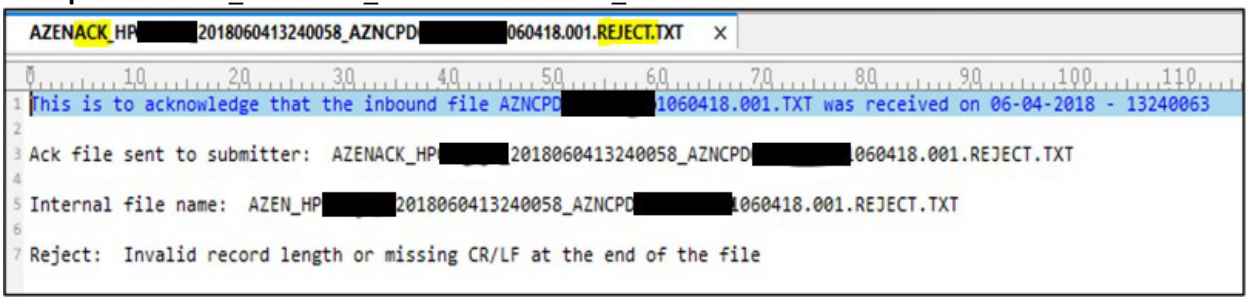
Inbound filenames can be any name designated by the Health Plan/Program Contractor but should not exceed 29 characters. Files should be rendered in a standard text file format and should not have a .tmp, .zip, and/or any other application file extension. NCPDP PAH 2.2 files that fail validation will be returned to the Health Plan EDI-Out directory with the original filename and a **.REJECT** file extension.

Correct files that are accepted will simply add "ACK" to the first section of the filename.

Example: AZENACK_HP123456_2016052617290989_AZNCPDP1100070401052316.002.TXT (this is the original filename).

Incorrect rejected files will also add the "ACK" to the first section of the filename and add the word "REJECT" to the end of the filename just before the extension.

Example: AZENACK_HP123456_2016060216105814_2016052319580898NCPDP.REJECT.TXT.



X. ASSIGNMENT OF AHCCCS CLAIM REFERENCE NUMBERS (CRNS)

Data that passes validation is translated and moved to the mainframe to be loaded for processing. Contractors should monitor the load/no-load status of their files. (See Chapter 6 for details on how to monitor the load status of files). Each encounter record is assigned a unique Claim Reference Number (CRN) when loaded into the adjudication system. AHCCCS subsequently uses the CRN to identify the encounter record and determine the encounter receipt date for timeliness calculations. A CRN is derived from the following information:

- **Julian Date (digits 1 - 5)** (xx = year and xxx = day of the year 1-365/6):
  - This date reflects the receipt of the New Day encounter file in Julian date format.
- **Batch Number (digits 6-9)** (Sequence 0001-9999)
- **Document Number (digits 10-12)** (Sequence 001-999)
- **Line Number (digits 13-15)** (Sequence 001-999):
  - This number applies to detail lines only.

XI. ADJUDICATION SYSTEM EDITS AND AUDITS

Each encounter record is evaluated against a series of claim-processing like adjudication edits and audits. The acceptable values and relational edits required for successful encounter adjudication are contained in the member enrollment, provider and reference files routinely provided to each Contractor by AHCCCS. When Contractors' claims adjudication systems utilize the most updated information in these files, AHCCCS editing should produce limited pended/denied encounters.

Adjudication Edit Process:

The adjudication edit process examines data fields necessary for the processing and adjudication of the encounter. These edits involve data quality checks of items such as member and provider information, dates of service, service and diagnosis codes, and Contractor payment data. When an encounter passes the edit checks without errors, it is then evaluated by the adjudication audit process.

Adjudication Audit Process:

The adjudication audit process evaluates the encounters against encounters already in history or other lines within the same claim for duplicates, potential duplicates, and service/benefit limits. Encounters must pass both edits and audits to be finalized and placed in history within the adjudicated encounter database. Each adjudicated encounter is assigned an adjudication status code (which may change over time with encounter processing).

Adjudication Status Codes:

- 11 = Pended,
- 31 = Adjudicated/Approved,
- 32 = Adjudicated/Void Original,
- 33 = Adjudicated/Replaced Original,
- 41 = Adjudicated/Denied by AHCCCS, and
- 43 = Adjudicated/Denied by Plan.

If an encounter fails one or more edits or audits, an error condition occurs, and AHCCCS either denies or pends the encounter. Denied encounters are returned in the 277U and 277S Supplemental Files. For error correction, pended encounters are also placed in the Contractors' Pend File. For further explanation on Pended Encounter correction, please see Chapter 4 of this manual.

AHCCCS denied encounters (status 41) like pended encounters, must be corrected, recouped, or voided in the Contractors' claim processing systems as appropriate and may be subject to Contractor performance standards. Re-adjudicated/corrected denied encounters may be submitted to AHCCCS as either New Encounter Submissions or Replacement Encounters.

Resubmitting as Replacement Encounters maintains the original encounter submission date for timely encounter submission evaluation.

NOTE: Replacement Encounters cannot replace voided encounters. The replacement will void the encounter and then replace the encounter within PMMIS. Resubmitting as New Encounter Submissions will generate a new encounter received date and, in some cases, could be included in untimely encounter submission calculations.

Only finalized adjudicated/approved (status 31) and adjudicated/denied by Contractor/Plan (status 43) encounters are used by AHCCCS to evaluate health outcomes, performance measures, rate development/setting, etc. Thus, Contractors should ensure that encounters are submitted according to AHCCCS requirements to avoid underreporting of data that may negatively affect Contractors.

XII. ADJUDICATION FILES AND REPORTS PRODUCED BY AHCCCS

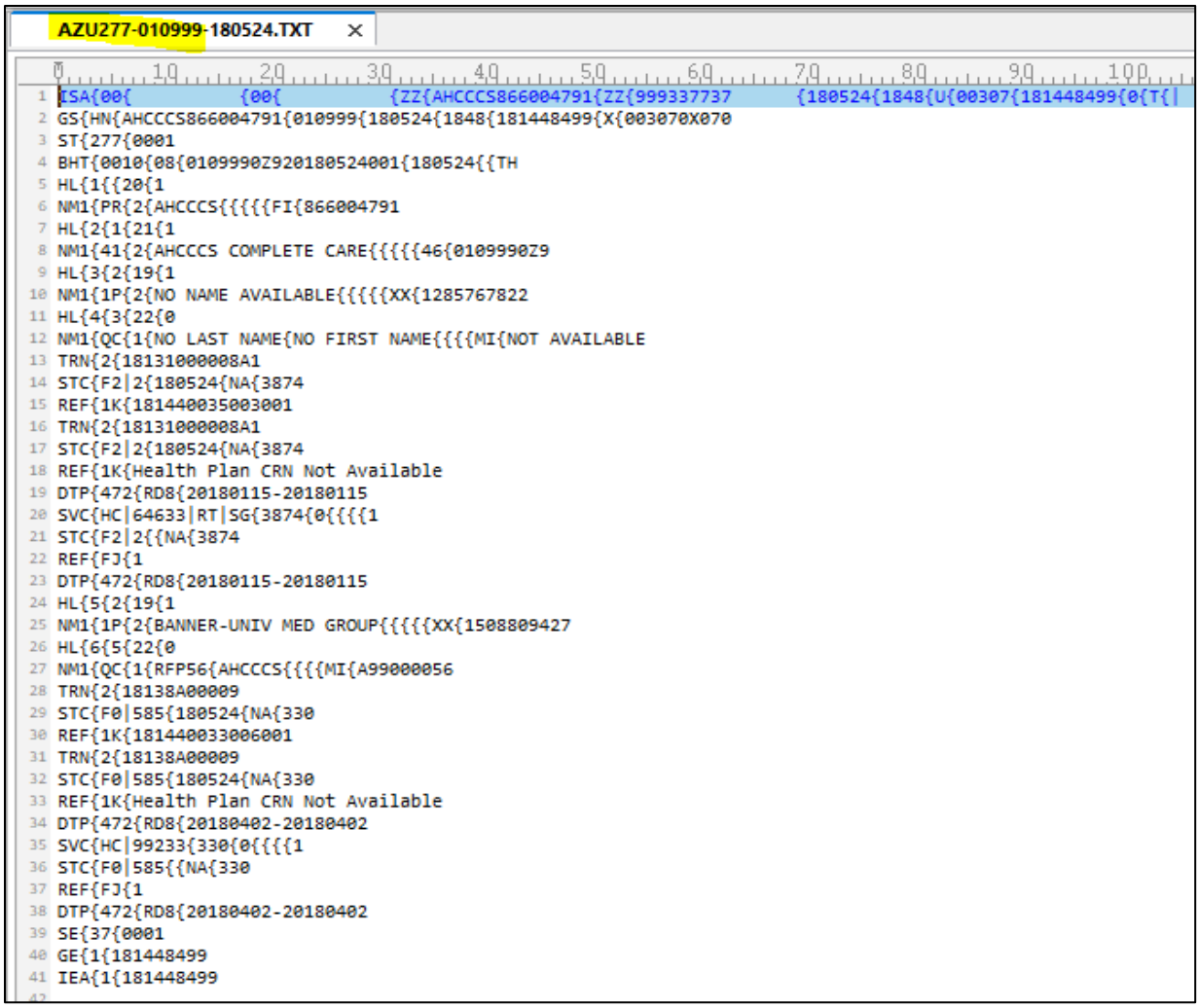
After encounter adjudication edit and audit processing, AHCCCS generates the following status and Pend Files for Contractors:

Status File (277U) – Unsolicited:

The status file provides the encounter status (finalized or pended) for all encounters from the most recent encounter processing. The file layout is available from Washington Publishing Company at www.wpc-edi.com (subscription required) and the AHCCCS Companion Document is available on the AHCCCS website at www.azahcccs.gov/Resources/EDI/EDITechnicaldocuments.html.

277U File Layout Reference:

www.azahcccs.gov/Resources/Downloads/EDIChanges/AZ_277U_Companion_Docv20160902.pdf.


AZU277-010999-180524.TXT

```
ISA{00{          {00{          {ZZ{AHCCCS866004791{ZZ{999337737      {180524{1848{U{00307{181448499{0{T{|
GS{HN{AHCCCS866004791{010999{180524{1848{181448499{X{003070X070
ST{277{0001
BHT{0010{08{0109990Z920180524001{180524{{TH
HL{1{{20{1
NM1{PR{2{AHCCCS{{{{{FI{866004791
HL{2{1{21{1
NM1{41{2{AHCCCS COMPLETE CARE{{{{{46{0109990Z9
HL{3{2{19{1
NM1{1P{2{NO NAME AVAILABLE{{{{{XX{1285767822
HL{4{3{22{0
NM1{QC{1{NO LAST NAME{NO FIRST NAME{{{{MI{NOT AVAILABLE
TRN{2{18131000008A1
STC{F2|2{180524{NA{3874
REF{1K{181440035003001
TRN{2{18131000008A1
STC{F2|2{180524{NA{3874
REF{1K{Health Plan CRN Not Available
DTP{472{RD8{20180115-20180115
SVC{HC|64633|RT|SG{3874{0{{{{1
STC{F2|2{{NA{3874
REF{FJ{1
DTP{472{RD8{20180115-20180115
HL{5{2{19{1
NM1{1P{2{BANNER-UNIV MED GROUP{{{{{XX{1508809427
HL{6{5{22{0
NM1{QC{1{RFP56{AHCCCS{{{{MI{A99000056
TRN{2{18138A00009
STC{F0|585{180524{NA{330
REF{1K{181440033006001
TRN{2{18138A00009
STC{F0|585{180524{NA{330
REF{1K{Health Plan CRN Not Available
DTP{472{RD8{20180402-20180402
SVC{HC|99233{330{0{{{{1
STC{F0|585{{NA{330
REF{FJ{1
DTP{472{RD8{20180402-20180402
SE{37{0001
GE{1{181448499
IEA{1{181448499
```

Supplemental Status (277S):

This file contains additional status information not found in the 277U Status File. For example, mainframe denial reasons for encounters and reinsurance information are found in the 277S file.

- **277U and** Supplemental **Status SFTP path:** ftp/XXX/prod/edi-out/file name.
- XXX = Contractor's 3-digit name abbreviation. **File** name **convention for these status files:** AZa277-PLANID-YYMMDD.TXT:
  - AZ = Arizona; 'a' represents an Unsolicited or "S" (Supplemental) file.
  - PLANID = Contractors' 6-digit AHCCCS assigned numeric Plan ID.
  - YYMMDD = the cycle date.

Additional files, as noted below, are placed on the SFTP server in the Contractors' **prod/out** folder **sftp/AZ/XXX(3-character mnemonic)/prod/out/file name** (XXX = the Contractors' 3-digit name abbreviation).

277S File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/277SFileLayoutTable.pdf.

AZS277-010999-180524.TXT

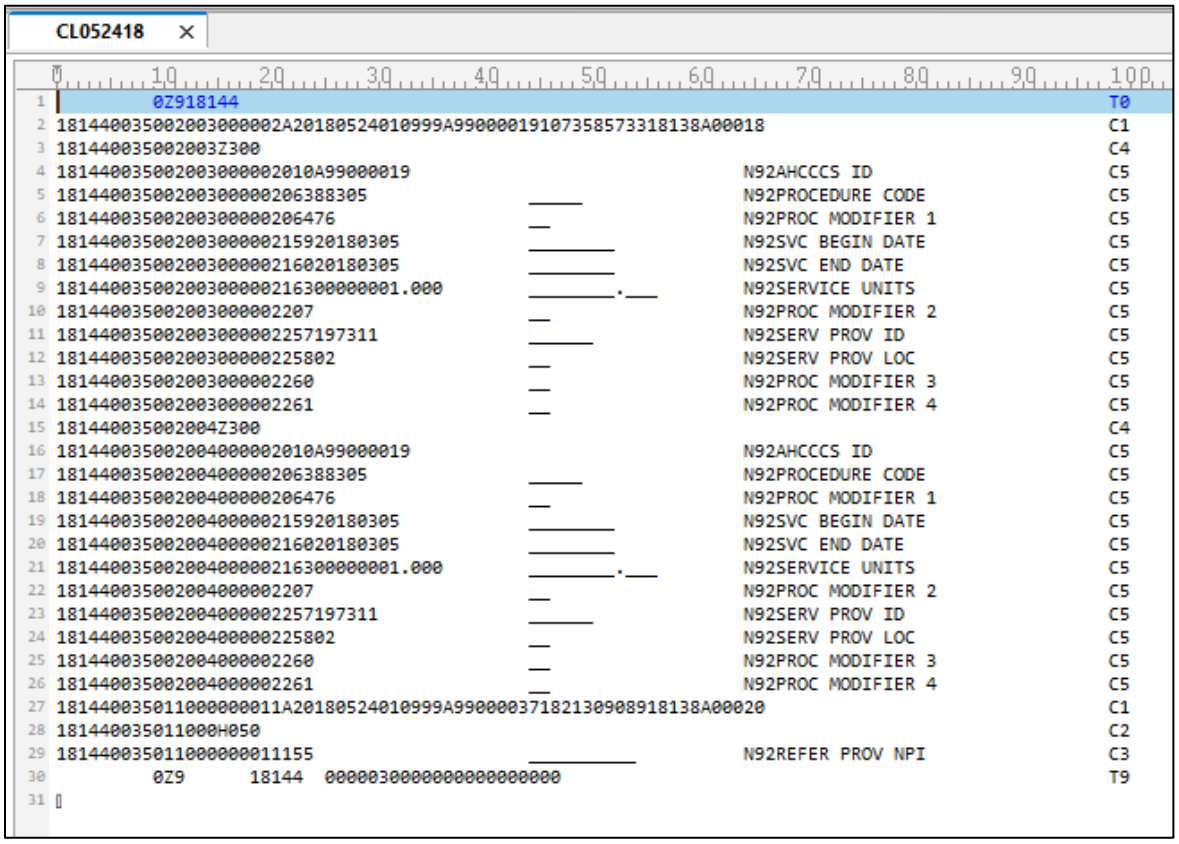
```
1  3109990Z9201805245U
2  181440035003001                    DNA          M47812              200.70      200.70H280
3  181440033006001                    DEA          I426   01             .00         .00
4  181440033006002                    DEA          I426   01             .00         .00
5  181440033006003                    DEA          I426   01             .00         .00
6  181440035004001                    DNA          Z00129 01           77.93       77.93P332
7  181440035004002                    DNA          Z00129 01           18.58       18.58P332
8  181440033004001                    DEA          R5381  01             .00         .00
9  181440033004002                    DEA          Z87828 01             .00         .00
10 181440017006                       DEO          N186   16             .00         .00
11 181440017007                       DEO          N186   16             .00         .00
12 181440035009001                    APA          Q673   15         4000.00     4000.00
13 181440035010001                    APA          Q673   15         4000.00     4000.00
14 181440035008001                    DNA          F840   47           54.72       54.72P332
15 181440035006001                    DNA          F809   07           17.82       17.82P332
16 181440035006002                    DNA          F809   07           75.61       75.61P332
17 181440035002001                    APA          D122   12           60.26       60.26
18 181440035002002                    APA          D123   12           60.26       60.26
19 181440035002003                    PEA          D124   12           60.26       60.26
20          0Z9      18144SU00000018
21
```

Pend Files (PEND):

File name = HPPLANID_CLMMDDYY.ZIP.

This file contains pended encounters that passed validation and translation, but failed the adjudication edit or audit process. These encounters will continue to pend and appear on the Pend File until the Contractor corrects the encounters.

The File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PendFileLayoutTable.pdf.

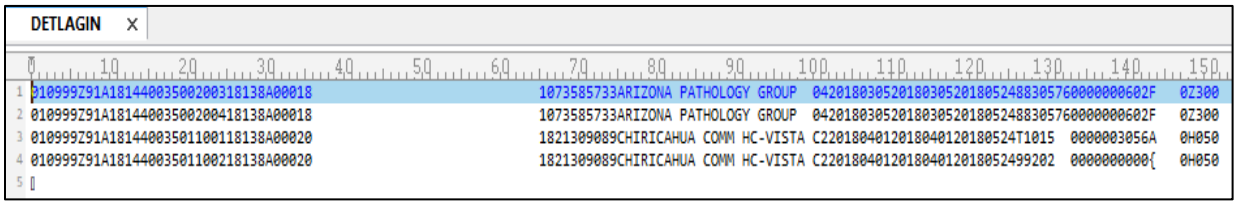


Pended Encounter Detail Aging File (Record Layout-DETLAGIN):

File name = HPPLANID_DETLAGINMMDDYY.ZIP.

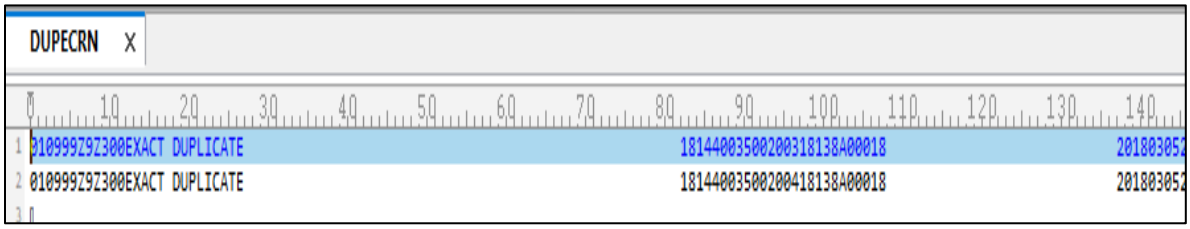
This file contains the number of days encounters have been pended and additional information regarding those pended encounters.

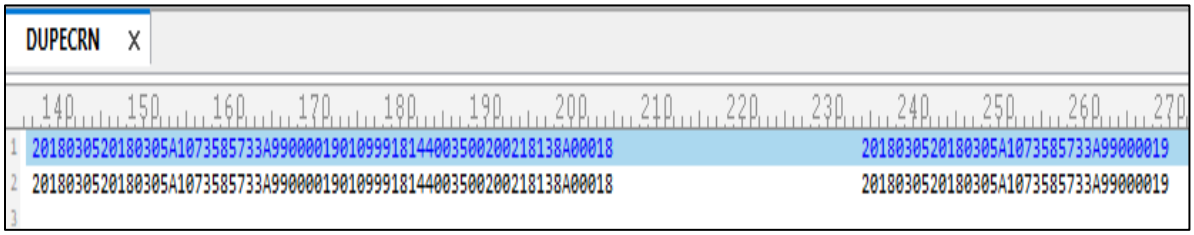
The File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PendedEncounterDetailedAgingFileLayoutTable.pdf.



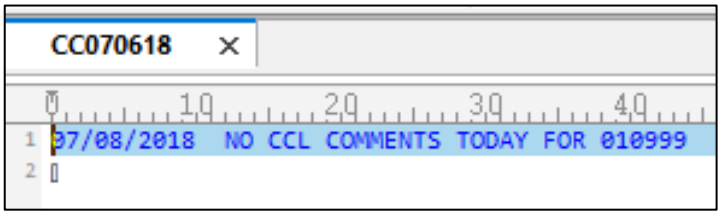
Pended Encounter Duplicate CRN File (Record Layout -DUPECRN):

File name = HPPLANID_DUPECRNMMDDYY.ZIP.
This file contains information regarding duplicate pended encounters and the encounters already in history that are causing the duplicate audit failure.
The File Layout is located at
www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PendingCRNFileLayoutTable.pdf.





Comment File (CC):
File name = HPPLANID_CCMMDDYY.ZIP.
This file contains comments regarding select pended encounters. The comments are intended to aid in the correction of these pended encounters.
The File Layout is located at
www.azahcccs.gov/Resources/Downloads/Contractor/Tables/CommentFileLayoutTable.pdf.

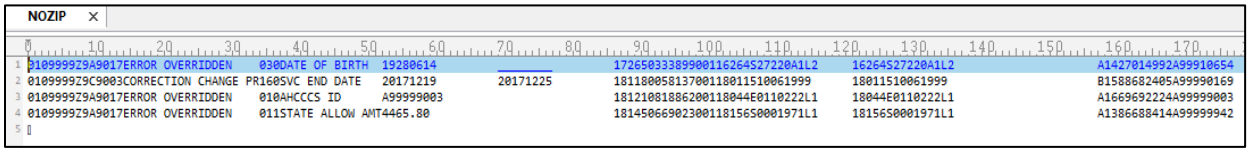


Detail Show Action Taken (Record Layout-ACTNTKN):

File name = HPPLANID.PNMMDDYY.TSN.ZIP.YYMMDD.ACTNTKN.ZIP.

This file contains information regarding action taken on pended encounters during the last cycle.

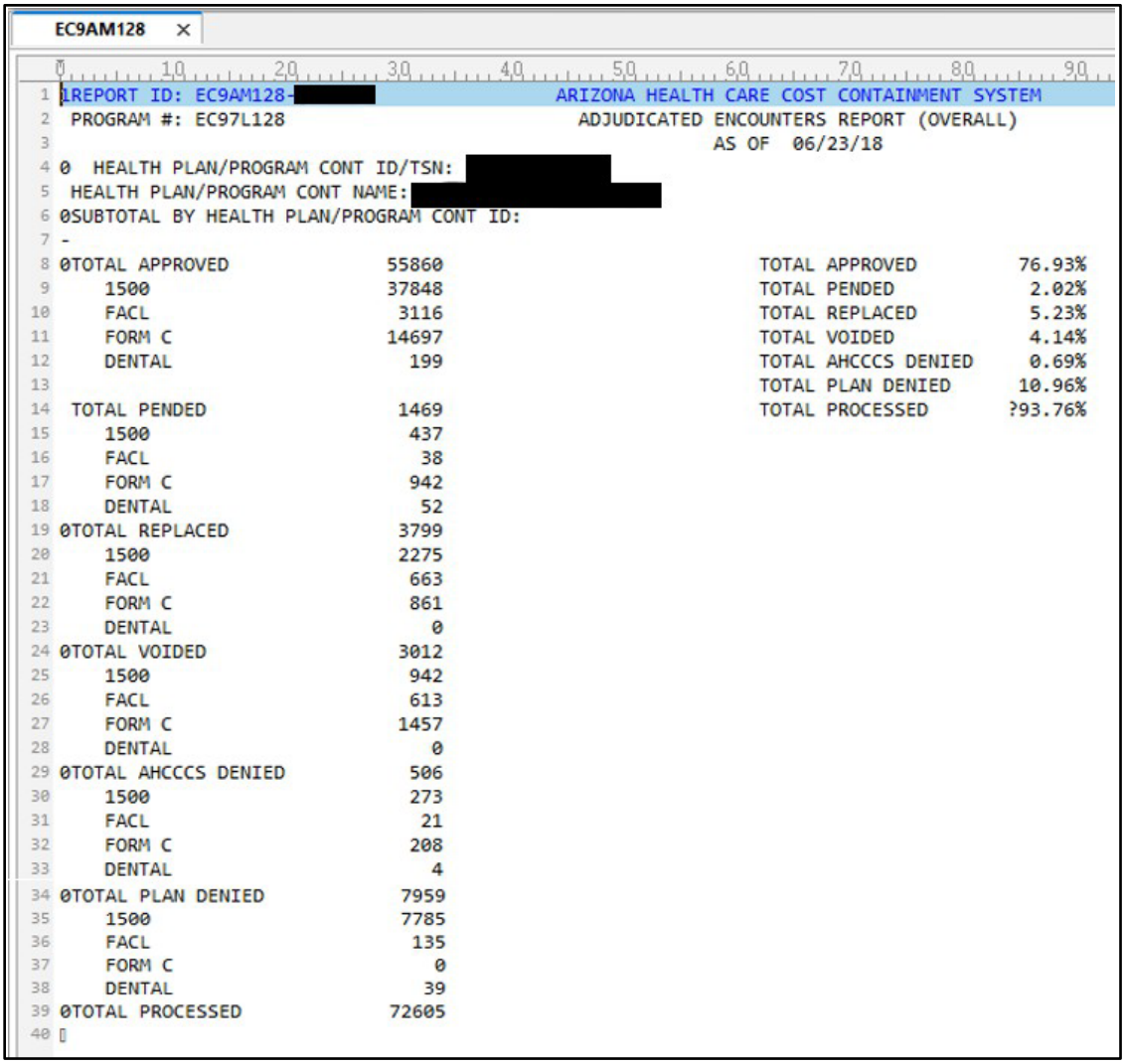
The File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/DetailShowActionFileLayoutTable.pdf.



Adjudicated Encounters Report Overall (Report ID-EC9AM128):

File name = HPPLANID_RC_EC9AM128MMDDYY.ZIP.

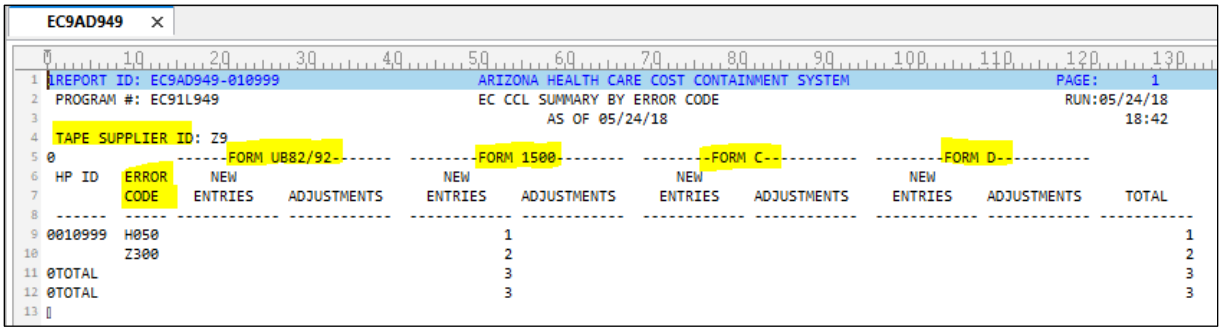
This report provides an encounter count of finalized and pended status by form type and an overall percent of finalized encounters by status.



EC CCL Summary by Error Code (Report ID-EC9AD949):

File name = HPPLANID_RC_EC9AD949MMDDYY.ZIP.

The cycle (CCL) Summary indicates the number of errors by transmission submitter number, by form type and by error code.



EC9AD949

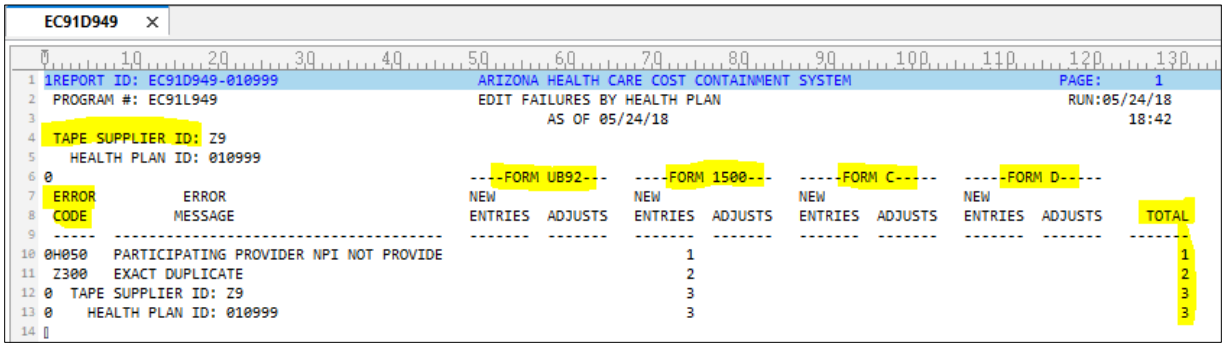
```
1REPORT ID: EC9AD949-010999                ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                PAGE:      1
 PROGRAM #: EC91L949                       EC CCL SUMMARY BY ERROR CODE                               RUN:05/24/18
                                                  AS OF 05/24/18                                            18:42

 TAPE SUPPLIER ID: Z9
0                 ------FORM UB82/92-------  --------FORM 1500--------  --------FORM C----------  --------FORM D----------
 HP ID    ERROR      NEW                        NEW                        NEW                        NEW
          CODE     ENTRIES    ADJUSTMENTS     ENTRIES    ADJUSTMENTS     ENTRIES    ADJUSTMENTS     ENTRIES    ADJUSTMENTS     TOTAL
 ------   -----  ------------ ------------  ------------ ------------  ------------ ------------  ------------ ------------ -----------
0010999   H050                                      1                                                                              1
          Z300                                      2                                                                              2
0TOTAL                                              3                                                                              3
0TOTAL                                              3                                                                              3
```

Edit Failures by Health Plan (Report ID-EC91D949):

File name = HPPLANID_RC_EC91D949MMDDYY.ZIP.

This report provides a count of pended encounters by transmission submitter number, error code, and form type.



EC91D949

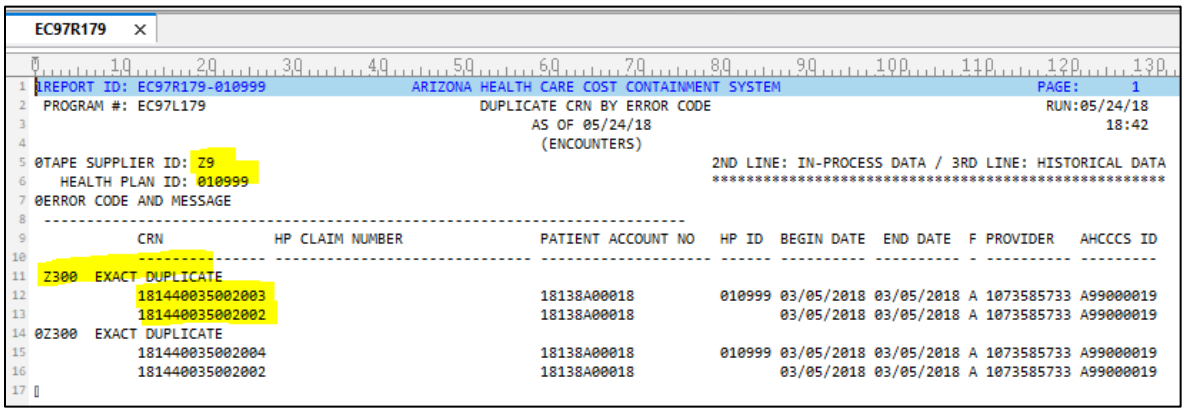
```
1REPORT ID: EC91D949-010999                ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                PAGE:      1
 PROGRAM #: EC91L949                       EDIT FAILURES BY HEALTH PLAN                               RUN:05/24/18
                                                  AS OF 05/24/18                                            18:42

 TAPE SUPPLIER ID: Z9
    HEALTH PLAN ID: 010999
0                                         ----FORM UB92---   ----FORM 1500---   -----FORM C-----   -----FORM D-----
 ERROR          ERROR                     NEW                NEW                NEW                NEW
 CODE           MESSAGE                   ENTRIES  ADJUSTS   ENTRIES  ADJUSTS   ENTRIES  ADJUSTS   ENTRIES  ADJUSTS    TOTAL
 -----  ---------------------------------- -------  -------   -------  -------   -------  -------   -------  -------   -------
0H050   PARTICIPATING PROVIDER NPI NOT PROVIDE                      1                                                        1
 Z300   EXACT DUPLICATE                                            2                                                        2
0  TAPE SUPPLIER ID: Z9                                            3                                                        3
0    HEALTH PLAN ID: 010999                                        3                                                        3
```

Duplicate CRN by Error Code (Report ID-EC97R179):

File Name = HPPLANID_RC_EC97R179MMDDYY.ZIP.

This report contains information regarding duplicate pended encounters and the encounters that are causing duplicate pended encounters. The File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/DupeCRNbyErrorFileLayoutTable.pdf.



EC97R179

```
1REPORT ID: EC97R179-010999              ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                  PAGE:      1
 PROGRAM #: EC97L179                     DUPLICATE CRN BY ERROR CODE                                 RUN:05/24/18
                                                AS OF 05/24/18                                            18:42
                                                (ENCOUNTERS)
0TAPE SUPPLIER ID: Z9                                                2ND LINE: IN-PROCESS DATA / 3RD LINE: HISTORICAL DATA
   HEALTH PLAN ID: 010999                                            **************************************************
0ERROR CODE AND MESSAGE
 ------------------------------------------------------------------------
           CRN            HP CLAIM NUMBER              PATIENT ACCOUNT NO   HP ID  BEGIN DATE  END DATE  F PROVIDER   AHCCCS ID
           ---------------                             ------------------   ------ ---------- ---------- - ---------- ---------
 Z300  EXACT DUPLICATE
           181440035002003                             18138A00018          010999 03/05/2018 03/05/2018 A 1073585733 A99000019
           181440035002002                             18138A00018                 03/05/2018 03/05/2018 A 1073585733 A99000019
0Z300  EXACT DUPLICATE
           181440035002004                             18138A00018          010999 03/05/2018 03/05/2018 A 1073585733 A99000019
           181440035002002                             18138A00018                 03/05/2018 03/05/2018 A 1073585733 A99000019
```

Pended Encounters Detailed Aging (Report ID-EC9EM187):

File name = HPPLANID_RC_EC9EM187MMDDYY.ZIP.

The detailed aging report is a list of pended encounters by transmission submitter number, aging category, form type, and error code. The File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PendedEncounterDetailedAgingFileLayoutTable.pdf.

EC9EM187

```
1REPORT ID: EC9EM187-010999                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                                  PAGE:        1
 PROGRAM #: EC97L187                             PENDED ENCOUNTERS DETAILED AGING REPORT                                   RUN:05/24/18
                              (SORTED BY HEALTH PLAN, TAPE SUPPLIER NUMBER, AGING CATEGORY, FORM TYPE AND CRN)                    18:43
0   HEALTH PLAN: 010999
  TAPE SUPPLIER: Z9
 AGING CATEGORY: 1 - 30 DAYS
0FM                                                  ========= SERVICE PROVIDER =======                      PROCESS  PROC  PEND
 TP     CRN        PATIENT ACCOUNT NUM  HEALTH PLAN CRN         ID      NAME                 TP BEG DOS  END DOS    DATE   -NDC   DAYS
 - --------------- -------------------- -------------------- ---------- ---------------------- -------- -------- -------- -----------
 A 181440035002003 18138A00018                                1073585733 ARIZONA PATHOLOGY GRO04 03/05/18 03/05/18 05/24/18 88305-76
0  TOT:$           ERRORS:  Z300                                                                                              0
0A 181440035002004 18138A00018                               1073585733 ARIZONA PATHOLOGY GRO04 03/05/18 03/05/18 05/24/18 88305-76
0  TOT:$           ERRORS:  Z300                                                                                              0
0A 181440035011001 18138A00020                               1821309089 CHIRICAHUA COMM HC-VIC2 04/01/18 04/01/18 05/24/18 T1015
0  TOT:$         3 ERRORS:  H050                                                                                              0
0A 181440035011002 18138A00020                               1821309089 CHIRICAHUA COMM HC-VIC2 04/01/18 04/01/18 05/24/18 99202
0  TOT:$           ERRORS:  H050                                                                                              0
0TOTALS:           4 ENCOUNTERS FOR HEALTH PLAN 010999, TAPE SUPPLIER Z9, PENDED 1 - 30 DAYS
                   4 ERRORS
0TOTALS:           4 ENCOUNTERS FOR HEALTH PLAN 010999, TAPE SUPPLIER Z9
       :            $426.13 TOTAL DOLLARS FOR HEALTH PLAN 010999, TAPE SUPPLIER Z9
                   4 ERRORS
1REPORT ID: EC9EM187-010999                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                                  PAGE:        2
 PROGRAM #: EC97L187                             PENDED ENCOUNTERS DETAILED AGING REPORT                                   RUN:05/24/18
                              (SORTED BY HEALTH PLAN, TAPE SUPPLIER NUMBER, AGING CATEGORY, FORM TYPE AND CRN)                    18:43
0   HEALTH PLAN: 010999
  TAPE SUPPLIER: Z9
 AGING CATEGORY:
0 ERROR
  CODE   ========================== ERROR MESSAGE ============================
  H050   PARTICIPATING PROVIDER NPI NOT PROVIDED OR INVALID
  Z300   EXACT DUPLICATE
1REPORT ID: EC9EM187-010999                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                                  PAGE:        3
 PROGRAM #: EC97L187                             PENDED ENCOUNTERS DETAILED AGING REPORT                                   RUN:05/24/18
                              (SORTED BY HEALTH PLAN, TAPE SUPPLIER NUMBER, AGING CATEGORY, FORM TYPE AND CRN)                    18:43
0   HEALTH PLAN: 010999
  TAPE SUPPLIER:
 AGING CATEGORY:
0FM                                                  ========= SERVICE PROVIDER =======                      PROCESS  PROC  PEND
 TP     CRN        PATIENT ACCOUNT NUM  HEALTH PLAN CRN         ID      NAME                 TP BEG DOS  END DOS    DATE   -NDC   DAYS
 - --------------- -------------------- -------------------- ---------- ---------------------- -------- -------- -------- -----------
-TOTALS:           4 ENCOUNTERS FOR HEALTH PLAN 010999
       :            $426.13 TOTAL DOLLARS FOR HEALTH PLAN 010999
                   4 ERRORS
```

Pended Encounters Summarized Error (Report ID-EC9FM187):

File name = HPPLANID_RC_EC9FM187MMDDYY.ZIP.

The summary of pended encounters illustrates the pended encounter error count in descending order.

EC9FM187

```
1REPORT ID: EC9FM187-010999          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM          PAGE:     1
 PROGRAM #: EC97L187                   PENDED ENCOUNTERS SUMMARIZED ERROR REPORT          RUN:  06/10/18
                                  (SORTED BY HEALTH PLAN AND ERROR COUNT IN DESCENDING ORDER)      08:04
    HEALTH PLAN: 010999
-
 ERROR                                                                          FORM
 CODE   ERROR MESSAGE                                                          TYPE  ERROR COUNT
 -----  ------------------------------------------------------------------------ ----  -----------
 Z305   NEAR DUPLICATE FOUND                                                   A            2010
0Z300   EXACT DUPLICATE                                                       A            1966
0A905   UNREASONABLE AHCCCS ALLOWED AMT IN RELATION TO BILLED AMT             C            1742
0Z300   EXACT DUPLICATE                                                       O             576
0H050   PARTICIPATING PROVIDER NPI NOT PROVIDED OR INVALID                    A             369
0H199   INGREDIENT COST + DISPENSE FEE + SALES TAX < HP PAID AMT              C             170
0Z305   NEAR DUPLICATE FOUND                                                  O             144
0Z800   EXACT DUPLICATE FOUND                                                 C             104
0H209   VACCINE ADMINISTRATION FEE EXCEEDS CONTRACTED AMOUNT                  C              99
0A905   UNREASONABLE AHCCCS ALLOWED AMT IN RELATION TO BILLED AMT             A              76
0Z305   NEAR DUPLICATE FOUND                                                  I              47
0Z340   RELATED PROVIDER DUPLICATE                                            A              29
0D045   RECIPIENT SEX INVALID FOR PRIMARY DIAGNOSIS                           A              26
0N027   DRUG NOT ELIGIBLE FOR MEDICAID COVERAGE                               C              21
0P353   PROVIDER TYPE NOT ELIGIBLE FOR SERVICE BILLED                         A              17
0R105   BIRTH WEIGHT IS OUT OF RANGE                                          I              15
0A905   UNREASONABLE AHCCCS ALLOWED AMT IN RELATION TO BILLED AMT             L              15
0S385   SERVICE UNITS EXCEED MAXIMUM ALLOWED                                  A              13
0Z300   EXACT DUPLICATE                                                       I              13
0R410   RECIPIENT NOT ELIGIBLE FOR AHCCCS SERVICES ON SERVICE DATES           A              12
0R100   BIRTH WEIGHT IS REQUIRED                                              I              12
0R480   RECIPIENT NOT ENROLLED ON SERVICE DATES                               A              11
0S445   PROCEDURE MODIFIER INVALID FOR PROCEDURE ON DATE OF SERVICE           A              11
-TOTAL                                                                                     7498
```

Detail and Summary Show Action Taken (Report ID-EC91R901):

File name = HPPLANID.PHMMDDYY.TSN.ZIP.YYMMDD.RPTS.ZIP.

This report contains information regarding action taken on pended encounters. The File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/DetandSumShowFileLayoutTable.pdf.

IMPORTANT NOTE: Contractors have 90 days from the date the files are placed on the server to retrieve files and reports before AHCCCS removes them from the SFTP Server site as a component of the automated processing.

XIII. ENCOUNTER MONTHLY RECONCILIATION DATA FILE AKA "MAGIC" FILE

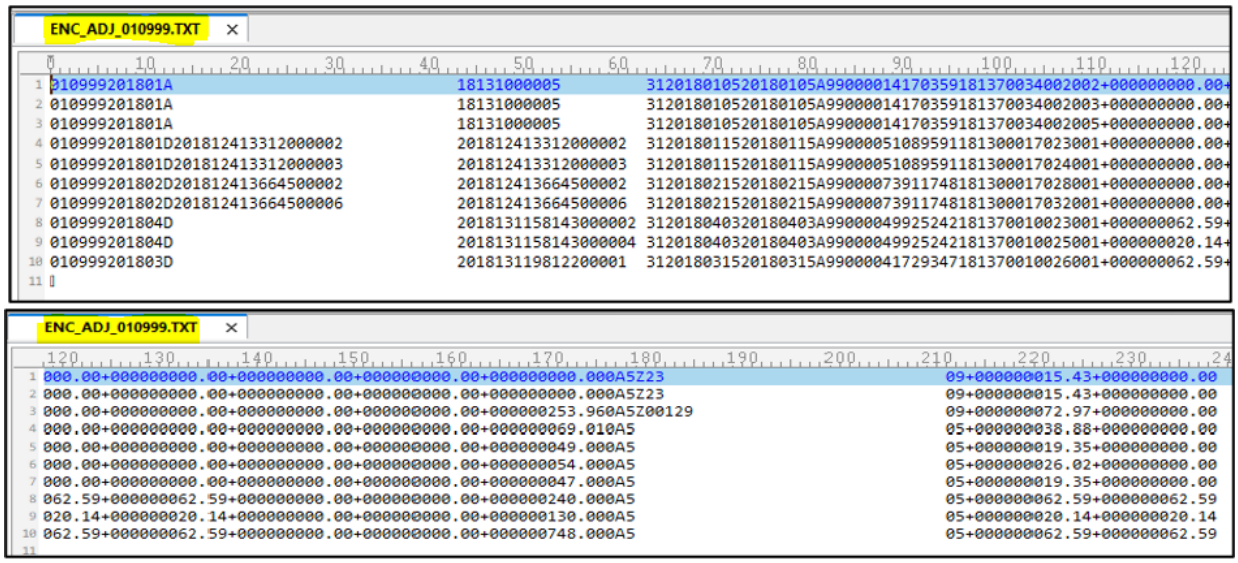
Monthly, AHCCCS provides each Contractor with an encounter data extract that Contractors must use to compare financial data in the AHCCCS Encounter Database with the Contractors' claims financial data. The file is replaced each month and contains the past 36 months of encounter financial data submitted to AHCCCS. If a Contractor misses processing for a month, the following month will include the previous months minus the oldest month and the new encounters reaching adjudicated status by AHCCCS in the current month. The file is to be used by the Contractor to verify what has been submitted to AHCCCS.

Encounter Monthly Extract File Layout (Magic File):
www.azahcccs.gov/Resources/Downloads/Contractor/Tables/EncounterMonthlyFileLayoutTable.pdf
The file is available on the SFTP server after the completion of the second encounter cycle of the month.

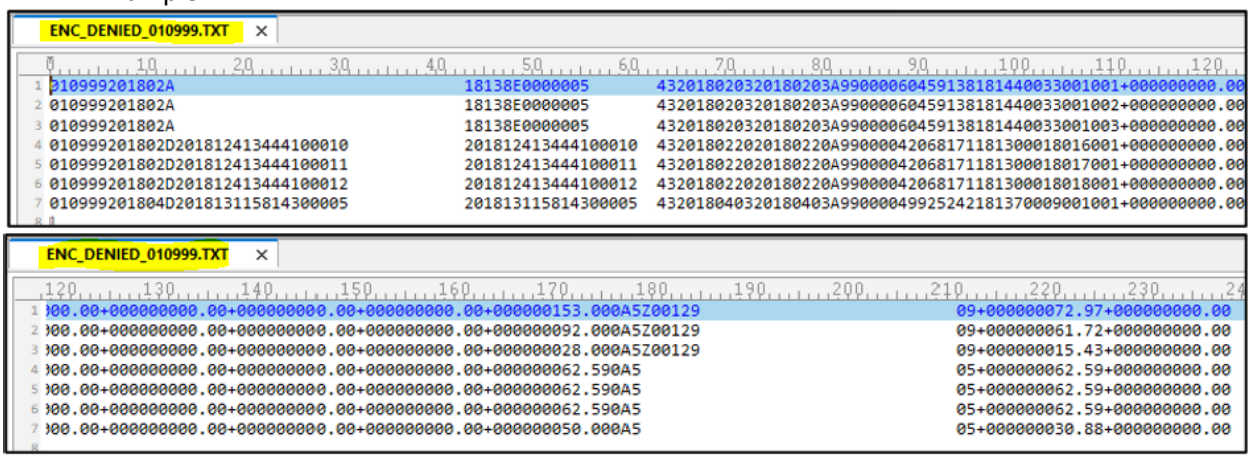
Location: sftp.statemedicaid.us\xxx\prod\out\ENC_nnnnnn.zip
xxx = 3 Character Plan Mnemonic assigned to each Contractor
nnnnnn = Health Plan ID
The zipped file contains the following five type codes for encounter file extracts named ENC_type code_nnnnnn.TXT:

- ADJ – Adjudicated/Approved – Status 31
- DENIED – Adjudicated/Plan Denied – Status 43
- ACCDNY – Adjudicated/AHCCCS Denied – Status 41
- PEND – Pended – Status 11
- VOID – Adjudicated/Voided – Status 32

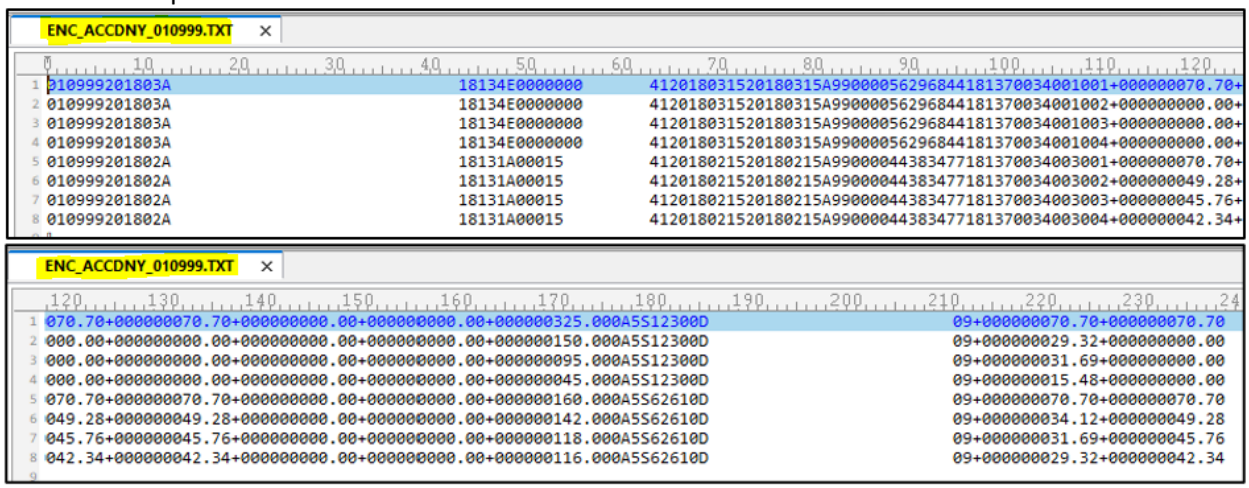
ADJ Example:



DENIED Example:



ACCDNY Example:



PEND Example:

ENC_PEND_010999.TXT

```
010999201801A                    18131000005         11201801052018010 5A990000141703591813700340020 01+000000022.32+
010999201801A                    18131000005         11201801052018010 5A990000141703591813700340020 04+000000000.00+
010999201801A                    18131A00010         11201801072018010 7A990000052752741813700340040 01+000000000.00+
010999201804A                    18131000003         11201804092018040 9A990000629279701813700350020 02+000000000.00+
010999201803A                    18134E0000009       11201803012018030 1A990000199293431813700350030 01+000000013.68+
0109992018040201812413532200001  201812413532200001  11201804092018040 9A990000247060121813000170250 01+000000116.44+
0109992018010201812413555500001  201812413555500001  11201801152018011 5A990000665167261813000170260 01+000000076.63+
0109992018020201812413664500001  201812413664500001  11201802152018021 5A990000739117481813000170270 01+000000301.30+
0109992018040201812413996400001  201812413996400001  11201804022018040 2A990000499441251813000170330 01+000000308.32+
010999201803D                    201813119812200003  11201803152018031 5A990000417293471813700100280 01+000000062.59+
```

ENC_PEND_010999.TXT

```
22.32+000000022.32+000000000.00+000000000.00+000000131.400A5Z23                                  09+000000015.43+000000022.32
00.00+000000000.00+000000000.00+000000000.00+000000000.000A5Z23                                  09+000000015.43+000000000.00
00.00+000000000.00+000000000.00+000000000.00+000000312.730A5Z113    Z6820                        09+000000183.44+000000000.00
00.00+000000000.00+000000000.00+000000000.00+000000000.000A5Z23                                  09+000000015.43+000000000.00
13.68+000000013.68+000000000.00+000000000.00+000000021.540A5F329                                 09+000000013.69+000000013.68
16.44+000000116.44+000000000.00+000000000.00+000000300.000A5                                     05+000000116.44+000000116.44
76.63+000000076.63+000000000.00+000000000.00+000000191.000A5                                     05+000000076.63+000000076.63
01.30+000000301.30+000000000.00+000000000.00+000000301.300A5                                     05+000000000.00+000000301.30
08.32+000000308.32+000000000.00+000000000.00+000000308.320A5                                     05+000000000.00+000000308.32
62.59+000000062.59+000000000.00+000000000.00+000000748.000A5                                     05+000000062.59+000000062.59
```

VOID Example:

ENC_VOID_010999.TXT

```
2017341NV90496          2017341NV90496          32201712022017120 2A9998131917619917352044441300 1+000000039.13+
2017343XX64943          2017343XX64943          32201712052017120 5A6223034217619917352044441800 1+000000030.00+
2017342XX75486          2017342XX75486          32201712022017120 2A4557019576461417352044500100 1+000000001.12+
2017343YY56451          2017343YY56451          32201712042017120 4A6940183596443817352044582500 1+000000051.25+
2017343AA76621          2017343AA76621          32201712032017120 3A3414001016336117352044852600 1+000000051.25+
2017342YY62721          2017342YY62721          32201712042017120 4A5641524436572717352045487800 1+000000030.89+
2017343YY68241          2017343YY68241          32201712022017120 2A1263027757119117352046157700 1+000000068.47+
2017343YY68242          2017343YY68242          32201712022017120 2A4313027757119117352046157800 1+000000002.39+
2017345YY78332          2017345YY78332          32201712032017120 3A5912003375820117352046159700 1+000000005.00+
2017344XX92521          2017344XX92521          32201712082017120 8A6286017120892717352046276400 1+000000051.25+
```

ENC_VOID_010999.TXT

```
39.13+000000039.13+000000000.00+000000000.00+000000077.50017Z01411                                02+000000039.13+000000039.13
30.00+000000030.00+000000000.00+000000000.00+000000030.00017I10                                   02+000000000.00+000000030.00
01.12+000000001.12+000000000.00+000000000.00+000000048.00017R112    C3412   Z5111                 02+000000001.12+000000001.12
51.25+000000051.25+000000000.00+000000000.00+000000080.00017J209    J069                          02+000000051.25+000000051.25
51.25+000000051.25+000000000.00+000000000.00+000000146.60017J329    A609    F319    N979          02+000000035.87+000000051.25
30.89+000000030.89+000000000.00+000000000.00+000000088.00017R1013   R079    K2970   K209          02+000000030.89+000000030.89
68.47+000000068.47+000000000.00+000000000.00+000000202.00017N3001   N7689                         02+000000055.41+000000068.47
02.39+000000002.39+000000000.00+000000000.00+000000021.00017N3001   N7689                         02+000000002.94+000000002.39
05.00+000000005.00+000000000.00+000000000.00+000000005.00017M542                                  02+000000000.00+000000005.00
51.25+000000051.25+000000000.00+000000000.00+000000114.00017M65311  F458                          02+000000051.25+000000051.25
```

XIV. MODIFICATIONS TO ENCOUNTERS

When the Contractor adjusts, replaces, voids, or reprocesses claims, the Contractor must revise the corresponding encounter records that were adjudicated and placed into history by AHCCCS. Please refer to the X12N technical reports or NCPDP implementation guide for procedures to void and/or replace previously approved pharmacy encounters in history.

AHCCCS accepts replacements and voids for all form types at the claim header level. Voiding or replacing professional, dental, or pharmacy encounters at the claim header results in a void or replacement of all claim line information regardless of each claim line's adjudication or pend status. Only the first 12 digits of the CRN should be submitted when replacing or voiding. Void or replacement at the claim header must reflect the Contractor's final disposition or all claim lines for the claim.

XV. ADJUDICATION SYSTEM ERROR CORRECTION

The correction of encounters denied or pended by AHCCCS allows Contractors to modify or correct encounter data and, for a limited set of edits, override edits such as a potential duplicate of another encounter or unit limitation guidelines. The 277 and Pend Files provided by AHCCCS identify the error conditions that caused the record to fail, assisting Contractors with identifying and resolving the problem. AHCCCS allows a grace period (refer to SANCTIONS in Section XIX) to correct aging pended or denied encounters. No penalty/sanction is applied to Contractor encounter corrections re-adjudicated as accepted within the grace period. Sanctions may be applied to denied or pended encounters that remain uncorrected or voided after the grace period.

XVI. COMPLETE, ACCURATE, AND TIMELY ENCOUNTER DATA

Contractors are required to monitor, track, and trend encounter submissions and corrections. If Contractors or their subcontracted encounter vendor is unable to resolve submission issues, correct errors or achieve acceptable encounter completion, accuracy, and timeliness rates, AHCCCS may require Corrective Action Plans and/or apply sanctions.

Completeness Measure:

Requires that encounters be submitted for all Contractor primary and secondary paid claims, as well as selected plan denials and Zero Medicaid Payment claims. These encounters must reach adjudicated/approved encounter status to eliminate omissions of AHCCCS eligible service utilization data required by contract.

Accuracy Measure:

Requires that the encounter data submitted correctly reflects the approved coding of the services reported. The encounter data must reflect the data coding submitted by the provider and enter as finalized in the Contractor's claims system. All required encounter elements must match provider claim submission and finalized claim adjudication in the Contractor's claims system.

Timeliness Measure:

Requires that all encounters reach approved adjudication status in the AHCCCS database within specified time periods. As per the contract, Professional, Institutional, and Dental Encounters (not eligible for Federal Drug Rebate processing) must be received by AHCCCS no later than 210 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Failure to submit encounters within 210 days may result in sanctions.

Pharmacy-related encounter data and other encounters involving services eligible for Federal Drug Rebate processing must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmacy item was dispensed. Adherence to each of these measures is partially monitored through Encounter Data Validation Studies routinely conducted by AHCCCS. The purpose of these studies is to compare submitted encounter data with other sources (e.g., medical records, provider claims submissions, Contractor claims system to the Contractor submitted encounter data). Further details on annual and focused Data Validation Studies can be obtained on the AHCCCS website at www.azahcccs.gov/PlansProviders/Downloads/Encounters/EncounterValidationTechnicalDocument.pdf. Adherence may also be evaluated during Annual Contractor Operational Reviews or through focused encounter reviews.

XVII. ENCOUNTER SUBMISSION BENCHMARKS – STANDARD MEASURE DATA POINTS

AHCCCS also monitors the overall volume of encounter submission and adjudication status by form type based upon a Contractor's enrollment. Based on a specified methodology, these encounter benchmarks will be based on rolling five (5) years of most recent data, and the data points will be reviewed annually for each contract year going forward and remeasured as the benchmarks are achieved and sustained by the Contractor. The goal of the benchmarks is to drive improvement. Benchmarks will be set for the following areas:

- Total approved encounters per member per month:
  - Approved percentage of total encounters.
- Total pended encounters per member per month:
  - Pended percentage of total encounters.
- Total voided encounters per member per month:
  - Voided percentage of total encounters.
- Total denied encounters per member per month:
  - Denied percentage of total encounters.

Benchmarks have been developed for the AHCCCS Complete Care (ACC) and Long-Term Care Contractors. Individual benchmarks were also created for each form type, A, C, D, I, O, and L; however, at this time, these benchmarks will be utilized by staff for internal monitoring only. The essential rule for standard compliance is one standard deviation from the five (5) contract year means. This rule identifies some outliers of encounter percentages and member month. Half of a standard deviation may be applied according to the plan performance and AHCCCS requirements.

XVIII. TRACKING ENCOUNTERS DENIED BY AHCCCS AND CONTRACTOR VOIDED ENCOUNTERS

Contractors are required to monitor encounters denied by AHCCCS and encounters voided by the Contractor. It is the Contractor's responsibility to either replace AHCCCS denied encounters, void the claims, recoup Medicaid funds, and correct or void pended encounters.

When AHCCCS denied and Contractor voided encounters due to data submission errors, the Contractor must replace or resubmit the encounters with revised data. The encounter must reflect the Contractor's final disposition of all claim lines for replacements. Data submission errors that are not replaced or resubmitted may affect the Contractor's encounter completeness rates.

AHCCCS denied encounters and Contractor voided encounters are not used by AHCCCS for Contractor capitation, rate setting development, evaluation of health outcomes, or Contractor performance. Contractors should ensure that encounters are submitted according to AHCCCS requirements to avoid underreporting data that may have a negative effect on Contractors.

Replaced encounters are linked to previous encounter submissions for purposes of encounter timeliness. Encounters resubmitted instead of replaced are treated as original submissions unrelated to prior encounter submissions. As a result, untimely encounter resubmissions may affect the Contractor's timeliness sanctions, supplemental payments, capitation and rate setting development, evaluation of health outcomes, or Contractor performance.

XIX. SANCTIONS

Aged-Pended Encounters:

AHCCCS Contractors are required by contract to monitor and resolve pended and AHCCCS denied encounters. Pended encounters are required to be corrected or appropriately voided within 120 days from the AHCCCS encounter received date, recorded as part of the AHCCCS assigned CRN.

AHCCCS conducts quarterly monitoring of pended encounter aging. The data pull for the quarterly pended encounter aging file is a snapshot of encounters in pended status as of the last day of that quarter. Any pends corrected online or by pend correction files processed up to that date would be excluded from the data pull. The result of this aging monitoring generates Contractor pended encounter letters that may result in monetary sanctions for those pended encounters aged over 120 days.

Monitoring information extracted for each Contractor for the three (3) month period at the end of the quarter is downloaded into a Statistical Package for the Social Sciences (SPSS) Program for review. The data set is filtered to eliminate "soft" (used internally for statistical information gathering purposes) error codes; other "hard" (pend or deny back to the Contractor for correction) error codes specifically waived from sanction by AHCCCS, and edits or audits identified by AHCCCS as related to internal only edits. The reports are produced, reviewed internally, and distributed as preliminary to each Contractor for review and response.

The preliminary sanction report is distributed via the SFTP server. Contractors have 30 days to review the findings and respond to AHCCCS. AHCCCS will review and consider the response provided by the Contractor, and then a final sanction letter will be issued.

Sanction amounts are calculated based on the following amounts per pended encounter:

- Over 120 days less than 180 days = $5.00
- Over 180 days less than 240 days = $10.00
- Over 240 days less than 360 days = $15.00
- Over 360 days = $20.00

Pended Encounter Sanction Grievances:

Contractors have the right to file a grievance regarding encounter sanctions. Grievances must be filed in a timely manner. The details on filing this type of grievance are included in the Contractor notification letter.

Encounter Timelines Sanctions:

All Encounters not involving services eligible for Federal Drug Rebate processing shall be received by AHCCCS no later than 210 days for DOS after 10/1/2018; after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Unique to the R805 & R806 edits, the logic will be applied upon initial submission of Encounters, and once failed and logged, the edit will not persist when the Encounter is next edited or recycled. If an Encounter is initially submitted (new day or denied) and is timely, any subsequent replacements/resubmissions if submitted as such will also be considered timely.

After each encounter cycle, the following text files will be posted to each Contractor's SFTP Server folder. AHCCCS will send a notification to the Health Plans when the files are available.

- XXX/OTHER/DHCM/OUT - Placement
- ENC_SANCTIONS_XXXXXX_RPT_YYMMDD.TXT

The timeliness sanctions are $2.00 per encounter, and quarterly, sanctions will be levied one-time at the end of the quarter, and include the total encounters exempted and not exempted for that quarter. For example, January, February, and March findings distributed with one total for sanctionable encounters for the quarter.

XX. ASSISTANCE

Encounter's customer service staff are available Monday through Friday (excluding State holidays) to assist Contractors. In addition, the Encounter Unit conducts ongoing meetings with each Contractor, both on a scheduled and as-needed basis. Contractors should contact their assigned Encounter Technical Liaison to request assistance or training.

Contractors may request encounter assistance or training via the AHCCCSEncounters@azahcccs.gov e-mail address. Questions regarding EDI Portal security issues, validation and/or translation should be submitted to https://servicedesk.azahcccs.gov/portal or send an email to servicedesk@azahcccs.gov. AHCCCS will acknowledge all requests within three (3) days and respond to the request within 30 days unless otherwise notified.

Table of Contents

Chapter Four – Encounter Error Resolution

Chapter 4 – Encounter Error Resolution

I. INTRODUCTION

This chapter provides an explanation of various files and reference information routinely provided by the Arizona Health Care Cost Containment System (AHCCCS) to Contractors to understand the status of encounters that have completed the AHCCCS encounter adjudication cycle and assist Contractors in the correction of failed encounters.

Contractors are liable for resolving encounters denied or pended by AHCCCS. Contractors must research encounters denied by AHCCCS and, when appropriate, resubmit with revised data. Pended encounters must be corrected or voided, and voids tracked. This chapter outlines actions that Contractors may take to resolve pended encounters.

II. AHCCCS ENCOUNTER STATUS REPORTS

Whenever AHCCCS accepts and adjudicates Contractor submitted encounter files, AHCCCS produces encounter Status Files (277U Unsolicited Status and 277S Supplemental Status) after adjudication processing cycle. These files contain information regarding each encounter's adjudication status. Additional details regarding the 277U File can be found in the 277 Unsolicited Encounter Status Companion Document on the AHCCCS website at www.azahcccs.gov/Resources/Downloads/EDIChanges/AZ_277U_Companion_Docv20160902.pdf. Additional information regarding the 277S File can be found in the 277S Supplemental File at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/277SFileLayoutTable.pdf. AHCCCS Technical Interface Guidelines (TIG) – Encounter, File Layouts can be found at www.azahcccs.gov/Resources/Contractor/Manuals/TIG/Encounters/Tables/encounterTables.html#277S.

AHCCCS also produces a Pended Encounter File for pended encounters at the conclusion of adjudication processing. This file contains all encounters pending in the AHCCCS Pre-paid Medicaid Management Information System (PMMIS) database. Contractors use the information in this file to change or approve specific pended encounters. Contractors then submit to AHCCCS a Pended Encounter File indicating the appropriate revisions necessary to clear the pends and allow the records to achieve adjudicated/approved status (status code 31). The Pended Encounter File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PendFileLayoutTable.pdf. Contractors should utilize the Pended Encounter Correction file process to override those encounters allowed for batch override.

IMPORTANT NOTE: The New Day encounter submission process must be used to submit Voided or Replacement Encounters for pended encounter edits related to errors in AHCCCS member ID, service provider ID, plan ID, financial data, paid units, payer data, and claim adjustment status data, as these errors cannot be corrected using the Pended Correction File.

III. ENCOUNTER EDIT CODE REPORTS

The Encounter Edit Resolution Report provides Contractors with information related to correcting various types or groups of specific pend errors. It provides various edits by form type, the fields involved in the edit, and how to correct the pend. It indicates if the correction must be made by submitting a replacement or void encounter, or if it can be corrected using the pend file or online PMMIS correction process. The Edit Status Report is a matrix of encounter edit codes to the following six (6) AHCCCS form types, indicating which edits/audits apply to which form types.

Form Type Indicator	Form
A	HCFA 1500
C	NCPDP
D	AMA DENTAL
I	UBO4 "**I**"NPATIENT HOSPITAL
L	UB04 "**L**"ONG TERM CARE FACILITY
O	UB04 "**O**"UTPATIENT HOSPITAL

The "S" columns in the matrix indicate whether the code will produce an encounter status of pend (Y) or denial by AHCCCS (D). Blanks in the form type "S" status field indicate that the edit is turned off for that form type. Values in the "LV" and "LC" columns indicate the staff level at AHCCCS required to adjust an encounter in PMMIS and override pends. Certain encounter edits and audits may be overridden by Contractor staff directly in the PMMIS system.
Check the AHCCCS website for a guide to online pend corrections using PMMIS and a sortable Excel version of this Edit status report to aid Contractors further in managing pends and denials.
An Edit Status Report is available on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/EncounterEditStatusListV2.pdf.

IV. ENCOUNTER PEND EDIT/AUDIT CODE STRUCTURE

The encounter pend edit/audit codes are four (4) digits alphanumeric (X999) with a leading alpha code that indicates logical grouping of edit reasons. Recognizing the alpha grouping structure helps to improve understanding and aid efficiency when Contractor staff is managing or working to clear pends. It provides a basis for parsing internal Contractor pend correction reports making encounter pend correction more efficient. Below is the alpha character key.

Alpha	Group Description	Form Types
A	COB/TPL and Parity Edits	All
C	Pharmacy RX field validity editing	C only
D	Diagnosis validity and age/gender/diagnosis relational editing	A, I ,L, O
F	Line level validity and relational editing	A, D
G	Dental validity and relational editing	D only
H	Validity editing for required fields	All
I	ICD_9 Procedure code validity and Age/Gender relational editing_	I, L, O

Alpha	Group Description	Form Types
N	Pharmacy and NDC coverage editing	C only
P	Provider related editing (enrollment, coverage, restrictions)	All
R	Recipient related editing (member eligibility, benefit other insurance coverage, plan enrollment)	All
S	Service code validity, coverage, and relational editing	All
T	Inpatient hospital editing including Tier editing	I only
U and V	UB validity and relational editing for header and lines (including condition, occurrence value, dates, revenue, revenue to CPT procedure)	I, L, O
Z	Exact and near duplicate pend editing, overlapping claims AND AHCCCS denials for header and line values(plan, provider, NPI, and more)	All

NOTE: Validity Editing = missing required values or invalid values/codes. Relational Editing = invalid coding combinations across multiple fields. "All" value in form types = certain edits in this grouping relate to many or all form types.

V. PENDED ENCOUNTER CORRECTION AND COMMENT FILES

The tables are ordered by record type, and include the data field name, field size, and in some cases, additional information regarding reporting requirements. Deviation from these requirements may cause a file to fail or an encounter to re-pend. The Pended Encounter File Record Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PendFileLayoutTable.pdf. The Comment File Layout is located at www.azahcccs.gov/Resources/Downloads/Contractor/Tables/CommentFileLayoutTable.pdf. This file contains comments intended to aid in the correction of select pended encounters.

VI. PENDED ENCOUNTER CORRECTION FILE RECORD TYPES

- T0 - Header record - reflects the start of the file.
- T9 - Trailer record - reflects the end of the file.
- C# - All related C1 - C5 records contain a common CRN. When the error relates to a header, the last three (3) positions of the CRN will be "000." When the error relates to a detail line, the last three (3) positions of the CRN must be the appropriate line number.
- C1 - Required. There is only one "C1" record per encounter (invoice). This record is followed by all the header and detail error records related to the encounter (invoice).
- C2 - Optional. This record relates to header errors only. It contains the error codes that have pended. There is only one "C2" record per encounter invoice.
  NOTE: This record is required when approving an encounter that pended as a duplicate of a previously accepted encounter.

- C3 - Required. This record is associated with the “C2” record. It contains key fields relating to the error, such as field name, original value, new value (if any), and action mode (defaulted to "N"). There may be many “C3” records for each “C2” record. Corrections are made on “C3” records by putting correct values into relevant fields and setting the action mode.
- C4 - Optional. This record relates to detail line errors. It contains the error codes that have pended. There is one “C4” record per detail line.
  NOTE: This record is required when approving an encounter that pended for being a duplicate of a previously accepted encounter.
- C5 - Required. This record is associated with the “C4” record. It contains key fields relating to the error, such as field name, original value, new value (if any), and action mode (defaulted to "N"). There may be many “C5” records for each “C4” record. Corrections are made on the C5 records by putting correct values into relevant fields and setting the action mode.

VII. SUBMISSION OF CORRECTED PENDED ENCOUNTERS

It is not necessary for Contractors to resubmit the entire Pended Encounter File to AHCCCS. Only C3/C5 records for which an action mode other than "N" have been set should be resubmitted. When submitting encounter records with an "A" action mode, the applicable C2 or C4 records must be included. Failure to return these records will result in a rejection of the "A" action mode transaction. The C1 record must also be present whenever a C3/C5 record is resubmitted.

VIII. ACTION MODES

In the Pended Encounter File, contractors can take one of three (3) actions relating to a pended encounter. AHCCCS refers to these as action modes.

- C = Correct a pended encounter:
  - Allows Contractors to input new information into the "new value" field on the correction detail. The "new value" will replace the "old value" field on the AHCCCS database when Contractors submit the Pended Encounter File. To delete the contents for the "old value" field, the "new value" field must contain only spaces.
- A = Approve or override an encounter edit:
  - Allows Contractors to approve or override an encounter that is pended for specifically allowed errors. For duplicates, Contractors must verify that both services were provided and were accurately reported before approving duplicate encounters. Contractors must maintain a log for all overrides. Refer to Chapter 3.
- N = No action:
  - This is the default action mode. Contractors should leave the action mode set to "N" when no action is desired.

NOTE: The action mode default is "N" when the Pended Encounter File is produced. To resolve the pended status, Contractors must first choose an appropriate action mode for each pended encounter. In addition to modifying pended encounters with the change "C" action mode in the pended encounter file, Contractors may also modify pended encounters using the replacement value in the 837 or the rebill value in the NCPDP transactions. For additional information regarding replacements, please refer to the 837 Standard Companion Guide Transaction Information or the NCPDP Post Adjudicated History Transaction Companion Guide. An override "A" action mode is not available in the 837 or NCPDP transactions. Therefore, overrides must be submitted using the pended encounter file or entered directly in PMMIS.

Action Mode Hierarchy:

In some cases, more than one action code can be provided for one pended encounter record. When multiple action modes are submitted for the same correction header record, the following hierarchy of application shall apply:

- Action Mode A - The use of action mode "A" will result in the approval or override of the encounter line for an 837P, 837D, or NCPD encounter, or the entire encounter for an 837I. No action mode value of "C" will be applied.
- Action Mode C - If there are no entries of action mode "A" for the record, an action mode of "C" will be applied.

IX. CONTRACTOR REQUEST TO OVERRIDE PENDED ENCOUNTERS

Overrides that Contractors cannot complete utilizing the Pended Encounter Correction File (EC790) or online in PMMIS (EC780) should be uploaded to the SFTP Server under "hpfolder/other." Utilizing the "Encounter Override Request Spreadsheet Template" posted on the AHCCCS website at www.azahcccs.gov/PlansProviders/HealthPlans/encounters.htm and an email notification to the AHCCCS Encounter Unit at AHCCCSEncounters@azahcccs.gov and to the Encounter Technical Liaison. Sufficient information must be submitted to approve and override the pend error. Failure to submit adequate information may result in a processing delay or return of the request for more information.

The override request will be acknowledged and normally processed within 30 days. AHCCCS expedites override requests related to reinsurance cases. Override requests involving reinsurance should be submitted on a separate spreadsheet and have "Reinsurance Cases" notated prominently on the request form. AHCCCS Encounters will not override encounters that Contractor staff have delegated to perform. Selected Contractor staff are assigned a security level within PMMIS that allows Contractors to override those encounters with and adjudication level of 50 and below.

X. AUTOMATION OF BATCH PEND AND DENIAL OVERRIDE PROCESS

The automation process is available for all pending encounter edits with an adjudication level of 50 and below and the current administrative denials submitted to the Encounter's Unit for processing. Contractors may override multiple errors for the same encounter if they are separate records in the submission file and comment reason. PMMIS screen EC790 provides a list of all edits available for this process. Edit errors that meet the criteria for an online override are listed in PMMIS on screen EC780 with an adjudication level of 50 and below. Edits with an adjudication level 51 and not listed in PMMIS screen EC790 will not be available for this process.

Contractors can submit overrides and administrative denial requests daily to the SFTP site, the automation will return two (2) text files, the success file and failure file of the final disposition of requests. Submissions will be validated to ensure the CRN is valid, in a pended status and allowed for an override. Comments are required and must state the reason for the override or denial.

XI. PENDED ENCOUNTERS REQUIRING AHCCCS INTERVENTION

Edits with an adjudication level 51 or above and not listed in PMMIS on screen EC790 must be submitted to the AHCCCS Encounter Technical Liaison for review and if appropriate, adjudicated. Adjudication level for those edits can be verified in PMMIS on screen EC780. These encounters will need to be submitted on the Encounters Override Request Spreadsheet Template.

Encounters totaling 200 or more that need to be overridden and above level 50, will also need to be sent to the Encounter Liaison for review and if approved, the Encounter Liaison will open ticket with the Information Services Division (ISD) to run a system override. These encounters should be submitted in a file to be overridden by pends error code and CRN. This job can accept multiple error codes, multiple comments, and multiple form types in a single request.

XII. OTHER REFERENCE FILES

AHCCCS also produces the following Other Reference Files, which are available from the AHCCCS SFTP server at \shareinfo\reference\prod\out\. The record layouts are located on the in the AHCCCS Technical Interface Guidelines (TIG) at www.azahcccs.gov/Resources/Contractor/Manuals/TIG/.

XIII. EXTRACTS

The following extracts are useful for understanding encounter error correction process.

- Field Information (ECFLD.TXT) extract from (EC720):
  - Provides PMMIS internal field name, number, length, and type code information for each form type in relationship to Form field names. Useful in understanding PMMIS Encounter (internal field) nomenclature used in other encounter tables.
- Error-to-Field Relationship (ECERRFLD.TXT) extract from (EC735):
  - For each encounter error code this file provides listing, by form type, of fields related to each encounter edit code. File uses internal field number from EC720 provided in file above.
- Error Information (ECERR.TXT) extract from (EC745):
  - Lists all current encounter error codes and descriptions.

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Chapter Five – Provider and Reference Files

Chapter 5 – Provider and Reference Files

I. INTRODUCTION

This chapter contains a description and examples of files generated by the Arizona Health Care Cost Containment System (AHCCCS) for Contractors. These files contain information and coding about the provider, reference, and encounter data intended to assist Contractors with accurate encounter submissions. It is an expectation that Contractors will use these data files and coded values as appropriate in the adjudication of their claims. Contractors should have programming to routinely update their systems with this information to replicate the editing logic needed to "pre" adjudicate claims to achieve approved encounter status efficiently. These files will help ensure Contractors meet AHCCCS encounter editing criteria resulting in timely encounter adjudication.

AHCCCS Technical Interface Guidelines (TIG):
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/

AHCCCS Technical Interface Guidelines (TIG) – Provider Interface:
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/provider.html

II. PROVIDER FILES

AHCCCS Technical Interface Guidelines (TIG) – Encounter - File Layouts:
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/providerTables.html#Provider.

AHCCCS produces the following provider files on a weekly basis:
APR-DRG Rate: (filename = provideraprdrg.txt)
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/APRDRGFileLayout.pdf
sftp\\shareinfo\provider\prod\out\provideraprdrg.txt.

Provider File Layout: Table (filename = profile.zip)
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ProviderLayoutTable.pdf
sftp\\shareinfo\provider\prod\out\profile.zip.

Profile Layout Table: (filename = provider.zip)
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ProfileLayoutTable.pdf
sftp\shareinfo\provider\prod\out\provider.zip.

Profile2 File Layout Table: (filename = provider.zip)
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/Profile2TableLayout.pdf
sftp\shareinfo\provider\prod\out\provider.zip.

Every registered AHCCCS provider is assigned an AHCCCS Registration Number and an AHCCCS provider type. Each AHCCCS registration number may have only one assigned provider type. The provider type drives encounter editing to ensure Contractors reimburse registered providers for services for which they are appropriately licensed/certified and are approved by AHCCCS.

APR-DRG Rate File:
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/APRDRGFileLayout.pdf.
The APR-DRG Rate file provides APR-DRG Rate related information used to adjudicate encounters.

Provider File Layout Table:
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ProviderLayoutTable.pdf.
The Provider File gives Contractors information specific to each AHCCCS registered provider. It is to be used to help adjudicate claims such that payment under the AHCCCS contract is made only to actively registered providers qualified to perform services approved by AHCCCS for that provider on that Date of Service (DOS).
Along with header (TO) and Trailer (T9) records, this file contains ten (10) plus three (3) date-sensitive record types- P1-P9 and R1-R4. The record layout also indicates the potential number of each record in the file for each provider ID (e.g., one, one to many, none to many, etc.). The PMMIS data table reference is indicated after each record number in the layout (e.g., PR***). The PR indicates that the data is from a PMMIS Provider table and is followed by the PMMIS table number.
For each AHCCCS registered provider, the following information is included as applicable:

- **P1 – Demographic (PR010)** – Provider type code, National Provider Identifier(NPI), and 340B drug pricing indicators.
- **P2 – Provider Enrollment Status (PR070)** – Coding indicating the provider's current and historical enrollment status with AHCCCS.
- **P3 – Category of Service (PR035)** – Multiple records indicating approved category of service (COS) for date spans; indicates which agency issues the license or certification and effective dates.
- **P4 – Payment Rates (PR050)** – Coded information and values related to AHCCCS provider-specific fee schedule payment rates to be used as default payment rates for certain providers unless Contractors have other rates established by contract with the provider.
- **P5 – License (PR020)** – Date-sensitive coding of license/certification records relevant to the provider.
- **P6 – Specialty (PR030)** – Date-sensitive AHCCCS proprietary provider specialty coding segments. Also includes the special date and coding related to the current Federal PCP Rate Parity Program.
  https://www.azahcccs.gov/PlansProviders/RatesAndBilling/PCPParity.html
- **P7 – Medicare Data (PR060)** – Data related to the provider's participation with Medicare programs and assigned Medicare Identification Numbers.
- **P8 – Exception (PR055)** – Information at the service/service range level that modifies the specific provider's approved services profile either restricting certain services or allowing services not in the standard provider type/COS profile indicated in P3 – COS (PR035).

- **P9 – Billing Associations (PR045)** – Records linking the provider to AHCCCS provider ID "01 group payment" records. **Address records type codes (PR015):**
  - C = correspondence
  - S = service site
  - P = pay to
- **R1 – Address record (PR015)** – **Correspondence**/mailing addressing information; each provider has one.
- **R2 – Address record** – Service site/location address(s) and phone number(s) for the provider; each provider has one or more (PR015).
- **R3 – Address record** – Payment address including related Tax ID info for payment (PR015)
- **R4 – Alternate ID (PR082)** – Date sensitive links to any Provider reported alternate provider ID number for this provider to aid in any research related to this primary provider ID number.
- **R5 – Provider File Taxonomy Record (PR021)** – Provides provider taxonomy codes associated with the provider. One provider may have several R5 records.
- **R6 Provider ED to Hospital (PR047)-** Provides affiliations between Freestanding Emergency Department and related Hospital.
- **R7- Provider Population Group (PR031)-** Provides detailed information of what a provider can specialize in for a particular category which gives full opportunity and range of what a provider can provide for services.

III. PROFILE/PROFILE2 LAYOUT TABLE (PROVIDER FILE)

www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ProfileLayoutTable.pdf
www.azahcccs.gov/Resources/Downloads/Contractor/Tables/Profile2TableLayout.pdf.
Provides Provider related reference table information used to adjudicate encounters. Data in this file is extracted from the AHCCCS PMMIS data tables. The PMMIS data table reference is indicated after each record number in the layout (e.g., RF***). The RF indicates that the data is from a PMMIS Reference table and is followed by the PMMIS table number. Along with a header (TO) and Trailer (T9) records, header (to) and trailer(header this file contains six (6) date-sensitive record types, P1-P6 that indicates:

- **P1 – Provider Type Profile (PR090)** – Indicating a provider type's relationship to any number of COS and COS specific service codes/code ranges; used to delineate the specific service codes which a particular provider type may perform. COS are indicated as mandatory or optional for the provider type.
- **P2 – Provider Type/COS/Licensing Agency (RF607)** – Date sensitive information by Provider type relating the various licensing agencies to COS coverage. For licensed and certified providers/facilities, the profile indicates which agency issues the license or certification, the effective dates and which COS are related to this license/certification.
- **P3 – Provider Type Rate Schedule (RF618)** – Service rates for provider type for covered services; lists multiple payment schedules.

- **P4 – Category of Service Code (RF603)** – COS is a grouping of services by AHCCCS defined category; records provide COS codes and description.
- **P5 – Provider Type Code (RF612)** – Provides provider type coding and description
- **P6 – Provider Type to Form Type (RF639)** – Provider type code relationship to form type. Certain provider types like Dental and Residential Treatment Centers may use more than one form for claims and encounters.
- **P7- Provider Type to Specialty Codes (RF611)**
- **P8- Provider Type to Population Group Codes (RF674)**

IV. REFERENCE FILES

AHCCCS Technical Interface Guidelines (TIG) – Reference Interface https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html:

- On the 1st and 15th of the month, AHCCCS produces multiple reference files with data used to adjudicate encounters.
- These files are available for download from the AHCCCS SFTP server filenames= refer01.zip through refer08.zip (e.g., sftp\\shareinfo\reference\prod\out\refer01.zip).
- Each file contains Header (T0) and trailer (T9) records and multiple records carrying codes and values **needed** to adjudicate AHCCCS claims for encounter acceptance efficiently.

Reference File 01:

The file name is Refer01.zip and is in the \sftp\shareinfo\reference\prod\out\ folder
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile01TableLayout.pdf:

- **H1 – Procedure Demographics (RF113)** – Basic procedure code information including maximum and minimum age limitations.
- **H2 – FFS and CMDP Max Allowed Charge (RF112)** – Provides the AHCCCS Fee For Service maximum allowable charge (MAC) by county for procedure codes for Date of Service (DOS) and Place of service (POS).
- **H3 – AHCCCS Coverage (RF123)** – Indicates AHCCCS coverage parameters for a procedure code. See Chapter 7 – AHCCCS Coverage Codes.
- **H4 – AHCCCS Medical Category of Service (RF769)** – Provides date sensitive revenue code, UB Bill Type, HCPCS code and NDC codes to COS. Indexed by service type code. **SERVICE TYPE CODES:**
  - B BILL TYPE
  - D ICD-9 DIAGNOSIS CODE
  - H HCPCS PROCEDURE CODE
  - I ICD-10 DIAGNOSIS CODE
  - J ICD-10 PROCEDURE CODE
  - P PHARMACY ITEM
  - R REVENUE CODE
  - S ICD-9 PROCEDURE CODE

- T THERAPEUTIC CLASS

- **H5 – AHCCCS Revenue Code to Bill Type (RF774)** – Used for relational editing between Revenue codes and UB bill type codes.
- **H6 – Revenue Code to Procedure Code (RF773)** – Provides valid, date sensitive revenue code to procedure code relationships.
- **H7 – Status Code B (RFC25)** – Separate payments for services designated with Status Code "B" on the Medicare Physician Fee Schedule for which payment should not be made when other services are provided by the same service provider, for the same recipient, on the same date of service. While these services are appropriately reported for utilization, these services are not separately paid under the AHCCCS fee schedule. All Contractors were required to implement logic to identify these services and disallowance of the separate payment beginning January 1, 2012.
- **H8 – Benefit Package Limits (RFC31)** – Provides service benefit limitations on services such as inpatient days, physical therapy visits and respite hours by effective plan year.
- **H9 – Benefit Package Limit exceptions (RFC32)** – Not in use for encounter processing – Provides the criteria for benefit limit exceptions.
- **N1 – Multiple Surgery (RF724)** – Extract of HCPCS codes to which multiple procedure discounting rule applies.
- **N2 – PCP** Specialty **Rates (RF144)** – New PCP Parity rate table providing special rates for applicable effective dates by Place of Service (POS) for qualified providers.
- **N3 – PCP Special Modifier Rate (RF147)** – Provides valid modifier rates, as applicable, for Parity eligible codes with the SL modifier for vaccine administration codes.
- **N4 – BHS Standard Service Set (RF724)** – Provides additional information needed for processing.

Reference File 02:

The file name is Refer02.zip and is in the \sftp\shareinfo\reference\prod\out\ folder
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile02TableLayout.pdf:

- **M1 – Procedure (RF113)** – Procedure code specific indicators and values e.g., family planning, TPL applicable, sterilization indicator, min-max age, etc.
- **M2 – FFS valid modifiers (RF122)** – Provides valid procedure code to modifier code relationships for RF112 FFS and CMDP rates includes modifier payment indicator Amount = A or Percentage = P to be used as multiplier.
- **M3 – NDC with Family Planning indicator = "Y"** – extract of NDC-National Drug Codes that are to be considered as family planning related.
- **M4 – ICD-9 with Family Planning indicator = "Y"** – extract of ICD-9 procedure and diagnosis codes indicated as Family Planning related.
- **M5 – NDC to HCPCS Associations** – lists the association of National Drug Codes (NDC) association to the **applicable** Healthcare Common Procedure Coding System (HCPCS) codes for required reporting of NDC information for drug- related HCPCS codes.

- **M6 – ICD-10 with family Planning indicator = "Y"** – extract of ICD-10 procedure and diagnosis codes indicated as Family Planning related.
- **M7 – Procedure Special Processing** – Specialty Payment Rate Schedule to supports various different processing situations and conditions. Formally utilized for the AZEIP rates only.

Reference File 03:

The file name is Refer03.zip and is in the \sftp\shareinfo\reference\prod\out\ folder https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile03TableLayout.pdf. Includes various table information related to AHCCCS-specific Outpatient Fee Schedule Pricing rules. For more information on the entire AHCCCS Outpatient Fee Schedule pricing methodology, refer to https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/outpatientrates.html.

- **N1 – Procedure OPFS (Outpatient Fee Schedule) Indicators and Values (RF127)** – OPFS procedure code specific indicators and values e.g., family planning, TPL applicable, EPSDT, sterilization indicator, min-max age, etc.
- **N2 – OPFS** Price **(RF126)** – Provides procedure code specific price for OPFS services.
- **N3 – OPFS Bundled Driver (RF797)** – Provides procedure code values and value ranges for services that drive bundled OPFS pricing.
- **N4 – Bundled Revenue Codes (RF796)** – Provides a listing of Revenue codes that are subject to bundled payment for OPFS.
- **N5 – CCI Codes (RF128)** – Lists Correct Coding relationships that indicate bundled and unbundled services editing required by AHCCCS.
  NOTE: CCI editing is not limited to OPFS.
- **N6 – Multiple Surgery Exemption Table (RF789)** – Lists procedure codes that are exempted from the OPFS Multiple surgery pricing rules.
- **N7 – Limit Override Modifiers (RF723)** – Indicating the relationship of modifier values to action codes that allow override of various types of edit rules, like value 02-frequency limitation on service codes editing is not limited to OPFS.
- **N8 – Override Action Codes (RF725)** – The 2-digit code values for modifier override of various rules.
  - OVERRIDE MULTIPLE SURGERY DISCOUNT
  - OVERRIDE FREQUENT SERVICE LIMIT
  - OVERRIDE CCI EDITS
  - OVERRIDE BUNDLED REVENUE CODES
  - 07 ENCOUNTER DUPLICATE EXCEPTION MODIFIER
  - 08 ENCOUNTER DUPLICATE EXCEPTION PROCEDURE
  - 09 ENCOUNTER DUPLICATE PROFEE/FACL EXCPTN
- **N9 – Valid OPFS procedure Modifiers (RF121)** – Provides relationship of procedure code to valid OPFS modifiers indicating amount (A) or percent (P) payment values.
- **P1 – Limit Override Procedures (RF739)** – Lists relationship of procedures to override action codes that allow override of various types of edit rules (see override action code table above).

- **P2 – MUE Units of Service (RF129)** – A **Medically Unlikely Edit** (MUE) is a claim edit applied to a procedure code for services rendered by one provider/supplier to one patient on one day. MUE are designed to limit fraud and/or coding errors. They represent an upper limit that unquestionably requires further documentation to support MUE as part of the National Correct Coding Initiative (NCCI) to address coding methodologies.
  NOTE: Not limited to OPFS only.
- **P3 – NCCI Associated Modifiers (RF131)** – Lists modifier values that are valid for National Correct Coding Initiative (NCCI) editing.
- **P4 – Procedure OPFS Clinic Price RCF (RF133)** – Lists statewide pricing values for procedure codes related to Outpatient Clinic charges, these values recognize this pricing is for facility component only of the clinic procedure code.
- **P5 – Secondary OPFS Bundled Rate Driver Codes OBS (RFC97)** – Lists two (2) codes, G0378 and G0379, as additional bundled rate drivers for OPFS pricing as defined in the OPFS pricing flow.

Reference File 04:
The file name is Refer04.zip and is in the \sftp\shareinfo\reference\prod\out\ folder
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile04TableLayout.pdf.

- **TA – Medicare Covered Part B Therapeutic Classes (RF350)** – Medicare Part B covered drug classification using a therapeutic class grouper.
- **EVV Procedure Code XReference (TB) (RF7C3)** – This file is intended for optional reference by MCO's as needed housing HCPCS/CPT procedure code, provider type, place of service and modifier. No specific processing use is defined.
- **T2 – Link Multiple Service Types (RF771)** – Indicates types of coding relationships between service code types like add on codes for HCPCS indicates that codes may or must be used in conjunction with one another
- **T3 – VFC Procedure Codes (RF729)** – Date sensitive pricing for toxoids and their administration when covered under Vaccine for Children's Program (VFC).
  NOTE: Plans have no liability for VFC covered toxoids.
- **T4 – Medicare Primary Payer Error Bypass (RF799)** – Lists encounter pend codes where related encounter editing is bypassed when Medicaid secondary claims are submitted to AHCCCS as encounters.
- **T5 – Medicaid Covered Therapeutic Classes (RF347)** – Lists Therapeutic Class Codes not covered by Medicare Part D or B.
- **T6 – ASC Rate Schedule (RFC23)** – Statewide date sensitive ASC rates.
- **T7 – Dental Procedures (RF103)** – Provides indicators by dental code related to tooth number, surface, and quadrant reporting requirements.
- **T8 – Procedure Place of service (RF115)** – Provides valid, date sensitive procedure code to Place of Service (POS) relationships.

Reference File 05:

The file name is Refer05.zip and is in the \sftp\shareinfo\reference\prod\out\ folder
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile05TableLayout.pdf.

Reference File 05 contains the maximum allowed charge and modifier records similar to those found in the Reference 01 and 02 files. This file contains the Long-Term Care MCO Capped Fee Schedule.

Reference File 06:

The file name is Refer06.zip and is in the \sftp\shareinfo\reference\prod\out\ folder.
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile06TableLayout.pdf.

Reference File 06 contains the maximum allowed charge and modifier records similar to those found in the Reference 01 and 02 files. This file contains the Acute Care MCO Capped Fee Schedule.

NOTE: Reference files 05 and 06 contain the maximum allowed charge and modifier records similar to those found in the Reference Files 01 and 02. The maximum allowed charge and modifier records in the: Reference 01 and 02 files are the AHCCCS FFS and CMDP Capped Fee Schedule; Reference 05 file is the Long-Term Care MCO Capped Fee Schedule, and Reference 06 file is the Acute Care MCO Capped Fee Schedule.

CAPPED FEE SCHEDULES	FILE – RECORD
AHCCCS FFS and CMDP	REFER01 – H2 and REFER02 – M3
ALTCS MCOs	REFER05 – M1/M2
ACUTE MCOs	REFER06 – M1/M2

Reference File 07:

The file name is Refer07.zip and is in the \sftp\shareinfo\reference\prod\out\ folder.
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html
https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile07TableLayout.pdf.

- **M1 – Co-pay to Service (RF7A7)** – Date sensitive data related to recipient copay requirements for service codes, include other information relevant to the service type and copay amount, e.g., POS, provider type, age, etc. specifically.
- **Transplant Contract Rates (M2) (RI315)** – Utilized to identify the AHCCCS transplant rates contract rates.
- **Specialty Drug (NDC) Rates (M3)** – Utilized to identify AHCCCS rates for specialty drugs.
- **M4 – Provider TIN Spec Processing (RF681)** – Indicators to identify the special processing associated with that specific provider Tax ID number. Can be associated with more than one processing indicator due to participating in more than one special processing program.
- **M5 – Provider ID Special Process (RF682)** – Indicator to identify the special processing associated with the specific provider.
- **M6 – Special Population Diagnosis (RF260)** – ICD-10 Diagnosis codes that are associated with special populations. The special populations identified to date are:

- Severely Emotionally Disturbed (SED),
- Neonatal Abstinence Syndrome (NAS),
- Severe Combined Immunodeficiency (SCI), and
- Autism or At Risk (AUT).

- **M7 – Evaluation and Management Process Codes (M7) (RF7B7)** – Allows MCOs to enforce edit Z340 for claims to avoid encounter failures.
- **M8- DAP Special Process Code/Amount (RF684)-** Differential Adjusted Payment Special Processing Code(s) and associated amounts/percentages
- **M9- Special Processing Codes (RF680)-** Differential Adjusted Payment code listing
- **D1- Provider Type/Special Process Code/DAP Amount (RF687)-** Will capture provider types, special processing codes, if a percentage or amount is applied and the form types the DAP special process codes will be applied to.

Reference File 08:

The file name is Refer08.zip and is in the \sftp\shareinfo\reference\prod\out\ folder. https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile08TableLayout.pdf. Reference 08 file contains data related ICD10 procedure and diagnosis codes.

Reference File 09:

The file is name is Refer09.zip and is in the \ftp\shareinfo\reference\prod\out\ folder. https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/reference.html https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/ReferenceFile09TableLayout.pdf.

- **C1 – Electronic Visit Verification (EVV) Provider Key Contact Data** – This file is intended for optional reference by MCO's as needed and no specific processing use is defined. (RF686).
- **S1 – School CTDS Information** – Provides new claims and encounters reporting requirements and an edit related to services provided in a school-based place of service. (RF7C4).
- **R1 – ROPA Exceptions** - Provides the MCO's with the necessary data for the ROPA providers that are not registered with AHCCCS because they are not registerable provider types.

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Chapter Six – How to…

Chapter 6 – "How to…"

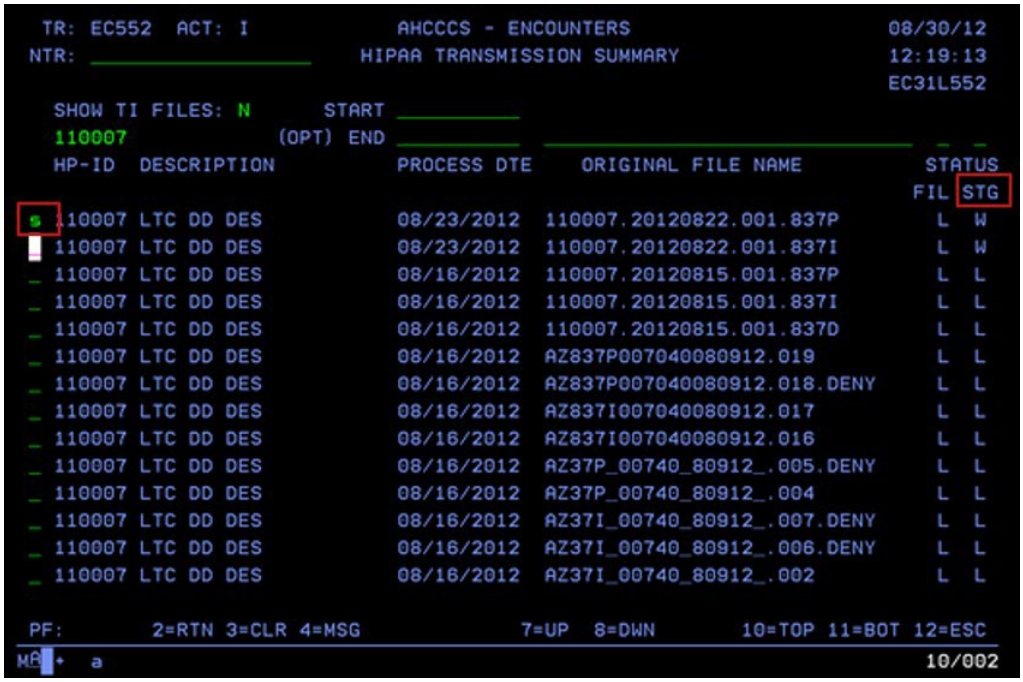
I. INTRODUCTION

The purpose of this chapter is to provide additional clarification for common questions presented to the Arizona Health Care Cost Containment System (AHCCCS) from Contractors regarding encounter processing. This section covers a variety of topics and is updated annually and is further supplemented by the AHCCCS encounter keys newsletter.

It is important to note that the AHCCCS contract requires that Contractors follow claims processing guidelines, applicable to managed care, that are maintained within the AHCCCS Fee-for-Service Provider Manual posted on the AHCCCS website at unless otherwise specified (where allowable) in a written contract between the Contractor and the provider. Therefore, the billing requirements, coding standards, and instructions reflected in that manual are the general guidelines for editing encounters.

II. CHECK STATUS OF ENCOUNTER FILE SUBMISSION

Mainframe availability for the inquiry of encounter files status is listed in the Pre-paid Medicaid Management Information System (PMMIS) on the EC552 HIPAA TRANSMISSION SUMMARY screen. To get to the next screen to view the file, type an "s" to select the file and hit "enter". The HIPAA TRANSMISSION DETAIL screen will come up.



STG = Staging Load Status:

"STG" on EC552 HIPAA TRANSMISSION SUMMARY screen is the same as "FILE STATUS: L" on EC552 HIPPA TRANSMISSION DETAIL screen.

(Staging) Load Status: W = Waiting, H = Hold, L = Loaded, E = Exclude. Fil – File Processing Status: U = Unprocessed, L = Loaded, F = Failed.

III. REPORTING INPATIENT COVERED DAYS

General reminders related to the reporting of covered days:

- This data element is critical to tracking the Inpatient Days actually covered and paid by each Contractor and is required to be submitted on all inpatient encounters. If this required data is not submitted, encounters may be rejected at validation.
- Covered days should only be reported on Inpatient Encounters.
- Contractors should report the number of days they covered for that encounter. If the stay is 20 days, but the Contractor only reimburses 15 days the covered days reported should be 15.
- Covered days cannot exceed the actual length of stay on the encounter. If the stay is four (4) days, contractors cannot report covered days greater than four (4) days.
- Covered days cannot be zero (0) unless the encounter is submitted as Contractor Administrative Denial or Zero Paid. On an inpatient claim, other than a same day admission discharge/transfer, Contractors must report covered days greater than zero, unless reporting the encounter as Contractor Administrative Denial or Zero Paid.
- For Inpatient claims, all allowed/covered days should be reflected only in the Covered Days reported by the Contractor; do not also include in non-covered related accommodation revenue code charges, as it will result in edit failures for out of balance conditions.
- If Covered Days are required by the outlined criteria and are not submitted on the encounter, a Covered Days Validation error 32006 will result: "2300 HI Value Information – Value code '80' Covered days required for Inpatient encounters."
- Please refer to the guidance found in the current version of the UB04 Manual to report the following value codes:
    - '80' Covered Days,
    - '82' Co-insurance Days, and
    - '83' Lifetime Reserve Days.

To report the above value codes, please reference the following 2-digit Bill types that are assigned as an inpatient designation for the AHCCCS Encounters process and considered for the Covered Days validation edit mentioned above:

• 11	Hospital Inpatient (Including Medicare Part A)	IP
• 12	Hospital Inpatient (Medicare Part B Only)	OP (AHCCCS uses as IP)
• 65	Intermediate care – Level I	IP/3
• 66	Intermediate care – Level II	IP/3
• 86	Residential Facility	IP/3
• 89	Special Facility - Other	IP/OP

Sample 837I
CLM*128000052*1505.1***11:A:7**A*Y*
DTP*434*RD8*20111001-20111002
DTP*435*DT*201110010600
CL1*4*5*01
REF*F8*113200010117
REF*EA*1892807 03-66-741
HI*BK:V3000
HI*BJ:V3000
HI*BF:V053
HI*BE:80:::5*BE:82:::10*BE:83:::30
NM1*71*1*ATTENDING*PROVIDERNAME****XX*1799742047
SBR*P*18*******MC
AMT*D*487.77
OI***Y***Y
NM1*IL*1*LASTNAME*FIRSTNAME****MI*A99999999
N3*801 E JEFFERSON ST
N4*PHOENIX*AZ*85034
NM1*PR*2* HEALTH PLAN OF ARIZONA*****PI*0101010782
REF*F8*128000052
LX*1

IV. REPORTING OF NON-COVERED CHARGES/PARTIAL DENIALS

Reporting Non-Covered Charges:

- Contractors must report applicable non-covered charges on encounters as outlined in the TR3 and AHCCCS Companion Guides.
- Non-covered charges should not be subtracted from the total billed charge as, the provider-submitted billed charge should not be altered.

Administrative Denials/Zero Paid Encounters:

- If all charges are non-covered on an encounter, it is an applicable Administrative Denial or Zero Medicaid Payment Claim. It should be reported as Administratively Denied/Zero Medicaid Paid per the instructions in Chapter 3 of this manual.

Disallowed Lines:

- Inpatient or outpatient facility encounters may have both paid and disallowed lines.
- To ensure that such encounters pass validation, do not split the encounter between covered and disallowed lines but submit as AHCCCS Partial Disallowed per instructions below and in Chapter 3.

Professional Paid versus Denied Lines:

- Only zero paid lines that meet the criteria for inclusion as outlined in this manual should be submitted in the denied/zero paid file; all others should be submitted in the paid file.
- Denied lines should only be submitted if they meet the criteria for inclusion as outlined in this manual, otherwise, it is not expected for MCOs to submit their denied Encounters even if a claim has mixed status of lines (i.e., some paid, some denied not meeting administrative denial criteria).

FQHC Claims Paid versus Denied:

- If the T1015 is paid greater than zero and has an approved ancillary code paid at zero, all lines write to the paid file.
- If the T1015 is denied, do not write to either file. Unless the reason for denial meets the criteria for inclusion as an administrative denial.

Sample of Claims Scenario:
3-line claim line 1 approved line 2 approved line 3 denied (non-administrative reason) **NOTE:** In this scenario, AHCCCS expects that lines 1 and 2 are submitted in the paid claims/new day file and that we would not receive line 3.
3-line claim line 1 approved line 2 denied for an administrative reason line 3 paid zero due to, for example, bundling with another service or under a capitation arrangement. **NOTE:** In this scenario, AHCCCS expects that lines 1 and 3 are submitted in the paid claims/new day file and line 2 submitted in the denied file.

V. BENEFIT SERVICE LIMITATIONS AND TIMING OF ENCOUNTER SUBMISSION

Benefit Limits "first in basis":

Certain AHCCCS Medicaid benefits have annual contract year service unit or per diem limits. Contractors' staff working encounter pends must be aware of these benefit limitations. These benefit restrictions are listed in AHCCCS contract Section D and delineated in AMPM Chapter 300. Contractors are notified of any changes to these benefit limitations. For example:

Effective January 1, 2014, outpatient physical therapy for adults (age 21 years and older) is limited to the following 15 visits per contract year to:

- Restore a particular skill or function the recipient previously had but lost due to injury or disease and maintain that function once restored, and
- Attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

When such a service limitation applies, AHCCCS combines AHCCCS Fee-for-Service (AFFS) paid claims, and all Contractor approved encounters on a" first-in basis" to calculate services applied during the contract year.

Contractors may receive Z295 pended encounters (A and O) indicating that the adult PT service units have been exceeded. Contractors may have prior authorized services and paid for services, but due to payment or encounter submission delays, another Contractor or AFFS (having an enrollment period within the same plan year) may have already submitted and had approved encounters exhausting the benefit. In such cases, the pended claims must be recouped and encounters voided. Other similar benefit-exhausted pend codes include Z297 (Inpatient limits exhausted) and Z298 (Respite Care Limits Exceeded).

It is imperative that Contractors have clear language in provider contracts and/or their provider manuals indicating that no payment may be made when the benefit is exhausted, even if the contractor issued a Prior Authorization (PA). PA is not a guarantee of payment; all claims must be for AHCCCS-covered benefits and be medically necessary at the time of service.

Duplicate or Near Duplicate Service Encounters from Different Contractors:

There are a series of encounter edits that indicate that Contractors have submitted an encounter that is either an exact or near duplicate of service for a member for which another Contractor has already reached AHCCCS adjudicated/approved status.

VI. ENCOUNTER/REFERENCE TABLE UPDATE COMMUNICATION

AHCCCS endeavors to keep all reference/code tables in PMMIS up to date by issuing regular agency revisions and AHCCCS-specific coding requirements. Contractors receive and have Web access to multiple communication tools to alert them of table and code updates. Several of these website locations also provide updates electronically by Listserv. To subscribe, go to https://www.azahcccs.gov/PlansProviders/AHCCCSlistserve.html and follow the directions.

"PMMIS System/Table Update E-mails":

AHCCCS Division of Analysis and Research (DAR) staff send out regular e-mails informing Contractor encounter staff and Contract Compliance Officers about significant AHCCCS program changes, including policy, scheduling, required reporting, benefits, PMMIS table updates, and encounter editing. These e-mails provide first notice of items and issues, including Encounter Manual changes, which may require remediation of Contractor system and encounter reporting. If you want to be added to e-mail distribution related to encounters, contact your Contractor's assigned encounter liaison or request through your Contract Compliance Officer.

Encounter Keys Newsletter:
Encounter Keys is a periodic supplement to the Encounter Manual containing updates and system changes. Published quarterly by DAR, this newsletter provides a recap, summarized by code type, of the table changes and other information that Contractors received by e-mail since the last newsletter issue. Current and historical issues are available on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/HealthPlans/encounterkeysnewsletter.html.
Provided as current encounter requirements; Contractors are responsible for incorporating the information into their encounter processes. It is important to note that some table values and relationships are retroactively dated and may affect previously adjudicated claims and encounter submissions. You will also find SFTP file layout changes, EDI technical interface changes, and other clarifications that need to be shared with the Contractors' IT staff.

AHCCCS Fee-for-Service Provider Manual:
AHCCCS contract requires that Contractors follow claims processing guidelines applicable to managed care, which are maintained within the AHCCCS FFS provider manual, unless otherwise specified (where allowable) in the provider subcontract. Therefore, the billing requirements, coding standards, and instructions reflected in that manual are the general guidelines for editing encounters. This manual is located on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html.

Claims Clues Newsletter:
Claims Clues is produced periodically by the AHCCCS Claims Department for Fee-For-Service (FFS) providers as an adjunct to the AHCCCS FFS Provider manual. As such, it is also beneficial for Contractors to keep up with changes in the AHCCCS FFS provider Manual. Issues can be accessed at the link https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html.
It provides useful information including, but not limited to, the following:

- Changes to the program,
- System changes and updates,
- Billing policies and requirements, and
- Provider Training opportunities.

AHCCCS Contractor's Operations Manual (ACOM):
This Manual provides AHCCCS policy specific to operations and reporting for Contractors. It is divided into chapters for Administrative, Claims, Financial, and Operational Policies of the AHCCCS Administration. The AHCCCS staff issues monthly updated Memo to Contract Compliance Officers for internal distribution. ACOM updated memos are also available by Listserv. These memos are intended to alert Contractors to a summary of changes. It is the Contractors' responsibility to review all policy changes and assess the impact on claims processing and encounter reporting. The ACOM manual is located on the AHCCCS website at https://www.azahcccs.gov/shared/ACOM/.

AHCCCS Medical Policy Manual (AMPM):
This Manual contains information regarding services covered within the AHCCCS program. The AMPM applies to both Managed Care and Fee-for-Service members. This manual defines covered services and their limitations, including special maternal and child health programs and services relevant to encounter reporting. Chapter 600 designates provider qualifications and licensing requirements. The AMPM should be referenced in conjunction with state and federal regulations, other Agency manuals (AHCCCS Contractors' Operations Manual [ACOM], and the AHCCCS Fee-for-Service Manual), and applicable contracts.
It is available online https://www.azahcccs.gov/shared/MedicalPolicyManual/
"What's New" memos (summaries of policy revisions), issued as needed and sequentially numbered by contract year, are distributed to AMPM holders and Contract Compliance Officers. Revision history is available at the bottom of the manual webpage.

VII. CONTRACTOR REFERENCE TABLE REVIEW UPDATE (RTRU) REQUESTS

AHCCCS makes every effort to keep the PMMIS reference table sub-system properly updated to reflect nationally recognized and AHCCCS-specific coding standards and requirements. Even so, Contractors may discover apparent inconsistencies or missing values, driving encounter edits that they believe are inappropriate.
IMPORTANT NOTE: Encounter pends related to provider registration issues; for example, P353-Provider type not eligible for service billed, must be directed to AHCCCS Provider Registration Unit. Contractors should be working with the provider in question, assisting them in contacting AHCCCS provider registration to have the provider's profile modified.
For questions regarding the provider registration process, please contact the AHCCCS Provider Registration Unit.

- In Maricopa County: 602-417-7670 and select option five (5),
- Outside Maricopa County: 1-800-794-6862, and
- Out-of-State: 1-800-523-0231.

Reference Table Review Update (RTRU) issues appropriate for review usually revolve around reference table values and relationships, for example, units, modifiers, POS, coverage, effective dates, etc. For example, a Contractor may have multiple claims from various providers, pending for POS invalid for service procedure code. If, after researching, Contractors determine that it is industry standard to provide that service in that POS and an RTRU is submitted and approved, the table maintenance will allow all the related pends to clear the next encounter cycle. It is important to indicate what effective DOS is needed in the tables to clear the related pends so that the table maintenance may cover all pended encounters.

Contractors must research their issues before submitting an RTRU e-mail request to AHCCCS for reference table revisions or updates. Contractors are provided PMMIS training to assist in this research effort. And it is important to review any communications (see section VII above) related to the specific issue. Contractor staff can also contact their assigned encounter representative to review the issue. Contractor staff may submit clearly labeled RTRU requests by e-mail to: AHCCCSEncounters@azahcccs.gov.

The subject line should indicate that this is a reference table review update request. If larger files are required as supporting documentation, they can be placed on the SFTP server and indicated in the e-mail. These e-mails should explain the issue and document the Contractor's research findings and any reference or authority supporting the update request. If a retroactive effective date is being requested, AHCCCS will evaluate and determine the appropriate starting date for the table maintenance.

In many instances, update requests must be deferred to the office of the AHCCCS Chief Medical Officer (CMO) for medical review and determination. Whether approved or not, Contractors will receive feedback on submitted requests. Because of the multiple unit review process, turnaround time on these RTRU requests may take up to 30 days.

VIII. CONTRACTOR ON-LINE VOIDS AND REINSURANCE PAYMENT CYCLE

The timing of Contractor entered PMMIS pend corrections/voids can adversely affect the Reinsurance (RI) payment cycle. Therefore, Contractors are prohibited from performing online encounter voids during the monthly Reinsurance payment cycle. The Reinsurance Payment/Pricing Cycle runs on the first Wednesday of every month. It takes two days for files to pass back and forth between systems. The Reinsurance Databases will be closed for online updates from the first Wednesday of the month, from 5:00 p.m. until the following Wednesday morning. Online voids cannot be performed during this time. Contractor compliance with this policy will ensure accurate disbursement of RI funds and prevent misallocation to closed RI years and RI payment recoupments.

IX. ENCOUNTERS FOR MEDICARE PART B ONLY AND MEDICARE PART A EXHAUSTED CLAIMS

AHCCCS has reviewed the encounter processing logic for members with Medicare Part B Only coverage and for members who have exhausted all their Medicare Part coverage. AHCCCS has subsequently revised the encounter instructions to ensure the Contractors receive full Reinsurance reimbursement when these encounters are associated with a reinsurance case.

Institutional Inpatient encounters being submitted by the Contractors for a member who effectively has only Medicare Part B Coverage (either Medicare Part B Only or the member has exhausted all their Medicare Part A coverage) should have the Medicare Part B payment reported using the following segments:

- 2320/SBR - Other Subscriber Information
- 2320/CAS - Claim Level Adjustments
- 2320/AMT – COB Payer Paid Amount

Loop	Element	Description	837 Note	AHCCCS Usage/Expected Value
2320	**SBR**	**OTHER SUBSCRIBER**		

		INFORMATION		
2320	SBR01	Payer Responsibility Sequence Number Code		Expect any value
2320	SBR02	Individual Relationship Code		Expect any value
2320	SBR03	Insured Group or Policy Number		NOT USED BY AHCCCS
2320	SBR04	Other Insured Group Name		NOT USED BY AHCCCS
2320	SBR05	Insurance Type Code		NOT USED
2320	SBR06	Coordination of Benefits Code		NOT USED
2320	SBR07	Yes/No Condition or Response Code		NOT USED
2320	SBR08	Employment Status Code		NOT USED
2320	SBR09	Claim Filing Indicator Code		Expect any value
2320	**CAS**	**CLAIM LEVEL ADJUSTMENTS**		01/08/13: AHCCCS expects Co-pay amounts to be reported at the 2430/CAS segment for Institutional files.
2320	CAS01	Claim Adjustment Group Code		Expect any value
2320	CAS02	Adjustment Reason Code	Occurrence 1	Expect Adjustment Reason Code
2320	CAS03	Adjustment Amount		Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment. FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported. Per section 1.4.5 Allowed/Approved Amount is determined as: Prior payer's payment (2320, AMT*D*$) + Total of all patient responsibility adjustment amounts (CAS*PR*RSN CD*$*, CAS03, 06, 09, 12, 15, 18) = Allowed Amount
2320	CAS04	Adjustment Quantity		Expect Adjustment Qty

Loop	Element	Description	837 Note	AHCCCS Usage/Expected Value
2320	CAS05	Adjustment Reason Code	Occurrence 2	Expect Adjustment Reason Code
2320	CAS06	Adjustment Amount		Expect Adjustment Amount
2320	CAS07	Adjustment Quantity		Expect Adjustment Qty
2320	CAS08	Adjustment Reason Code	Occurrence 3	Expect Adjustment Reason Code
2320	CAS09	Adjustment Amount		Expect Adjustment Amount
2320	CAS10	Adjustment Quantity		Expect Adjustment Qty
2320	CAS11	Adjustment Reason Code	Occurrence 4	Expect Adjustment Reason Code
2320	CAS12	Adjustment Amount		Expect Adjustment Amount
2320	CAS13	Adjustment Quantity		Expect Adjustment Qty
2320	CAS14	Adjustment Reason Code	Occurrence 5	Expect Adjustment Reason Code
2320	CAS15	Adjustment Amount		Expect Adjustment Amount
2320	CAS16	Adjustment Quantity		Expect Adjustment Qty
2320	CAS17	Adjustment Reason Code	Occurrence 6	Expect Adjustment Reason Code
2320	CAS18	Adjustment Amount		Expect Adjustment Amount
2320	CAS19	Adjustment Quantity		Expect Adjustment Qty
2320	**AMT**	**COB PAYER PAID AMOUNT**		
2320	AMT01	Amount Qualifier Code		Expect 'D'
2320	AMT02	Payer Paid Amount		Expect COB Payer Paid Amount
2320	AMT03	Credit/Debit Flag Code		NOT USED

X. RECORD STATUS CODE AND CLEARING H290 PENDS

Contractors receiving pend error code H290 “Adjustment/ Void Code Invalid” are advised to check the Record Status Code (Element 399). That value must be accurate for the type of transaction being submitted. A mismatch on this code will fire this pend. The edit status code values are for transactions as follows:

- 1 Paid: Code indicating that the transaction was adjudicated using plan rules and was payable. **(New encounter submission)**.
- 2 Rejected: Code indicating that the transaction was denied/rejected. **(HP Denied)**.
- 3 Reversed: Code indicating that the paid transaction was canceled. **(Voided)**.
- 4 Adjusted: Code indicating that the previous transaction was changed. **(Replaced)**.

XI. SAME DAY ADMIT DISCHARGE ENCOUNTER REPORTING

AHCCCS utilizes the APR-DRG inpatient claims payment methodology. Inpatient claims with an admission date equal to the discharge date will be paid using the AHCCCS outpatient fee schedule methodology, including same-day admission and discharge claims for maternity and nursery. There is one exception to this methodology. Claims with the same admission date and death date will be reimbursed with a full DRG payment. The DRG edit A956 DRG - DOES NOT MEET CRITERIA FOR ANY DRG will apply if financial fields do not match AHCCCS DRG calculation. For detailed information on DRG billing requirements, see the AHCCCS Fee for Service Provider Manual addendum at www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap11_Addendum.pdf. This payment methodology differs from the Tiered Per Diem methodology for claims with discharge dates before October 1, 2014. Billing information for that methodology is available in the FFS Provider Manual.

XII. KEYSTROKES FOR ONLINE ENCOUNTER OVERRIDES

PMMIS screen (EC780) provides an override summary of edit encounter errors that Contractors can override online. Each encounter overrides performed online must include a numeric override reason on the PMMIS screen (RF747) and a notation explaining why the override is appropriate. Below are the available keystrokes by form type utilized to perform an online override and where the overriding reason (F4) and notation (F5) are entered in the record.

1500 – EC205C and Dental – EC203C	Pharmacy – EC215C	UB – EC810C
Enter CRN	Enter CRN	Enter CRN
F4 and enter override reason code.	F4 and enter override reason code.	F4 and enter override reason code.
F2	F2 Move from panel 2 to panel 3	F2 Move from panel 3 to panel 4
F3	F8	F11
F8	F5 Enter error code and override comment	F8
F5 Enter error code and override comment.	F9	F5 Enter error code and override comment
F9	F2	F9
F2	F2	F2
F2	F9	F2
F9		F9

XIII. ENCOUNTERS SUBMITTED FOR "UNIDENTIFIED" INDIVIDUALS

When encounters are submitted for "unidentified" individuals (such as in crisis when a person's eligibility or enrollment status is unknown), Contractors shall require the provider to use the applicable pseudo-ID numbers that are assigned to each RBHA. For assistance, contact the DHCM/DAR Encounters Unit. Pseudo-ID numbers are not assigned to TRBHAs. Encounters are not submitted for prevention services.

XIV. ENCOUNTERS EDIT STATUS H140 AND H141

Effective 11/1/2022, Encounter edit H140 (pick up information) and H141 (drop off information) will be set to 'hard' to gain compliance with gathering this information from non-emergency medical transportation (NEMT) providers. These edits validate that the pick-up and drop-off information are included in the encounter. For NEMT Providers, the information will be submitted through the 837P for HCFA 1500 files loop 2310E (Pick Up) and 2310F (Drop Off).

2310E	**NM1**	AMBULANCE PICK-UP LOCATION
2310F	**NM1**	AMBULANCE DROP-OFF LOCATION

This will be accomplished when the EDI 837 Professional file is loaded into the Encounter subsystem, looking at loop 2310E/2310F to ensure it contains pickup/drop-off address data. The correct address data needs to include Address line 1; Address line 2 if provided; City, State, and Zip Code. If the encounter does not have this information populated on the 837P, the encounter will pend for H140 and/or H141. Correct any encounter that pends for H140 or H141, this will be accomplished through a Replacement Record.

Table of Contents

Chapter Seven – Supplemental Information

Chapter 7 – Supplemental Information

I. INTRODUCTION

Throughout this manual, you will find links to online resource information necessary or helpful to the understanding of requirements and processes related to the Arizona Health Care Cost Containment System (AHCCCS) encounter reporting and error resolution. Most of this information is available in various site locations on the AHCCCS website at https://www.azahcccs.gov/.

General Information:

AHCCCS Provider Registration:
https://www.azahcccs.gov/PlansProviders/APEP/ProviderEnrollment.html

AHCCCS Capitation Information:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitation.html

AHCCCS Fee-For-Service Fee Schedules:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

AHCCCS Fee-For-Service Provider Manual:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS Transition to DRG-based Payment:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html

AHCCCS Medical Policy Manual (AMPM):
https://www.azahcccs.gov/shared/MedicalPolicyManual/

AHCCCS Solicitations, Contracts & Purchasing:
https://www.azahcccs.gov/PlansProviders/HealthPlans/purchasing.html

HIPAA Technical Resources:

Electronic Data Interchange (EDI) Technical Documents:
https://www.azahcccs.gov/Resources/EDI/EDITechnicalDocuments.html

HIPAA 5010 Consortia and Documentation:
https://www.azahcccs.gov/Resources/EDI/consortium.html

X-12 reports/code sets:
www.wpc-edi.com

AHCCCS Technical Interface Guidelines (TIG):
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/

Encounter Specific:

AHCCCS Data Access and Forms:
https://www.azahcccs.gov/PlansProviders/ISDresources.html

AHCCCS Encounter Resources:
https://www.azahcccs.gov/PlansProviders/HealthPlans/encounters.html

PMMIS Training Manual – Introduction to Encounter Processing:
https://www.azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/DeskLevelInstructionsForAccessingPMMIS.pdf

AHCCCS Encounter Data Validation Technical Document:
https://www.azahcccs.gov/PlansProviders/Downloads/Encounters/EncounterValidationTechnicalDocument.pdf

National Correct Coding Initiative (NCCI):
https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

II. CN1 TO SUBCAP CODE CROSSWALK

CN101 Contract Type Code	Description	Sub Cap Code	Description
01	Diagnosis Related Group (DRG)	00 *	**Fee-For- Service Arrangement:** Used to report services paid under a DRG arrangement.
02	Per Diem	00 *	**Fee-For- Service Arrangement:** Used to report services paid under a Per Diem arrangement.
03	Variable Per Diem	00 *	**Fee-For- Service Arrangement:** Used to report services paid under a Variable Per Diem arrangement.
04	Flat	00 *	**Fee-For- Service Arrangement:** Used to report services paid under a Flat Fee arrangement.
05	Capitated	01 *	**Sub-Capitation/Contractual Arrangement:** Used to report services provided under a sub-capitated/contractual arrangement.
06	Percent	00 *	**Fee-For- Service Arrangement:** Used to report services paid under a Percent arrangement.
09	Other	08	**Negotiated Settlement:** Used to report services that are included in a negotiated settlement. For example, claims paid as part of a grievance settlement.
09	Other	04	**Contracted Transplant Service:** Used to report covered transplant services paid via catastrophic reinsurance. *Member must be identified as a Transplant Recipient (Member Exception code = '25').*
* 01, 02, 03, 04, 05, 06		05	**Non-Transplant Service for Transplant Recipient:** Used to report services provided when a member is a Transplant Recipient (Member Exception code = '25').
		06	**Denied Service:** Used to report valid AHCCCS services that are denied. For example, if a claim was denied for untimely submission.
Blank		00	**Fee-For-Service Arrangement:** Used to report services paid under a Fee-For-Service arrangement.

III. COUNTY CODES

The two-digit codes used for reporting the Arizona County in which the recipient is enrolled are listed in the following table.

County Codes			
Code	**County**	**Code**	**County**
01	APACHE	21	PINAL
03	COCHISE	23	SANTA CRUZ
05	COCONINO	25	YAVAPAI
07	GILA	27	YUMA
09	GRAHAM	29	LA PAZ
11	GREENLEE	31	OUT OF STATE
13	MARICOPA	33	OUT OF COUNTRY
15	MOHAVE	35	UNKNOWN
17	NAVAJO	99	STATEWIDE (FOR PRICING)
19	PIMA		

IV. CATEGORY OF SERVICE (COS)

AHCCCS has developed a two-digit coding definition called a Category Of Service (COS). Contractors do not provide the COS, and it cannot be changed on the pended encounter correction file. All "Mandatory" COS are assigned automatically, and "Optional" COS are only assigned during the registration process if the "Optional" COS doesn't require additional license/certification. The COS is determined by AHCCCS.

The COS is determined based on an encounter's:

- Procedure code,
- Bill type,
- Revenue code, or
- Pharmacy National Drug Code (NDC).

For professional and dental encounters, the COS assignment is determined by the range or description of each HCPCS procedure code. For example, AHCCCS assigns COS 12 (pathology & laboratory) to HCPCS procedure code G0001 (Routine venipuncture of finger/heel/ear for collection of specimen/s). For institutional encounters, the COS assignment is based on the bill type and revenue codes used on the individual encounter. For pharmacy encounters, the COS is based on the NDC. A current list of the AHCCCS assigned COS is summarized in the following tables.

COS Code	COS Description
PM	Performance Measure
01	Medicine
02	Surgery
03	Respiratory Therapy
05	Occupational Therapy
06	Physical Therapy
07	Speech/Hearing Therapy
08	EPSDT
09	Pharmacy
10	Inpatient Hospital (Room & Board and ancillary)
11	Dental
12	Pathology & Laboratory
13	Radiology
14	Emergency Transportation
15	DME and Appliances
16	Out-Patient Facility Fees
17	ICF
18	SNF
19	ICF/MR
20	Hospice Inpatient Care
21	Hospice Home Care
22	Home Delivered Meals
23	Homemaker Service
24	Adult Day Health Service
25	Personal Emergency Response system

COS Code	COS Description
26	Respite Care Services
27	IHS Outpatient Services
28	Attendant Care
29	Home Health Aid Service
30	Home Health Nurse Service
31	Non-Emergency Transportation
32	Habilitation
33	E-Arch
34	Non-Medical Transportation
35	Adult Foster Care
36	Assisted Living
37	Chiropractic Services
38	Crisis Shelter
39	Personal Care Services
40	Medical Supplies
41	Outreach
42	DD Programs (DD Day Care Programs)
43	Specialized Services
44	Home & Community Based Services (Other)
45	Rehabilitation
46	Environmental
47	Mental Health Services
48	Licensed Midwife
49	Specialized Medical Equipment
98	Case Manager

Note that there are relational edits and audits for the appropriateness of the service code reported relative to the provider type. A mismatch between provider type and COS may cause an encounter to pend. The AHCCCS Provider Registration Unit assigns a provider's provider type based on information submitted by the prospective provider regarding the services to be offered and licensing/certification requirements. The absence of licenses or certifications may limit the COS assignments for a specific provider, regardless of the typical range of services available to that provider type. The provider will be given the option when completing the application to add the "Optional" COS associated with the provider type; whichever COS is chosen, the provider will be prompted to upload the associated license/certification to the COS.

V. AHCCCS COVERAGE CODES

The AHCCCS Coverage Code describes the coverage parameters determined by AHCCCS for each procedure code.

AHCCCS Coverage Codes		
01	Covered service/Code available	Service as described by code is covered and appropriate for reporting.
02	Not covered service/Code available	Service as described by code is not covered or used by AHCCCS but may be allowed on an exception/contract basis by MCO's (related encounters will deny for this reason but be captured for utilization purposes).
03	Covered service/Use other code	Service as described by code is covered; however, another code is more appropriate for reporting.
04	Not covered service/Code not available	Service as described by code is neither covered nor appropriate for reporting.
05	Outpatient hospital services	Service as described by code is covered and appropriate for outpatient hospital reporting.
06	Not covered service/Header record	ICD 10 structure header and detail standards define when it is okay to use the header level value with or without the detail. Refer to CMS ICD10 Guidelines.
08	Covered service/Code replaced	Service as described by code is covered; however, it has been replaced by another code
09	Medicare only	Service as described by code is not covered, but it is appropriate for reporting when Medicare is primary.
10	Non pay Category II Codes	Regardless of coverage determination, allows plans to report performance measurement codes.

VI. JULIAN CALENDAR

The attached matrices show the three-digit Julian date for each day of the year. Matrices are provided for both regular and leap years. In addition, the Julian date of receipt of a New Day Encounter File is incorporated into the Control Reference Number (CRN) assigned to each encounter record.

JULIAN CALENDAR

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
1	001	032	060	091	121	152	182	213	244	274	305	335
2	002	033	061	092	122	153	183	214	245	275	306	336
3	003	034	062	093	123	154	184	215	246	276	307	337
4	004	035	063	094	124	155	185	216	247	277	308	338
5	005	036	064	095	125	156	186	217	248	278	309	339
6	006	037	065	096	126	157	187	218	249	279	310	340
7	007	038	066	097	127	158	188	219	250	280	311	341
8	008	039	067	098	128	159	189	220	251	281	312	342
9	009	040	068	099	129	160	190	221	252	282	313	343
10	010	041	069	100	130	161	191	222	253	283	314	344
11	011	042	070	101	131	162	192	223	254	284	315	345
12	012	043	071	102	132	163	193	224	255	285	316	346
13	013	044	072	103	133	164	194	225	256	286	317	347
14	014	045	073	104	134	165	195	226	257	287	318	348
15	015	046	074	105	135	166	196	227	258	288	319	349
16	016	047	075	106	136	167	197	228	259	289	320	350
17	017	048	076	107	137	168	198	229	260	290	321	351
18	018	049	077	108	138	169	199	230	261	291	322	352
19	019	050	078	109	139	170	200	231	262	292	323	353
20	020	051	079	110	140	171	201	232	263	293	324	354
21	021	052	080	111	141	172	202	233	264	294	325	355
22	022	053	081	112	142	173	203	234	265	295	326	356
23	023	054	082	113	143	174	204	235	266	296	327	357
24	024	055	083	114	144	175	205	236	267	297	328	358
25	025	056	084	115	145	176	206	237	268	298	329	359
26	026	057	085	116	146	177	207	238	269	299	330	360
27	027	058	086	117	147	178	208	239	270	300	331	361
28	028	059	087	118	148	179	209	240	271	301	332	362
29	029		088	119	149	180	210	241	272	302	333	363
30	030		089	120	150	181	211	242	273	303	334	364
31	031		090		151		212	243		304		365

JULIAN CALENDAR (LEAP YEAR)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
1	001	032	061	092	122	153	183	214	245	275	306	336
2	002	033	062	093	123	154	184	215	246	276	307	337
3	003	034	063	094	124	155	185	216	247	277	308	338
4	004	035	064	095	125	156	186	217	248	278	309	339
5	005	036	065	096	126	157	187	218	249	279	310	340
6	006	037	066	097	127	158	188	219	250	280	311	341
7	007	038	067	098	128	159	189	220	251	281	312	342
8	008	039	068	099	129	160	190	221	252	282	313	343
9	009	040	069	100	130	161	191	222	253	283	314	344
10	010	041	070	101	131	162	192	223	254	284	315	345
11	011	042	071	102	132	163	193	224	255	285	316	346
12	012	043	072	103	133	164	194	225	256	286	317	347
13	013	044	073	104	134	165	195	226	257	287	318	348
14	014	045	074	105	135	166	196	227	258	288	319	349
15	015	046	075	106	136	167	197	228	259	289	320	350
16	016	047	076	107	137	168	198	229	260	290	321	351
17	017	048	077	108	138	169	199	230	261	291	322	352
18	018	049	078	109	139	170	200	231	262	292	323	353
19	019	050	079	110	140	171	201	232	263	293	324	354
20	020	051	080	111	141	172	202	233	264	294	325	355
21	021	052	081	112	142	173	203	234	265	295	326	356
22	022	053	082	113	143	174	204	235	266	296	327	357
23	023	054	083	114	144	175	205	236	267	297	328	358
24	024	055	084	115	145	176	206	237	268	298	329	359
25	025	056	085	116	146	177	207	238	269	299	330	360
26	026	057	086	117	147	178	208	239	270	300	331	361
27	027	058	087	118	148	179	209	240	271	301	332	362
28	028	059	088	119	149	180	210	241	272	302	333	363
29	029	060	089	120	150	181	211	242	273	303	334	364
30	030		090	121	151	182	212	243	274	304	335	365
31	031		091		152		213	244		305		366

VII. PMMIS INTERNAL ENCOUNTER/CLAIMS LOCATIONS

Upon completion of the PMMIS encounter cycle, encounters are assigned or abended to a location. Each encounter has a location within PMMIS, which can change as the encounter moves through the edit and audit process or is manually adjudicated by a User. RF711 defines the Encounter/Claim Location.

The Encounter Department/ISD Date Management & Oversight Department utilizes the following internal locations for specific oversight of encounter edits. The encounters' location may or may not be recycled based on the location. All pending encounters have an adjudication status of **11- In Process.**

- 30 MMIS UNIT – INTERNAL LOCATION (Does not recycle)
- 55 OMC – DATA GATHERED FIELD ERRORS (Recycles)
- 59 RESERVED – INTERNAL LOCATION (Recycles)
- 99 CONTACT MMIS – INTERNAL LOCATION (Recycles)

Encounters located in internal locations will not be returned on the Encounter response files outlined in Chapter 4 of this manual.

VIII. ENCOUNTER MANUAL REVISION HISTORY

Date	Author	Chapter	Description
10/1/24	G. Aker	All	Remove EncounterTI email from document, obsolete due to new EDI Portal contact requirements.
10/1/24	G. Aker	All	Replace all references to TI Portal to EDI Portal.
10/1/24	T. Garcia	All	Removed DHCM and CMDP from Table of contents and definitions. Added DMCS, DMCO, ISD, DCS CHP, and TCU. Updated page numbers.
10/1/24	T. Garcia	All	Changed AHCCCS branding color.
10/1/24	T. Garcia	2	Revised on information from TI Portal to AHCCCS new vendor EDI Solutions Portal and how to gain access.
10/1/24	G. Aker	3	Revised updated section VIII to reflect new EDI Web Portal file validation process.
10/1/23	G. Aker	7	Added section VII PMMIS Internal Encounter/Claims Locations
10/1/22	G. Aker and updated by L. Peary	2	Removed footer and header on Exhibits 2A and 2B for Contractors to be able to print and submit the forms.
10/1/22	G. Aker and updated by L. Peary	3	1.) Added sub-bullets with scenarios (provider's failure to supply requested supporting documentation) under Section V – Contractor Administrative Denials/Zero Payment Encounter Submissions. 2.) Removed Encounter Submission and Revision Tracking Reports (ESTR) section.
10/1/22	G. Aker and updated by L. Peary	4	1.) Added Automation of Batch Pend and Denial Override Process under Section X. 2.) Added Pended Encounters Requiring AHCCCS Intervention under Section XI.
10/1/22	G. Aker and updated by L. Peary	5	1.) Added TIG link to Reference Files 01 and 02. 2.) Added N4 Record Update (RF724) to Reference File 01. 3.) Added M7 Evaluation and Management Process Codes

			(M7)(RF7B7) to Reference File 07. 4.) Added Reference File 09 to include C1 – EVV Provider Key Contact Data, S1 – School CTDS Information, and R1 – ROPA Exceptions.
10/1/22	G. Aker and updated by L. Peary	6	1.) Removed Inpatient Hospital DRG Encounter Editing section. 2.) Removed Implant Carve Out Encounters Consideration for Reinsurance section. 3.) Added Encounters Edit Status H140 and H141 as Section XIV.
10/1/22	G. Aker and updated by L. Peary	All Chapters	1.) Updated FTP to SFTP. 2.) Added TOC to chapters (for individual publishing).