

# Encounter Data Submission Guidelines



DIVISION OF MEDICAL ASSISTANCE PROGRAMS

Instructions for Oregon Medicaid  
Prepaid Health Plans and Coordinated  
Care Organizations

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## Introduction

The Encounter Data Submission Guide is designed to assist Prepaid Health Plans and Coordinated Care Organizations who submit encounter claims to the Oregon Health Authority (OHA) for services to their members.

This guide outlines the required data elements for encounter claims and provides helpful hints on how to avoid common submission errors.

Use this guide along with the Oregon Administrative Rules [Chapter 410 Division 141](#) (Encounter Data, 410-1410-3130) and [Chapter 943 Division 120](#) (Electronic Data Transmission, 943-120-0100 through 943-120-0200) which contain information on policy and requirements for submission.

- Each CCO must demonstrate that it is able to provide coordinated care services efficiently, effectively and economically. CCOs shall maintain sound financial management procedures, maintain protections against insolvency and generate periodic financial reports for the submission to the OHA or DCBS as provided in these rules.
- The rules of the Authority have been developed in consultation with the Department of Consumer and Business Services (DCBS) in accordance with Section 13(3) of 2011 House Bill 3650, 2011 Oregon Laws chapter 602, and Chapter 8 of the Coordinated Care Organizations Implementation Proposal (January 24, 2012) approved by the Section 1, 2012 Senate Bill 1580, 2012 Oregon Laws chapter 8.

The most recent version of the Encounter Data Submission Guide is available on the OHA Web site at: [www.oregon.gov/OHA/edi/resources.shtml#oregon](http://www.oregon.gov/OHA/edi/resources.shtml#oregon).

## Encounter Claims Processing

The federal government requires OHA to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS). This system is a combination of people and computers working together to process claims.

Each week, the MMIS produces a submission report that lists all encounter claims submitted. The DMAP Encounter Data Liaison reconciles the report with the Submission Certification form submitted by each plan. DMAP sends the results of the reconciliation as a Claim Count Validation to the plan's identified Claims Contact.

Four times daily, the system audits all claims received since the last cycle to ensure that they conform to program policy. Every weekend, a payment cycle runs which finalizes all claims processed during the previous week and creates the **electronic remittance advice (835)**. The 835 lists all encounter claims paid, denied or denied requiring correction. The 835 is delivered the Monday after this cycle to Oregon MMIS Trading Partner mailboxes.

DMAP also sends a **weekly status file** that identifies which encounter claims remain in a Denied Must Correct (DMC, or "pending") status. This file reports only historical DMC claims that have been in that status at least a week.

**Note:** The MMIS processes all claims in real time but the actual financial cycle occurs weekly. Encounter claims are available for review on the Web portal in real time.

# Encounter Claim Instructions

## When to submit encounter claims

Plans are required to submit all encounter pharmacy data within 60 days of service, and must submit at least 50 percent of all other encounter claim types monthly. All encounter data must be submitted within 180 days of service.

Plans must submit one Inpatient Hospital Encounter per hospitalization. The encounter must represent all hospital services delivered to the DMAP Member.

Inpatient Nursing Facility Encounters must be submitted for the actual dates of service for each calendar month. The Discharge Status Code for Nursing Facility patients who are not discharged shall be “30.”

## Accepted encounter claim formats

DMAP accepts encounter data in the following formats:

- 837 Professional, Institutional, Dental Claim
- NCPDP Pharmacy Encounter

Encounter data files must meet the following requirements for successful submission to DMAP:

- National standards: See the HIPAA X12 TR3s available through the [Washington Publishing Company](#);
- State standards: See the Oregon Companion Guides on the Oregon Health Authority’s [Administrative Simplification](#) Web page; and
- Oregon MMIS Technical Specifications: Once approved, they will be available at [www.oregon.gov/OHA/edi/resources.shtml#oregon](http://www.oregon.gov/OHA/edi/resources.shtml#oregon).

## Before you submit encounter data

1. **Verify provider enrollment status.** All providers listed on the encounter claim must be enrolled with DMAP (see Appendix for enrollment options).
2. **Verify member eligibility and enrollment.** Plans will receive daily and monthly enrollment rosters (**834 files**) that list the eligible members currently enrolled with them. See Appendix for other options.
3. **Report third party liability (TPL)** and the correct billed and paid dollar amounts as applicable.
4. **Use the correct adjustment reason codes.** When reporting a claim where the plan rejected TPL on part or all of the claim, send a crosswalked adjustment reason code on each rejected detail line using the Group

Code of PI. Otherwise, the claim will enter Deny Must Correct (DMC) status.

5. **Include the Plan/PMP ID** as indicated in the appropriate Oregon MMIS Technical Specifications.

## How to submit encounter data

Submit data to your Oregon MMIS Trading Partner Mailbox (MB#####) using Secure File Transfer Protocol (SFTP) software. Submit all information required by X12 to create a compliant claims transaction. The Data Elements specified in this section constitute the minimum data elements required for processing.

### Required data elements for 837 encounters

Data Elements <i>Required elements for each encounter type are marked "X."</i>	837P	837I	
		Outpatient	Inpatient
Plan PHP ID (NPI or Oregon Medicaid ID)	X	X	X
Member Name	X	X	X
Member ID (Prime ID)	X	X	X
Claim Adjustment Reason Code(s) (CARCs) to show whether third-party liability (TPL) exists	X	X	X
CARCs to show reason for reduced payment on claims where TPL exists but the full amount was not paid	X	X	X
Amount paid by plan to provider	X	X	X
Any TPL payments, including Medicare	X	X	X
Billing Provider ID <sup>1</sup>	X	X	X
Rendering Provider ID <sup>1</sup>	X		
ICD-9-CM or ICD-10 diagnosis code(s) at the highest level of specificity	X	X	X
Date(s) of service	X (for each line item)	X (for each line item)	X (from admission through discharge) <sup>2</sup>
Modifier(s) if applicable	X		
Procedure code(s) (e.g., CPT, HCPCS)	X	X (for some Revenue Center Codes)	
National Drug Code (NDC), as applicable, including units of measure <sup>3</sup>	X	X	
Line item charges	X	X	X
Units of service	X	X	
Revenue Center Codes		X	X (for accommodation and ancillary services)
Type of admission code			X

<sup>1</sup> NPI and Taxonomy required for all providers eligible for NPI; for providers of non-health-related services, use Oregon Medicaid Provider Number.

<sup>2</sup> For nursing facility continuous stays, use the last of the month for the discharge date. Not to exceed the 20-day post-hospital extended care benefit.

<sup>3</sup> Report the total number of units of each dosage form, strength and package size by NDC of each covered outpatient drug administered to DMAP members.

Data Elements <i>Required elements for each encounter type are marked "X."</i>	837P	837I	
		Outpatient	Inpatient
Patient discharge status code <sup>4</sup>			X
Total charge			X
ICD-9-CM or ICD-10 procedure codes			X

### Required data elements for pharmacy (NCPDP) encounters

- Plan PHP ID (NPI or Oregon Medicaid ID)
- Member Name
- Member ID (Prime ID)
- Claim Adjustment Reason Code(s) (CARCs) to show whether third-party liability (TPL) exists
- CARCs to show reason for reduced payment on claims where TPL exists but the full amount was not paid
- Amount paid by plan to provider
- Any third-party liability payments, including Medicare
- Pharmacy ID (NPI and Provider Taxonomy Code)
- National Drug Code (NDC)
- Quantity
- Dispense date
- Amount billed (See Exhibit K, K2 Report line item #2)
- Prescribing Provider ID (NPI and Provider Taxonomy Code)
- Prescription number
- Refill number
- Days supplied
- Dispense as written (DAW) indicator

### How to resubmit encounter data

Send an adjusted 837 or make the correction on the Provider Web Portal.

You must resubmit data in order to revise an original encounter claim. Reasons to resubmit include but are not limited to:

- Adding additional services to the original encounter claim. Interim and late billings are prohibited.
- Correcting a claim that is in a Denied Must Correct (Pended) status.

<sup>4</sup> If the Member is found appropriate for Long Term Psychiatric Care during the Acute Inpatient Hospital Psychiatric Care stay, use a discharge code of 05.

## Appendix

### Provider enrollment

Plans must ensure that all providers reported in their encounter data are enrolled as Oregon Medicaid providers. DMAP will only enroll providers who are not excluded per federal and state standards as defined in OAR 943-120-0100 through 943-120-0200 and as specified in 42 CFR 455.400 through 455.400.

- Enroll providers using the **Enrollment Request for Managed Care Providers** ([DMAP 3108](#)).
- DMAP will not process incomplete forms; instead, DMAP will notify the plan of any incomplete enrollments.

Plans may request enrollment for providers who are in the process of enrolling with DMAP as a fee-for-service (FFS) provider. However, the FFS enrollment will supersede the encounter enrollment.

### Eligibility and enrollment verification

Plans will receive daily and monthly enrollment rosters (**834 files**) that list the eligible members currently enrolled with them. You can also verify member eligibility and enrollment using one of the services listed on DMAP's [Eligibility Verification Web page](#).

- [Provider Web Portal](#): Go to <https://www.or-medicaid.gov>;
- [Automated Voice Response](#) (AVR): Call 866-692-3864;
- 270/271 EDI transaction: Available to approved Electronic Data Interchange (EDI) providers. Go to [www.oregon.gov/OHA/edi](http://www.oregon.gov/OHA/edi) for more EDI information.

### Contact your encounter data liaison for all encounter claim questions

If you have questions about any issues related to correct submission of encounter claims, contact your assigned Encounter Data Liaison or designated back-up. Such issues include:

- Signing up for the 835 or other electronic data interchange transactions
- Updating your contact information
- Provider enrollment questions
- Accessing the current Oregon MMIS Technical Specifications
- Using Adjustment Reason Code crosswalks