

**Arizona Health Care
Cost Containment System**



Encounter Manual

October 2016

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The Encounter Manual

The Encounter Manual may be downloaded at no charge from the AHCCCS Internet web page at www.azahcccs.gov. Revisions and updates to the manual will be posted to the AHCCCS web page. The Contractor is responsible for providing copies of this manual and any revisions to its staff, Third Party Administrators (TPAs), and other interested parties.

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DEFINITIONS

Action Modes	The three 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 that has been received and processed by the Contractor which resulted in a payment or denial of payment.
Administrative Denial	Encounter denied for administrative reasons for claims which are for valid Medicaid covered services provided to eligible members that were denied by Contractors for administrative issues.
AHCCCS	Arizona Health Care Cost Containment System
AHCCCS Contractor Operations Manual (ACOM)	The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov .
AHCCCS Medical Policy Manual (AMPM)	The 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)	The Centers for Medicare and Medicaid Services, an organization within the Department of Health and Human Services, which has 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 that may be processed without obtaining additional information from the provider of service or from 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.
Comprehensive Medical and Dental Program (CMDP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. § 8-512.

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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 that has a prepaid capitated contract with the AHCCCS administration pursuant to A.R.S. § 36-2904 to provide goods and services to members either 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 to be 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 Health Care Management (DHCM)	The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, rate setting, encounters, and financial/operational oversight.
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),

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	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 that 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 encounter types are: <ul style="list-style-type: none"> • Professional services are reported with an 837P (Form A/1500); • Dental services are reported with an 837D (Form D/ADA); • Pharmacy services are reported with a NCPDP transaction (Form C); and • Institutional services are reported with an 837I (Form B/UB04). Institutional encounters are further subdivided into three 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 that are required to submit encounter data to AHCCCS.
Enrollee	A Medicaid recipient who is currently enrolled with a Contractor. [42 CFR 438.10(a)].
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 that were paid and/or charges that were rejected.
Fee-For-Service Member	A Title XIX or Title XXI eligible individual who is 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.

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Health Plan	See “CONTRACTOR”.
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 date of January 20, 2008 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.
Liabile Party	A individual, entity, or program that is or 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 by means of 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 of the comprehensive management and administrative services necessary for the operation of the Contractor.
Material Omission	A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following 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.

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Medically Necessary Services	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
Member	An eligible person who is 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 ANSI-accredited group that maintains a number of 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 that had previously been 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's 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

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	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 or not they share facilities, supporting staff, or equipment).
Qualified Medicare Beneficiary Dual Eligible (QMB Dual)	A person, eligible under A.R.S. § 36-2971(6), who is entitled to Medicare Part A insurance and meets certain income and residency requirements of the Qualified Medicare Beneficiary program. A QMB, who is 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 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 who is 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 that 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 with any other organization or person who agrees to perform any administrative function or service for the Contractor

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	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	<ol style="list-style-type: none"> 1. A provider of health care who agrees to furnish covered services to members. 2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities. 3. 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.
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, benefit 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 in accordance with 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.

CHAPTER 1 – OVERVIEW

I. INTRODUCTION

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

II. ENCOUNTER DEFINITION

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

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

III. ENCOUNTER REPORTING REQUIREMENTS

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

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

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

IV. PURPOSE OF ENCOUNTER DATA COLLECTION

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

1. Evaluate health care quality

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

2. Evaluate Contractor performance

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

3. Develop and evaluate capitation rates

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

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

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

5. Determine Disproportionate Share (DSH) payments to hospitals

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

6. Determine Reinsurance risk-sharing payments to Contractors

Encounter data is used as the basis for reinsurance payments.

7. Process reconciliations and risk adjustments

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

V. GENERAL PRINCIPLES

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

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

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

VI. ENCOUNTER REPORTING DEADLINES

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

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

VII. ENCOUNTER FORMATS AND CLAIM FORM TYPES

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

- 837Professional (Form A=1500 claim) Encounters
Used primarily for professional services, i.e., all HCPCS Level I (0XXXX-99999) and Level II (AXXXX-VXXXX), excluding dental services. These services include but are not limited to: physician visits, nursing visits, surgical services, anesthesia services, free standing ambulatory surgical centers (ASC), laboratory tests, radiology services, home and community based services (HCBS), therapy services, durable medical equipment (DME), medical supplies and transportation services.
- 837Dental (Form D=ADA claim) Encounters
Used for dental services; i.e., HCPCS Level II codes beginning with DXXXX.
- 837Institutional (Form B=UB04 claim) Encounters
Used for institutional facility based services, such as inpatient or outpatient hospital services, dialysis centers, hospice, birthing centers, nursing facility services, and other institutional services.

NOTE: Institutional encounters are further subdivided into three additional form types for encounter editing purposes:
 1. Form type “I” for inpatient hospital services
 2. Form type “O” for outpatient hospital services
 3. Form type “L” for long-term care facility service*Form type is determined based upon the reported type of bill (bill type code)*
- NCPD (Form C) Encounters
For retail pharmacy services, such as prescription medicines and medically necessary over-the-counter items.

VIII. PROVIDER REGISTRATION AND PROVIDER TYPE TO FORM TYPE REQUIREMENTS

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

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

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

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

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

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

IX. SERVICE UNIT GUIDELINES

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

X. TRANSPLANT ENCOUNTERS

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

XI. REINSURANCE FORM TYPES

Submission requirements by form type are as follows:

▪ 837I (Form B) Encounters

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

▪ 837P (Form A) Encounters

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

▪ NCPD (Form C) Encounters

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

XI. STANDARDIZED FILE LAYOUTS

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

▪ The X12N technical reports are available from the Washington Publishing Company (www.wpc-edi.com).

▪ The NCPDP implementation guide is available from the National Council for Prescription Drug Programs (www.ncpdp.org).

▪ Additionally, AHCCCS Companion Documents, which delineate AHCCCS specific and situational requirements, provide supplemental information for encounter reporting and are available from AHCCCS web site at:

<https://azahcccs.gov/Resources/EDI/EDITechnicalDocuments.html>

XII. ACCURATELY REPORTING ENCOUNTER DATA

1. Coordination of Benefits

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

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

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

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

2. National Correct Coding Initiative

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

3. Claim to Encounter accuracy

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

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

4. Encounter processing outcomes

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

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

CHAPTER 2 – ENCOUNTER AUTHORIZATIONS & CONTROL DOCUMENTS

I. INTRODUCTION

Before a Contractor may submit encounter data, AHCCCS requires the completion of certain agreements, authorizations and control documents. 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 a number of legal purposes. They 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 the Contractor intends to subcontract its encounter reporting function to a vendor, terminate, or change its contract with such a vendor, the Contractor must notify the Encounter Unit a minimum of 60 days prior to the change. AHCCCS will then normally require the completion of new control documents authorizing encounter data exchanges.

III. TESTING PROCESS FOR NEW CONTRACTORS OR ENCOUNTER VENDOR CHANGES

In order 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. Prior to beginning the testing phase, the Contractor must have provided all necessary control documents to the AHCCCS Encounter Unit email address, AHCCSEncounters@azahcccs.gov. Once the Encounter Unit receives the necessary control documents, AHCCCS will also schedule a training session for the Contractor during which the testing process will be reviewed.

When AHCCCS verifies that the Contractor has successfully completed the testing process, as defined with 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. Any data that does not meet the standards required by AHCCCS shall not be accepted by AHCCCS. In the event of any

inconsistencies between the input data and underlying source documents AHCCCS shall rely on the input data only.

The Contractor further agrees to indemnify and hold harmless the State of Arizona and AHCCCS from any and 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 the Contractor in the submitted input data. Neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to the Contractor's providers (subcontractors) resulting from such error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

The Contractor is also responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCS. If any unreported inconsistencies are subsequently discovered, the Contractor shall be responsible for the necessary adjustments to correct its records at its own expense.

The Contractor authorizes 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 CFR Sections 438.604 and 438.608 the CEO, CFO or a direct report must certify encounter data prior to processing. By incorporating the attestation process noted below the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to Chief Executive Officer or Chief Financial Officer, attests that the data and/or documents so 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 now in effect. If any of those procedures, rules, regulations or statutes is hereafter amended, the Contractor agrees to conform to those amendments of which Contractor has been notified. The Contractor further certifies that it 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 attestation add one repetition of the PER Segment within the 1000A Submitter

Name Loop. This allows the health plans 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*TOMYKNOWLEDGEINFORMATIONANDBELIEFTHE DATAINTHISFI  
LEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM*FX*602  
5556789*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" (again, 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" (again, 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

Transaction Insight (TI) is the AHCCCS front end editor that validates syntax, code sets and code relationships in submitted encounter files. Records that pass validation are then translated into formats for processing and adjudication.

Access to TI permits the Contractor's staff to view processing statistics, errors and, when requested, staff may correct select TI errors. AHCCCS follows HIPAA security and privacy rules for the Contractor security and TI system access.

Requests for access to TI, security requests and password resets should be sent to AHCCCSTIEncounters@azahcccs.gov. The Contractor will receive a TI User Manual when requested access to the TI portal is approved.

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 furnishes an estimate of monthly encounters to be reported by the Contractor. 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 the Contractor identification number(s), county codes, and lines of business for which that transmission submitter is authorized to submit encounters.

For each TSN the Contractor must have the Health Plan Contractor Encounter Submission Notification and Transmission Submitter Number Application (Exhibit 2A) form on file at AHCCCS. The Contractor must also have completed and submitted the EDI Trading Partner Agreement (Exhibit 2B) in order to exchange data with AHCCCS. Once the Trading Partner Agreement is completed, the Contractor is given an EDI account for data exchanges.

VIII. ACCESS TO AHCCCS PMMIS

PMMIS is the AHCCCS integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements. Contractor access to PMMIS allows staff to view select member, provider, reference, and encounter information helpful in resolving pending and denied encounter issues.

It is expected that Contractor staff will 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.

In order for Contractor 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 Encounter Unit AHCCCSEncounters@azahcccs.gov for processing. These forms are available online <https://www.azahcccs.gov/PlansProviders/ISDresources.html>

To maintain access privileges the User must sign-on at least once every 30 days, change passwords as required and complete an annual recertification. Additional information on accessing PMMIS and frequently utilized PMMIS reference screens are available on the AHCCCS website

<https://azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/DeskLevelInstructionsForAccessingPMMIS.pdf>

Exhibit 2A

Contractor Encounter Submission Notification And Transmission Submitter Number (TSN) Application	
<p>In order 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 AHCCSEncounters@azahcccs.gov .</p>	
1. Contractor Name:	2. Contractor ID Number:
<p>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.</p>	
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
TRADING PARTNER AGREEMENT**

THIS AGREEMENT is entered into between 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 and 162.
 - 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' 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.

CHAPTER 3 – ENCOUNTER PROCESSING

I. INTRODUCTION

The purpose of this chapter is to provide the Contractor with the sequence of events that occur for encounter processing, and to provide the criteria that AHCCCS uses to determine when encounter files and/or individual records are acceptable.

Record layouts for each of the four form types may be found in the X12N 005010 technical reports or NCPDP Post Adjudication History (PAH) Version 2.2 implementation guide

- 837P – Form A\1500s,
- 837D\ADA – Form D,
- 837I – Form B\UB04, and
- NCPD – Form C

Record layout for the status file (277U) may be found in the X12N 3070 implementation guide. In addition, the AHCCCS Encounter Companion Documents 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 normally scheduled to process in PMMIS twice a month.

- The first processing cycle is scheduled to begin on the first Friday after the first Wednesday of the month. For the first cycle, newly submitted Encounter (New Day) Files, Pend Correction Files, all currently pended encounters will be recycled regardless of the action taken by the Contractor and all replacement and void transactions will be processed. The Reinsurance Case Creation cycle will run immediately following the completion of this cycle.
- The second processing cycle is normally scheduled to begin on the third Friday after the first Wednesday of the month. For the second cycle, pend corrections submitted since the first cycle will be processed, however, pended encounters with no action will not be recycled. In addition, replacement and void transactions associated to a reinsurance case will not be processed in the second cycle.

Only those Contractors submitting files for a cycle will receive cycle reports and files for that cycle, which will consist of only those encounters processed in that cycle.

The Encounter current processing schedule is available on the AHCCCS website at https://azahcccs.gov/PlansProviders/HealthPlans/encounters.html#Encounter_Processing_Schedules

III. ENCOUNTER DATA FILES SUBMITTED BY THE CONTRACTOR

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

- **New Encounter Submissions (837P, 837I, 837D, NCPDP)**

The 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, and replacements (resubmissions) and voids.

- **Pended Encounter Corrections**

On the Pended Encounter Correction File, the Contractor submits allowed corrections for encounters that failed the edit and audit process and were returned on the Pend file. This pend file is the accumulation of all current and previously pended encounters. Not all AHCCCS mainframe edit/audits allow this type of correction.

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

The Contractor 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 placed on the AHCCCS server. The Contractor is assigned a directory on the SFTP for placing plan submitted-“incoming” and AHCCCS deposited “outgoing files”. When logging on to the AHCCCS SFTP server an Arizona Contractor must first choose between AZ and HI directory paths. After choosing AZ the next selection-XXX- represents the Contractor’s own three (3) character name abbreviation. Within each Contractor’s SFTP directory there are folders designed for specific data exchange purposes.

Files placed in the wrong path and/or folder or which cannot be recognized and validated by AHCCCS will not be processed. Notification of such errors will not be provided by AHCCCS and additional file processing will not occur.

For depositing incoming encounter files the directory structure and file naming standards are below:

- **New Encounter Submission files 837 and NCPDP PAH path:**

ftp/AZ/XXX/prod/edi-in/file name

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

The file name cannot exceed 29 characters.

The Contractor can use its own naming convention as long as 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:**

ftp/AZ/XXX/prod/in/file name

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

NOTE: *there are two “in” and “out” folders for each Contractor- the “in” for pended encounters is **prod/in/**, whereas incoming 837 New Day encounters are to be placed in the **prod/edi-in/** folder (see above section). Outgoing encounter pend reports will be placed by AHCCCS in the **prod/out** folder. Response files to New Day file submission are placed by AHCCCS in the **prod/edi-out** folder.*

These files **must** be zipped.

There is an AHCCCS file naming convention that is required for submitting Pended Encounter Corrections:

AZSTNDPLANIDTSNXMMDDYY.SEQ

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 supplier number
- 1 = One-byte code distinguishing denied encounter files from other encounter files. ‘1’ value indicates all other encounter files including pend correction files
- MMDDYY = Current date
- 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 this SFTP server by AHCCCS acceptance of properly completed and submitted forms listed below: <https://azahcccs.gov/PlansProviders/ISDresources.html>

- **Electronic Data Exchange Request Form**

The *Electronic Data Exchange Request Form* is intended for use 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 are agreeing to abide by all applicable laws, rules and AHCCCS directives.

A Contractor is required to submit individual data exchange application forms and affirmation statements for each staff member who requires access to the SFTP to place or remove encounter related files or data.

The AHCCCS Information Services Division (ISD) CustomerSupport Center is the primary contact for all questions related to submission of electronic transactions and data. The preferred method of contact is 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 have been completed and the provider's claim or encounter must be finalized Paid, Denied for Administrative reasons, or Zero Medicaid Payment by the Contractor.

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.

1. Contractor Administrative Denials encounters are defined as Contractor adjudicated claims that have been denied or non-covered in full for specific types of reasons. Denials for administrative reasons represent those claims which are for valid Medicaid covered services provided to eligible members that were denied by Contractors for administrative issues such as:
 - Failure of the provider to obtain a required Prior Authorization (PA)
 - Untimely submission of the claim to the Contractor
 - Provider billed units are in excess of Medicaid service benefit limits
 - Provider's failure to supply required claims supporting documentation
2. Zero Medicaid Payment encounters are encounters for which there was primary payment and no pass thru or secondary payment was made under Medicaid.

Denied/Zero Medicaid Payment 837 files must have the input mode of '6' in Loop 1000A NM109, value of 'AHCCSDENIED' in GS03 (per current companion document) and **add the extension of '.deny' to the file name.**

NCPDP Administratively Denied/Zero Payment encounter reporting file specifications are in progress and will be published as soon as possible.

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 or resubmitted.

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 prior to the encounter processing cycle must submit the request to the DHCM Encounter Manager and DAR Manager via email. All Encounter File Hold Requests must be received no later than 12:00 Noon one day prior to the scheduled PMMIS Encounter processing date. All requests must appropriately identify the location and name of the file the Contractor is 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 current companion document). These files will undergo validator syntax editing and, after passing validation, will be moved to the mainframe as a paid file.

VIII. FILE VALIDATION-TRANSACTION INSIGHT (TI)

All 837 files are subject to AHCCCS' front-end validation edits. When the Contractor submits encounters through TI, the Validator reviews the data and validates (good and bad). These transactions are then passed to WTX (Web sphere Transaction Extender 8.1) for translation onto the mainframe for processing. The Contractor can log in to their account and correct transactions that failed validation. Once corrected, the transactions are sent to WTX for translation and onto the mainframe for adjudication.

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

The TI Portal lets you use 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. All of these can be filtered in various ways. In addition, users with the appropriate permissions can view specific transactions at various levels of detail.

Following validation of each New Encounter Submission file, validation results are generated by AHCCCS and placed in the Contractor's outgoing FTP directory-prod/edi-out. Files that fail validation must be resubmitted. Following file validation, the data within the file is also validated. Data that passes validation is translated and placed on the mainframe for processing.

Pend Correction and NCPDP PAH files undergo limited validation to ensure that the file is readable and catalogues properly within the system. The edit checks on the Pend files validate the presence and format of the data.

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 status (pass/fail) of each encounter or file.

- **TA1 Interchange Acknowledgement:**
The TA1 acknowledgment is used by AHCCCS to notify the Contractor of problems that were found in the interchange control structure. The TA1 verifies X12 envelopes only.
- **999 Functional Acknowledgement:**
The 999 Functional Acknowledgement is used by AHCCCS to acknowledge each 837 functional group that has passed or failed translator edits.
- **824 Acknowledgement:**
The 824 acknowledgement is used by AHCCCS to report 837 syntactical problems or data structure errors.
- **277CA Claims Acknowledgement**
The 277CA is an acknowledgement to an 837 transaction at the pre-adjudication stage. This transaction identifies claims that are accepted or rejected for adjudication. A summary level as well as an individual claim level pre-adjudication status is included in the 277CA.

For outgoing acknowledgement files, the encounter FTP directory structure and file name conventions are:

- **837 Acknowledgement path:**
FTP/XXX/prod/edi-out/file name

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

File Name Convention for Acknowledgement 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 Contractor’s outgoing FTP directory-Pend=prod/out and NCPDP=prod/edi-out.

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

X. ASSIGNMENT OF AHCCCS CLAIM REFERENCE NUMBERS (CRNs)

Data that passes validation is translated and moved to the mainframe to be loaded for processing. The Contractor should monitor the load/no-load status of their files. (See Chapter 6 – Section II for details on how to monitor load status of files) When loaded to the adjudication system each encounter record is assigned a unique Claim Reference Number (CRN). The CRN is subsequently used by AHCCCS 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)**
This date reflects the date of receipt of the New Day encounter file in Julian date format. (xx=year and xxx (day of the year 1-365/6))
- **Batch Number (digits 6-9)**
(Sequence 0001-9999)
- **Document Number (digits 10-12)**
(Sequence 001-999)
- **Line Number (digits 13-15)**
This number applies to detail lines only. (Sequence 001-999)

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 the Contractor's claims adjudication system utilizes the most updated information in these files, AHCCCS editing should produce limited pending/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 encounter 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 in order to be finalized and placed in history in the adjudicated encounter database. Each adjudicated encounter is assigned an adjudication status code (which may change over time with encounter processing).

Adjudicated Status Codes

- 11=Pended
- 31=Adjudicated/Approved
- 32=Adjudicated/Void Original
- 33=Adjudicated/Replaced Original
- 41=Adjudicated/Denied by AHCCCS
- 43=Adjudicated/Denied by plan

If an encounter fails one or more edit/s or audit/s, an error condition occurs and AHCCCS either denies or pends the encounter.

- AHCCCS Denied encounters are returned in the 277U and 277S Supplemental files (see section XI that follows).
- Pended encounters are also placed on the Contractor's pend file for error correction. For further explanation on Pended Encounter correction please see Chapter Four of this manual.

AHCCCS denied encounters (status 41), like pended encounters, must be corrected, recouped or voided in the Contractor's claim processing system as appropriate and may be subject to Contractor performance standards. Readjudicated/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.
- 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 for evaluation of health outcomes, performance measures, rate development/ setting, etc. Thus, the Contractor should ensure that encounters are submitted according to AHCCCS requirements, in order to avoid underreporting of data that may have a negative effect on the Contractor.

XII. ADJUDICATION FILES AND REPORTS PRODUCED BY AHCCCS

Following encounter adjudication edit and audit processing AHCCCS generates status and pend files for the Contractor. The filenames for each report are listed. Sample reports and file layouts are included as exhibits

STATUS FILES

- Status File (277U) - Unsolicited

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

- Supplemental Status (227S)

This file contains additional status information not found on the 277U status file. For example, mainframe denial reasons for encounters and Rensurance information are in this file. See File Record Layout in Chapter 4-exhibit 4A

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 = the Contractor's 6 digit AHCCCS assigned numeric Plan ID
YYMMDD = the cycle date

Additional files, as noted below, are placed on the SFTP server in the Contractor's **prod/out** folder

ftp/AZ/XXX(3 character mnemonic)/prod/out/file name

XXX = the Contractor's 3 digit name abbreviation

PEND FILES

- Pend File (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 encounters are corrected. See File Record Layout-Chapter 4-Exhibit 4B this manual.

- 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. See exhibit 3A
- Pended Encounter Duplicate CRN File (Record Layout -DUPECRN)
filename= HPPLANID_DUPECRNMMDDYY.ZIP
 This file contains information regarding duplicate pended encounters and the encounters already in history that are causing the duplicate audit failure. See exhibit 3B
- Comment File (CC)
filename= HPPLANID_CCMMDDYY.ZIP
 This file contains comments regarding select pended encounters. The comments are intended to aid in the correction of these pended encounters. See File Record Layout-Chapter 4-Exhibit 4C this manual.
- Detail Show Action Taken (Record Layout-ACTNTKN)
filename=HPPLANID.PNMMDDYY.TSN.ZIP.YYMMDD. ACTNTKN.ZIP
 This file contains information regarding action taken on pended encounters during the last cycle. See exhibit 3C
- Adjudicated Encounters Report Overall (Report ID-EC9AM128)
filename= 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. See exhibit 3D
- EC CCL Summary By Error Code (Report ID-EC9AD949)
filename= HPPLANID_RC_EC9AD949MMDDYY.ZIP
 The CCL summary indicates the number of errors by transmission submitter number, by form type and by error code. See exhibit 3F
- Edit Failures by Health Plan (Report ID-EC91D949)
filename= HPPLANID_RC_EC91D949MMDDYY.ZIP
 This report provides a count of pended encounters by transmission submitter number, error code and form type. See exhibit 3G
- Duplicate CRN by Error Code (Report ID-EC97R179)
filename= HPPLANID_RC_EC97R179MMDDYY.ZIP
 This report contains information regarding duplicate pended encounters and the encounters that are causing duplicate pended encounters. See exhibit 3H
- Pended Encounters Summarized Aging (Report ID-EC9CM187)
filename= HPPLANID_RC_EC9CM187MMDDYY.ZIP

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The pended encounters aging summary shows a count of pended encounters in age categories by form type. See exhibit 3I

- Pended Encounters Detailed Aging (Report ID-EC9EM187)
filename= 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. See exhibit 3J
- Pended Encounters Summarized Error (Report ID-EC9FM187)
filename= HPPLANID_RC_EC9FM187MMDDYY.ZIP
The summary of pended encounters illustrates the pended encounter error count in descending order. See exhibit 3K
- Detail and Summary Show Action Taken (Report ID-EC91R901)
filename= HPPLANID.PHMMDDYY.TSN.ZIP.YYMMDD.
RPTS.ZIP
This report contains information regarding action taken on pended encounters. See exhibit 3L

IMPORTANT NOTE: The Contractor has 90 days, from the date the files are placed on the server, to retrieve files and reports before AHCCCS removes them from the Contractors FTP server site as a component of our automated processing.

XIII. Encounter Monthly Data File aka “Magic” file

On a monthly basis, AHCCCS provides each Contractor with an encounter data extract that Contractors must use compare financial data in the AHCCCS encounter database with the Contractor’s 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, as well as, the new encounters reaching adjudicated status by AHCCCS in the most current month. The file is to be used by the Contractor to verify what has been submitted to AHCCCS.

The file is available on the SFTP server after the completion of the 1st Encounter Cycle of the month.

Location: sftp.statemedicaid.us\xxx\prod\out\ENC_#####.zip

- **xxx** 3 Character Plan Mnemonic assigned to each Contractor
- **#####** Health Plan ID

The zipped file contains the following encounter file extracts named ENC_type code_#####.TXT

type code = (5 file types):

- o **ADJ** Adjudicated/approved - status 31
- o **DENIED** Adjudicated/ plan denied - status 43
- o **ACCDNY** Adjudicated/AHCCCS Denied - status 41
- o **PEND** Pended - status 11
- o **VOID** Adjudicated/voided - status 32

= Health Plan ID

File Record Layout

Field	Start	End	Length	Description/Notes
HP ID	1-6	6	6	
Contract Year	7	12	6	CCYYMM Format
Form Type	13	13	1	A – Form 1500 I, O, L – UB C – RX D – Dental
HP Claim No	14	43	30	
Patient Account No	44	63	20	
Adjudication Status	64	65	2	
Service Begin Date	66	73	8	CCYYMMDD Format
Service End Date	74	81	8	CCYYMMDD Format
AHCCCS ID	82	90	9	
Provider ID	91	97	6	
CRN	98	110	15	
HP Paid Amount	111	123	13	
Filler	124	136	13	Not currently used
MDC Paid Amount	137	149	13	Medicare Paid Amount
INS Paid Amount	150	162	13	Other Coverage Payment Amount
Bill Amount	163	175	13	BILL-AMT (FACL – TOT-BILL-AMT)
TSN	176	178	3	Tape Supplier Number
Diagnosis 1	179	186	8	8 bytes in required for ICD10
Diagnosis 2	187	194	8	8 bytes in required for ICD10
Diagnosis 3	195	202	8	8 bytes in required for ICD10
Diagnosis 4	203	210	8	8 bytes in required for ICD10
Contract Type	211	212	2	Does not apply to Drug
AHCCCS Allowed Amount	213	225	13	State Allowed Amount
HP Approved Amount	226	238	13	
VBP-Contract-ID	240	269	30	Value Based Payment Contract ID

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. When replacing or voiding, only the first 12 digits of the CRN should be submitted. Void or replacement at the claim header must reflect the Contractor's final disposition or all claims lines for the claim.

XV. ADJUDICATION SYSTEM ERROR CORRECTION

The correction of encounters denied or pended by AHCCCS allows the Contractor the opportunity 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 condition(s) that caused the record to fail, assisting the Contractor in the identification and resolution of the problem. AHCCCS allows a grace period (refer to section XVIII) for the correction of aging pended or denied encounters. No penalty/sanction is applied to Contractor encounter corrections readjudicated as accepted within this grace period. Sanctions may be applied to denied or pended encounters that remain uncorrected or voided after this period has expired.

XVI. COMPLETE, ACCURATE AND TIMELY ENCOUNTER DATA

The Contractor is required to monitor, track and trend encounter submissions and corrections. If the Contractor 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.

The **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 in order to eliminate omissions of AHCCCS eligible service utilization data required by contract.

The **accuracy measure** requires that the encounter data submitted correctly reflect the approved coding of the services reported. The encounter data submitted must reflect the data coding as submitted by the provider and entered as finalized in the Contractor's claims system. All required encounter elements must match provider claim submission as well as finalized claim adjudication in the Contractor's claims system.

The **timeliness measure** requires that all encounters reach approved adjudication status in the AHCCCS database within specified time periods.

As per contract, Professional, Institutional and Dental encounters (not eligible for Federal Drug Rebate processing) must be received by AHCCCS no later than 240 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.

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:

<https://azahcccs.gov/PlansProviders/Downloads/Encounters/EncounterValidationTechnicalDocument.pdf>

Adherence may also be evaluated during Annual Contractor Operational Reviews or through focus 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 (4) years of most recent data, and the data points 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 Acute, Long Term Care and CRS lines-of-business.

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 key rule for the standard compliance is one standard deviation from the four (4) contract year means. This rule identifies some possible 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

The Contractor is 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 or void the claims and recoup Medicaid funds and to correct or void pended encounters.

When AHCCCS denied and Contractor voided encounters are due to data submission errors, the Contractor must replace or resubmit the encounters with revised data. For replacements the encounter must reflect the Contractor's final disposition of all claim lines. 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, in order to avoid underreporting of data that may have a negative effect on Contractors.

Replaced encounters are linked to previous encounter submissions for purposes of encounter timeliness. Encounters that are resubmitted instead of replaced are treated as original submissions and are not linked 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 FOR 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 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 on-line 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 month period at the end of the quarter is downloaded into a SPSS (statistical) program for review. The data set is then filtered to eliminate "soft" error codes; other hard error codes specifically waived from sanction by AHCCCS and edits or audits identified by AHCCCS as related to internal only

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edits. The reports are produced, reviewed internally and distributed as preliminary to each Contractor for review and response.

Note: Hard edits (pend or deny back to the Contractor for correction);
Soft edits (are used internally for statistical information gathering purposes)

The preliminary sanction report is distributed via the FTP server. The Contractor has 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.

Sanctions 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

XX. PENDED ENCOUNTER SANCTION GRIEVANCES

Contractors have the right to file a grievance regarding encounter sanctions. Grievances must be filed in a timely manner pursuant to Article 8 of the AHCCCS Rules. The details on filing this type of grievance are included in the Contractor notification letter.

XXI. ASSISTANCE

Encounter customer service staff is available Monday through Friday (excluding State holidays) to assist the Contractors. In addition, the Encounter Unit conducts ongoing meetings with each Contractor, both on a scheduled, and as needed basis.

To request assistance or training Contractors should contact their assigned encounter customer service representative.

Contractor may also request encounter assistance or training via the AHCCSEncounters@azahcccs.gov e-mail address.

Questions regarding TI security issues, validation and/or translation should be submitted to AHCCSTIEncounters@azahcccs.gov

AHCCCS will acknowledge all requests within three days and respond to the request within 30 days unless otherwise notified.

XXII. ENCOUNTER SUBMISSION AND REVISION TRACKING REPORTS (ESTR)

In order to insure that Contractors do not inappropriately void or override encounter pends in an effort to avoid sanctions, a Contractor is required to maintain logs for all overridden or voided encounters.

AHCCCS will conduct periodic focused audits based on the information provided on the logs, AHCCCS will select a valid sample from each log. The file samples will be submitted to the Contractor with a request to provide documentation justifying the pend override or encounter void. AHCCCS will review the documentation for appropriateness and return the preliminary

audit findings to the Contractor. Contractor will have an opportunity to mitigate the preliminary findings as described in sample notification letter. AHCCCS considers mitigation before issuing the final report to the Contractor.

The Finalized Claims Submitted report also provides information used to track and monitor the overall volume and expenditure associated with monthly New Encounter Submissions and Plan Administratively Denied encounters in relationship to the Contractor's claims system. This detail helps to identify any claims system/encounter reporting aberrations over time by form type and month for each Contractor.

The Contractor must submit all three reports quarterly, in the required format to AHCCCS via the SFTP. When necessary the reports may be requested on a more frequent basis according to Encounter Unit instructions. The submission of these reports will be due by 5 PM on the 15th of the month following the end of a quarter, unless otherwise specified by contract or agreed to by the AHCCCS Encounter Manager. If the 15th falls on a weekend or holiday, the due date will be the following business day.

Finalized Claims Report

- Summarizes the number of claims and plan paid amounts finalized by the Contractor and subsequently submitted as encounters to AHCCCS for the reporting timeframe. (See example on page 21)

Override Log

- A list of CRNs and other requested data, including a detailed override reason, for each of the three months itemizing all encounters overridden in PMMIS either directly by the Contractor or per Contractor request by AHCCCS encounter staff. (See example on page 22)

Void Log

- A list of CRNs and other requested data, including a detailed void reason, for each of the three months itemizing all encounters voided in PMMIS either directly by the Contractor or per Contractor request by AHCCCS encounter staff. (See example on pages 23-24)

Note: RBHA's must split the quarterly reports by DDD enrolled members versus non DDD enrolled members no later than July 1, 2016.

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EXAMPLE

Oct-Dec Quarterly 2011 Finalized Claims Submitted to AHCCCS (Submission Dates October 1, 2011 through December 31, 2011)
 Source: Paid and Administratively Denied Claims from Contractor Claims System

October 1, 2011- October 31, 2011

Form Type	Finalized Claims		Encounters Submitted to AHCCCS	
	Count	Health Plan Paid Amount	Count	Health Plan Paid Amount
Professional (837P/1500 or Form A)	9,872	\$ 1,846,064	9,863	\$ 1,844,672
Institutional (837I/UB or Form B)	1,320	\$ 8,343,720	1,317	\$ 8,326,801
Retail Pharmacy (NCPDP or Form C)	3,701	\$ 303,482	3,700	\$ 303,333
Dental (837D/ADA or Form D)	2,193	\$ 223,686	2,193	\$ 223,686
Total All Form Types	17,086	\$ 10,716,952	17,073	\$ 10,698,492

November 1, 2011- November 30, 2011

Form Type	Finalized Claims		Encounters Submitted to AHCCCS	
	Count	Health Plan Paid Amount	Count	Health Plan Paid Amount
Professional (837P/1500 or Form A)	9,772	\$ 1,827,364	9,699	\$ 1,813,999
Institutional (837I/UB or Form B)	1,364	\$ 8,621,844	1,359	\$ 8,592,348
Retail Pharmacy (NCPDP or Form C)	3,499	\$ 286,918	3,492	\$ 286,281
Dental (837D/ADA or Form D)	2,104	\$ 214,608	2,098	\$ 213,996
Total All Form Types	16,739	\$ 10,950,734	16,648	\$ 10,906,624

December 1, 2011- December 31, 2011

Form Type	Finalized Claims		Encounters Submitted to AHCCCS	
	Count	Health Plan Paid Amount	Count	Health Plan Paid Amount
Professional (837P/1500 or Form A)	9,815	\$ 1,835,405	9,806	\$ 1,834,011
Institutional (837I/UB or Form B)	1,188	\$ 7,509,348	1,184	\$ 7,485,902
Retail Pharmacy (NCPDP or Form C)	3,876	\$ 317,832	3,856	\$ 316,122
Dental (837D/ADA or Form D)	2,011	\$ 205,122	2,006	\$ 204,612
Total All Form Types	16,890	\$ 9,867,707	16,852	\$ 9,840,647

An encounter is defined as an inpatient or outpatient institutional claim; or each service line of professional, dental, or pharmacy claim.

Prepared January 12, 2012 for January 16, 2012 submission to AHCCCS

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EXAMPLE

HCFA Spreadsheet for Override												
	AHCCCS comments	Contractors comments										Audited (DV use only)
Pended encounters			Reinsurance Case # (if applicable)	Member ID	Service Begin Date	Service End Date	Service code (REV code, CPT, HCPCS, NDC)	All modifiers	paid units	AHCCCS procedure daily max units		
0000000000000000			N/A	A1111333	1/1/2010	1/1/2010	78787	26, 76	2	2		
Adjudicated encounters												
0000000000000000				A1111333	1/1/2010	1/1/2010	78787	26	2	2		

<https://www.azahcccs.gov/PlansProviders/HealthPlans/encounters.html>

**Exhibit 3A
Pended Encounter Detail Aging File
Record Layout (DETLAGINMMDDYY.ZIP)**

Data Name	Picture	Actual Positions		Remarks
		From	To	
Contractor Identifier	X(06)	001	006	Health Plan ID
Transmission Submitter Number	X(02)	007	008	
Aging Category	X(01)	009	009	
Form Type	X(01)	010	010	
Control Reference Number	X(15)	011	024	AHCCCS CRN
Plan Claim Reference Number	X(20)	025	044	Plan Claim Reference Number
Patient Account Number	X(20)	045	064	Provider Patient Account Number
Service Provider Identifier	X(10)	065	074	
Service Provider Name	X(25)	075	099	
Provider Type	X(02)	100	101	
Beginning Date of Service	X(08)	102	109	CCYYMMDD
Ending Date of Service	X(08)	110	117	CCYYMMDD
Status Effective Date	X(08)	118	125	CCYYMMDD
HCPCS Procedure Code	X(05)	126	130	
HCPCS Procedure Modifier	X(02)	131	132	
Days Pended	X(04)	133	136	
Error Code 01	X(04)	137	140	
Error Code 02	X(04)	141	144	
Error Code 03	X(04)	145	148	
Error Code 04	X(04)	149	152	
Error Code 05	X(04)	153	156	
Error Code 06	X(04)	157	160	
Error Code 07	X(04)	161	164	
Error Code 08	X(04)	165	168	
Error Code 09	X(04)	169	172	
Error Code 10	X(04)	173	176	
Error Code 11	X(04)	177	180	
Error Code 12	X(04)	181	184	
Error Code 13	X(04)	185	188	
Error Code 14	X(04)	189	192	
Error Code 15	X(04)	193	196	

Exhibit 3B
Pended Encounter Duplicate CRN File
Record Layout (DUPECRNMMDDYY.ZIP)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Contractor Identifier	X(06)	001	006	Health Plan ID
Transmission Submitter Number	X(02)	007	008	
Error Code	X(04)	009	012	
Error Message	X(70)	013	082	
Control Reference Number	X(15)	083	096	AHCCCS CRN
Patient Account Number	X(20)	097	116	Provider Patient Account Number
Plan Claim Reference Number	X(20)	117	136	Plan Claim Reference Number
Beginning Date of Service	X(08)	137	144	CCYYMMDD
Ending Date of Service	X(08)	145	152	CCYYMMDD
Form Type	X(01)	153	153	
Service Provider Identifier	X(10)	154	163	
Member Identifier	X(09)	164	172	AHCCCS Member ID
Duplicate Contractor Identifier	X(06)	173	178	Other Health Plan ID
Duplicate Control Reference Number	X(15)	179	192	Other AHCCCS CRN
Duplicate Patient Account Number	X(20)	193	212	Other Provider Patient Account Number
Duplicate Plan Claim Reference Number	X(20)	213	232	Other Plan Claim Reference Number
Duplicate Beginning Date of Service	X(08)	233	240	CCYYMMDD
Duplicate Ending Date of Service	X(08)	241	248	CCYYMMDD
Duplicate Form Type	X(01)	249	249	
Duplicate Service Provider Identifier	X(10)	250	259	
Duplicate Member Identifier	X(09)	260	268	Other AHCCCS Member ID
Reserved	X(20)	269	280	

Exhibit 3C

Detail Show Action Taken File

Record Layout (PNMMDDYY.TSN.ZIP.YYMMDD.ACTNTKN.ZIP)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Health Plan Identifier	X(06)	001	006	Health Plan ID
Transmission Submitter Number	X(02)	007	008	
Action Request	X(01)	009	009	
Action Done	X(01)	010	010	
Error Code	X(04)	011	014	
Error Description	X(20)	015	034	
Field Number	X(03)	035	037	
Field Description	X(15)	038	052	
Old Value	X(17)	053	069	
New Value	X(17)	070	086	
Control Reference Number	X(15)	087	100	AHCCCS CRN
Patient Account Number	X(20)	101	120	Provider Patient Account Number
Plan Claim Reference Number	X(20)	121	140	Plan Claim Reference Number
Begin Date of Service	X(08)	141	148	CCYYMMDD
End Date of Service	X(08)	149	156	CCYYMMDD
Form Type	X(01)	157	157	
Service Provider Identifier	X(06)	158	163	
AHCCCS Member Identifier	X(09)	164	172	
Filler	X(10)	173	182	

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CHAPTER 3 – ENCOUNTER PROCESSING

Report ID: EC9AM128 Exhibit 3D ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PAGE: 1
Program: EC971128-001 ADJUDICATED ENCOUNTERS REPORT (OVERALL) RUN 08/24/12
AS OF 08/24/12 :
15:50

HEALTH PLAN/PROGRAM CONT ID : 224466
HEALTH PLAN/PROGRAM CONT NAME : XYZ CARE SYSTEMS

SUBTOTAL BY HEALTH PLAN/PROGRAM CONT ID:

TOTAL APPROVED	106	TOTAL ADJUDICATED VERSUS:	
1500	55	TOTAL APPROVED	% 55.50
FACL	51	TOTAL DENIED	% 13.09
FORM C	0	TOTAL PENDED	% 31.41
FORM D	0		
TOTAL DENIED	25		
1500	22		
FACL	3		
FORM C	0		
FORM D	0		
TOTAL PENDED	60		
1500	51		
FACL	9		
FORM C	0		
FORM D	0		
TOTAL PROCESS	191		

CHAPTER 3 – ENCOUNTER PROCESSING

Exhibit 3E

Report ID: EC97X130	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	PAGE: 1
Program: EC97C130	ADJUDICATED ENCOUNTERS REPORT	RUN: 08/24/12 15:50

TSN	TRANSMISSION SUBMITTER DESCRIPTION	HP ID	HEALTH PLAN DESCRIPTION			
089	XYZ CARE SYSTEMS	224466	XYZ CARE SYSTEM			
DATASET : \$ACS.EC129. FILET50.G0021V						
NAME						
RECORD : 360						
COUNT						
VOLSER1 : 702850						
VOLSER2 :						
VOLSER3 :						
VOLSER4 :						
VOLSER5 :						
TOTAL REELS : 1						
ENCOUNTER TOTALS						
HP ID	TOTAL ADJUDICATE D APPROVED	TOTAL ADJUDICAT ED VOID	TOTAL ADJUDICAT ED DENIED	TOTAL IN PROCES S	TOTAL OTHER STATUS	GRAND TOTAL
224466	101	0	23	55	0	179
TOTAL	101	0	23	55	0	179
L						

Exhibit 3F

Report ID: EC9AD949
 Program: EC91L949

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
 EC CCL SUMMARY BY ERROR CODE
 AS OF 08/24/12

PAGE: 1
 RUN: 08/24/12
 15:50

TRANSMISSION 089
 SUBMITTER ID: 224466

HP ID	ERROR CODE	-----FORM B-----		-----FORM A-----		-----FORM C-----		TOTAL
		NEW ENTRIES	ADJUSTMENTS	NEW ENTRIES	ADJUSTMENTS	NEW ENTRIES	ADJUSTMENTS	
224466	D035	1						1
	D045	1						1
	H490	2						2
	H790	6						6
	V002	2						2
	V160	176						176
	Z260	6						6
	Z560	1						1
	Z630	285						285
	Z640	7						7
TOTAL		527						487

AHCCCS DIVISION OF HEALTHCARE MANAGEMENT (DHCM) ENCOUNTER MANUAL

CHAPTER 3 – ENCOUNTER PROCESSING

Report ID:	EC91D949	Exhibit 3G	PAGE:	1
Program:	EC91L949	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	RUN:	08/24/12
		EDIT FAILURES BY HEALTH PLAN		15:50
		AS OF 08/24/12		

TRANSMISSION **089**
SUBMITTER ID: **224466**

HP ID	ERROR CODE	ERROR MESSAGES	TOTAL
224466	D035	RECIPIENT AGE EXCEEDS PRIMARY DX ALLOWABLE MAX AGE	1
	D045	RECIPIENT SEX INVALID FOR PRIMARY DIAGNOSIS	1
	H490	FROM DATE OF SERVICE IS PRIOR TO ADMIT DATE	2
	H790	PATIENT STATUS IS NOT ON FILE	6
	V002	DISCHARGE DAY NOT COVERED	2
	V160	ACCOMMODATION DAYS NOT VALID FOR DATE OF SERVICE SPAN	176
	Z260	RECIPIENT NOT ON FILE AND NO ALTERNATE ID FOUND	6
	Z560	INPATIENT CLAIM OVERLAPS DATE OF SERVICE ON LTC CLAIM	1
	Z630	NEAR DUPLICATE FOUND - FROM - THROUGH DATES OVERLAP	285
	Z640	NEAR DUPLICATE FOUND - PROVIDER NOT MATCHED, DATES OVERLAP	7
TOTAL			487

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CHAPTER 3 – ENCOUNTER PROCESSING

Report ID:	EC97R179	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	PAGE:	1
Program:	EC97L179	DUPLICATE CRN BY ERROR CODE	RUN:	08/24/12
		AS OF 08/24/12		
		(ENCOUNTERS)		15:50

Exhibit 3H

TRANSMISSION	:	089	TOP LINE:	IN-PROCESS DATA / BOT LINE: HISTORICAL
SUBMITTER ID				DATA
HEALTH PLAN ID	:	224466	*****	

ERROR CODE	ERROR MESSAGES	CRN	INVOICE	PATIENT ACCOUNT NO.	HP ID
Z720	EXACT DUPLICATE FOUND	083427015717100 080637006718010	000123 000456	0805512345 0731234567	
Z720	EXACT DUPLICATE FOUND	081567007619100 071577015621800	000789 000987	0805552345 0712345678	
Z720	EXACT DUPLICATE FOUND	081737002621200 080917003418100	000321 000654	0805553467 0706618578	
Z720	EXACT DUPLICATE FOUND ERROR-INVALID HISTORICAL HP ID-ERROR	082897002819100 080837003671400	100323 200456	0805896784 0701234567	06666

AHCCCS DIVISION OF HEALTHCARE MANAGEMENT (DHCM) ENCOUNTER MANUAL

CHAPTER 3 – ENCOUNTER PROCESSING

Report ID:	EC9CMI87	Exhibit 3I	PAGE:	1
Program:	EC97L187	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	RUN:	08/24/12
		PENDEDED ENCOUNTERS SUMMARIZED AGING REPORT		15:50
		(SORTED BY HEALTH PLAN, FORM TYPE, PEND TYPE)		

HEALTH PLAN ID : 224466

FOR M TYPE	0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	121-150 DAYS	151-180 DAYS	181-240 DAYS	241-360 DAYS	OVER 360	TOTAL PENDS	0-120 DAYS	OVER 120
A	230	55	0	20	10	0	55	0	4	376	307	69
C	2	5	0	40	0	0	5	0	0	52	47	5
D	0	0	0	0	0	0	0	0	0	0	0	0
I	10	0	0	60	40	0	0	0	0	110	70	40
L	0	20	0	80	0	0	15	0	0	115	100	15
O	12	15	0	100	0	0	0	0	2	129	127	2
O	150	350	0	250	0	0	0	0	0	750	750	0
HEALTH PLAN TOTALS	404	445	0	550	50	0	75	0	6	1532	1401	131

Report ID: EC9EMI87	Exhibit 3J	PAGE:	1
Program: EC97L187	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	RUN:	08/24/12
	PENDED ENCOUNTER DETAILED AGING REPORT		15:50
	(SORTED BY HEALTH PLAN, TRANSMISSION SUBMITTER NUMBER, AGING CATEGORY, ERROR CODE AND PROVIDER ID)		

HEALTH PLAN ID : 224466
 : 089

TSN
 AGING CATEGORY : OVER 180 DAYS

ERROR CODE	MESSAGE PROVIDER ID AND NAME	PROCESS DATE PATIENT ACCOUNT NO	SERVICE DATES	CRN PROC-HCPCS-NDC	FORM TYPE	DAYS PENDED
H470	DATE OF SERVICE IS PRIOR TO DATE OF DEATH 260153-SUESS/DOCTOR	06/28/08 0896452138	11/04/08 11/04/08	083367123456718	A	184
R350	DATE OF DEATH PRIOR TO DOS 020117-RICHARD KIMBLE CENTER	05/07/08 0874561234	09/27/07 09/27/07	081237013679011	I	235

Report ID:	EC9FMI87	<u>Exhibit 3K</u>	PAGE:	1
Program:	EC97L187	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	RUN:	08/24/12
		PENDED ENCOUNTERS SUMMARIZED ERROR REPORT		15:50
		(SORTED BY HEALTH PLAN, AND ERROR COUNT IN DESCENDING ORDER)		

HEALTH PLAN ID : 224466

ERROR CODE	ERROR MESSAGE	FORM TYPE	ERROR COUNT
S445	PROCEDURE MODIFIER INVALID FOR PROCEDURE ON DATE OF SERVICE	A	178
R350	DATE OF DEATH PRIOR TO DOS	O	21
Total			199

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CHAPTER 3 – ENCOUNTER PROCESSING

Report ID:		EC91R901		Exhibit 3L						ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM		PAGE:		1	
Program:		EC91L901		SHOW ACTION TAKEN - DETAIL						RUN:		08/24/12		15:50	
HEALTH PLAN ID		:		224466											
Req	Do n	Erro r Cod e	Action Descriptio n	Int Fld #	Ext Fld Descripti on	Old Value	New Value	CRN	Patient Account Number	Health Plan Claim Number	Begin Date	End Date	Form Type	Provider ID	AHCCCS ID
A	A	9017	Error Overridden	010	AHCCCS ID	A00000000		090650465310100	2009027801617011	2009027801617011	10/08/2009	10/08/2009		1234567890	A99999999
A	A	9017	Error Overridden	034	Condition CD 1			090650465311000	2009027801617011	2009027801617011	10/08/2009	10/08/2009		1234567890	A99999999
A	A	9017	Error Overridden	035	Condition CD 1			090650465310100	2009027801617011	2009027801617011	10/08/2009	10/08/2009		1234567890	A99999999
A	A	9017	Error Overridden	036	Condition CD 1			090650465310100	2009027801617011	2009027801617011	10/08/2009	10/08/2009		1234567890	A99999999
A	A	9017	Error Overridden	037	Condition CD 1			090650465311000	2009027801617011	2009027801617011	10/08/2009	10/08/2009		1234567890	A99999999
A	A	9017	Error Overridden	038	Condition CD 1			090650465310010	2009027801617011	2009027801617011	10/08/2009	10/08/2009		1234567890	A99999999
A	A	9017	Error Overridden	159	Svc Begin Date	20081008		090650465311000	2009027801617011	2009027801617011	10/08/2009	10/08/2009		1234567890	A99999999

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CHAPTER 3 – ENCOUNTER PROCESSING

Report ID:	EC91R901	Exhibit 3L			PAGE:	1
Program:	EC91L901	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM			RUN:	08/24/12
		SHOW ACTION TAKEN - SUMMARY				15:50
File Name is: AZPEND2244660891120509.001 zip						
TSN:	089					
HEALTH PLAN ID	:	224466				
Actions Requested		Request Count	As % of All CCL's	Request Processed	Request Rejected	
CCL Changed		549	27.12	544	5	
No Action		1265	62.50	1265	0	
Overridden		210	10.37	201	9	
Deleted		0	.00	0	0	
Invalid Action Code		0	.00	0	0	
Totals		2024	100.00	2011	14	

Error Code	Actions Taken	Action Count	As % of All CCL's
9001	Enc Header Deleted	0	.00
9002	Enc Detail Deleted	0	.00
9003	CCL Change Processed	544	26.87
9004	No action taken	1265	62.50
9005	Header not on file	0	.00
9006	Alpha not on file	0	.00
9007	Detail not on file	0	.00
9008	Detail ALPH not on file	0	.00
9009	Enc Not in CCL LOC	14	.69

CHAPTER 4 – ENCOUNTER ERROR RESOLUTION

I. INTRODUCTION

This chapter provides explanation of various files and reference information routinely provided by 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.

As previously stated, the Contractor is liable for resolving encounters that were denied or pended by AHCCCS. Encounters denied by AHCCCS must be researched by the Contractor and, when appropriate, resubmitted with revised data. Pended encounters must be corrected or voided and voids tracked. This chapter outlines actions that the Contractor 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 Status file and 277S- Supplemental Status file)** at the conclusion of the adjudication processing cycle. These files contain information regarding each encounter's adjudication status. Additional information regarding the 277U file may be found in the Companion Document for the 277U on the AHCCCS website at <https://www.azahcccs.gov/PlansProviders/HealthPlans/encountertechnicaldocuments.html>

The **277S Supplemental** file layout is included in this chapter as **Exhibit 4A**.

For pended encounters AHCCCS also produces a **Pended Encounter File** at the conclusion of adjudication processing. This file contains all encounters pending in the AHCCCS PMMIS database. The Contractor uses the information in this file to change or approve certain pended encounters. The Contractor then submits 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). This chapter contains file specifications and record layouts for the Pended Encounter File. (**Exhibit 4B**)

***IMPORTANT NOTE:** The New Day encounter submission process must be used to submit Void 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

An Edit Status Report and an Encounter Edit Resolution report are available on the AHCCCS website at <https://www.azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/EncounterEditStatusList.pdf>

The Encounter Edit Resolution Report provides a Contractor with information related to the correction of various types or groups of specific pend errors. It provides for various edits, by form type, the fields involved in the edit and how to correct the pend. It will indicate if the correction must be made by submitting a replacement or void encounter or if it can be corrected using the pend file or on-line PMMIS correction process.

The Edit Status Report is a Matrix of encounter edit codes to the six AHCCCS form types; indicating which edits/audits applies to which form types.

FORM TYPE INDICATOR	FORM
A	HCFA 1500
C	NCPDP
D	AMA DENTAL
I	UB04 “I”NPATIENT HOSPITAL
L	UB04 “L”ONG TERM CARE FACILITY
O	UB04 “O”UTPATIENT HOSPITAL

The “S” columns in this 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. Additionally, values in the LV and LC columns indicate what staff level at AHCCCS is 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 on-line pend corrections using PMMIS and a sortable Excel version of this Edit status report to aid Contractors further in managing pends and denials.

IV. ENCOUNTER PEND EDIT/AUDIT CODE STRUCTURE

The encounter pend edit/audit codes are 4 digits alphanumeric (X999) with leading alpha code that indicates logical grouping of edit reasons. Although the groupings have become somewhat loose over time, 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 to make encounter pend correction more efficient. Below is the alpha character Key:

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

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
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

V. PENDED ENCOUNTER CORRECTION AND COMMENT FILES

Exhibit 4B lists the record layout for the Pended Encounter File. 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.

Exhibit 4C shows the record layout for the Comment File. 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 positions of the CRN will be "000". When the error relates to a detail line, the last three 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 of the header and detail error records related to the encounter (invoice).
- C2 Optional. This record relates to header errors only. It contains the error code(s) 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 value(s) into relevant field(s), and setting the action mode.
- C4 Optional. This record relates to detail line errors. It contains the error code(s) 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 value(s) into relevant field(s), and setting the action mode.

VII. SUBMISSION OF CORRECTED PENDED ENCOUNTERS

It is not necessary for the Contractor to resubmit the entire Pended Encounter File to AHCCCS. Only those C3/C5 records for which an action mode other than "N" has 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 actions relating to a pended encounter. AHCCCS refers to these as action modes:

Action Modes	
C	= Correct a pended encounter
A	= Approve or override an encounter edit
N	= No action

The action mode default is "N" when the Pended Encounter File is produced. To resolve the pended status, the Contractor first chooses an appropriate action mode for each pended encounter.

Action modes are further described below.

- **C** To correct a data field on a pended encounter.

Allows the Contractor 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 the Contractor submits the Pended Encounter File.

To delete the contents for the "old value" field, the "new value" field must contain only spaces.
- **A** To approve or override a pended encounter.

Allows the Contractor to approve or override an encounter that is pended for specifically allowed errors. For duplicates, the Contractor must verify that both services were provided and were accurately reported before approving duplicate encounters. For all overrides, the Contractor must maintain a log. Refer to the Pended Encounter Override Log section Chapter 3.
- **N** No change to the data field content.

This is the default action mode. The Contractor should leave the action mode set to "N" when no action is desired.

Note: In addition to modifying pending encounters with the change (C) action mode in the pending encounter file, the Contractors may also modify pending 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 technical reports or NCPDP implementation guide. An override (A) action mode is not available in the 837 or NCPDP transactions. Therefore overrides must be submitted using the pending encounter file or entered directly in PMMIS.

Action Mode Hierarchy

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

1. 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.

2. 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

For those overrides that the Contractor may not complete themselves in PMMIS, Override Requests should be submitted to the AHCCCS Encounter Unit utilizing the ‘Override Request Form’ (see the link below). Sufficient information must be submitted in to approve and override the pend error. Failure to submit adequate information may result in a processing delay or return of your request for more information.

The override request will be acknowledged and normally processed with 30-45 days.

AHCCCS expedites override requests related to reinsurance cases. Override requests involving reinsurance should be submitted on a separate form and have “Reinsurance Cases” notated prominently on the request form.

An example of the override request form is inserted below.

<https://www.azahcccs.gov/PlansProviders/HealthPlans/encounters.html>

X. OTHER REFERENCE FILES

AHCCCS also produces the following other reference files, which are available from the AHCCCS FTP server at \shareinfo\reference\prod\out\. The record layouts are provided in Exhibits 4D-4F.

Exhibit 4D-F- Extracts 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.

Exhibit 4A Supplemental Status File Record Layout

T0 Record

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Contractor ID	X(06)	01	06	Health Plan ID
Transmission Submitter Number (TSN)	X(03)	07	09	
Process Date	X(08)	10	17	CCYYMMDD
File Type Code	X(02)	18	19	Value 'SU' – Adjudicated Encounter Supplemental File
Filler	X(179)	20	198	
Record Type	X(02)	199	200	"T0"

C1 Record

One Per Encounter

Data Name	Picture	Actual Positions		Remarks
		From	To	
AHCCCS CRN	X(15)	01	15	
RI Number	X(10)	16	25	
Filler	X(13)	26	38	blank
AHCCCS CRN Status	X(02)	39	40	
Form Type	X(01)	41	41	
Alternate ID	X(17)	42	58	
Primary Diagnosis Code	X(07)	59	65	
Category of Service	X(02)	66	67	
Filler	X(17)	68	84	blank
HP Paid Amount	X(12)	85	96	
Approved Amount	X(12)	97	108	
Denial Reason	X(04)	109	112	
Patient Account #	X(30)	113	142	
VBP Contract ID	X(30)	143	172	
Filler	X(26)	173	198	blank
Record Type	X(02)	199	200	"C1"

T9 Record

One Per File

Data Name	Picture	Actual Positions From To		Remarks
Filler	X(09)	01	09	blank
Transmission Submitter Number (TSN)	X(03)	10	12	
Filler	X(06)	13	18	blank
Current Year	X(02)	19	20	YY
Current Julian Date	X(03)	21	23	DDD
File Type Code	X(02)	24	25	Value 'SU' – Adjudicated Encounter Supplemental File
# of C1 Records on File	X(08)	26	33	
Filler	X(165)	34	198	blank
Record Type	X(02)	199	200	"T9"

EXHIBIT 4B

Pended Encounters File Record Layout

100 Column Format

T0 Record

One Per File

Data Name	Picture	Actual Positions From	Actual Positions To	Remarks
Filler	X(09)	01	09	
Transmission Submitter Number (TSN)	X(03)	10	12	
Date Created	X(05)	13	17	YYDDD (Julian Date Format)
Filler	X(81)	18	98	
Record Type	X(02)	99	100	Value "T0"

Pended Encounters File Record Layout

100 Column Format

C1 Record

One Per Encounter

Data Name	Picture	Actual Positions		Remarks
		From	To	
CRN	9 (15)	01	15	
Invoice Number	9(06)	15	20	
Form Type	X(01)	21	21	
Date Created	X(08)	22	29	YEARMMDD
Contractor ID	X(06)	30	35	
AHCCCS Recipient ID	X(09)	36	44	
Service Provider ID	X(10)	45	54	
Health Plan Claim Number	X(30)	55	84	Contractor's Claim Identification Number
Filler	X(14)	85	98	
Record Type	X(02)	99	100	Value "C1"

Pended Encounters File Record Layout

100 Column Format

C2/C4 Records

Errors Present

Data Name	Picture	Actual Positions		Remarks
		From	To	
CRN	N (15)	01	15	
Error Code 1	X(4)	15	18	
Error Code 2	X(4)	19	22	
Error Code 3	X(4)	23	26	
Error Code 4	X(4)	27	30	
Error Code 5	X(4)	31	34	
Error Code 6	X(4)	35	38	
Error Code 7	X(4)	39	42	
Error Code 8	X(4)	43	46	
Error Code 9	X(4)	47	50	
Error Code 10	X(4)	51	54	
Error Code 11	X(4)	55	58	
Error Code 12	X(4)	59	62	
Error Code 13	X(4)	63	66	
Error Code 14	X(4)	67	70	
Error Code 15	X(4)	71	74	
Filler	X(24)	75	98	
Record Type	X(2)	99	100	Value "C2" or "C4"

Pended Encounters File Record Layout

100 Column Format

C3/C5 Records

Fields in Error

Data Name	Picture	Actual Positions From	Actual Positions To	Remarks
CRN	9(15)	01	15	
Invoice Number	9(6)	15	20	
Internal Field Number	X(3)	21	23	
Old Value	X(20)	24	43	
New Value	X(20)	44	63	Underscores to size of allowed input.
Action Mode	X(1)	64	64	Defaults to 'N' Input 'C' = Correct 'N' = No Action 'A' = Approve Duplicate Audit
CCL Location	X(2)	65	66	Always "92"
Form Field Name	X(15)	67	81	
Filler	X(17)	82	98	
Record Type	X(2)	99	100	Value "C3" or "C5"

Pended Encounters File Record Layout

100 Column Format

T9 Record

One Per File

Data Name	Picture	Actual Positions From	To	Remarks
Filler	X(9)	01	09	
Transmission Submitter Number (TSN)	X(3)	10	12	
Filler	X(6)	13	18	
Current Date	X(5)	19	23	'YYDDD' (Julian Date Format)
Filler	X(2)	24	25	
Total Records on File	N(7)	26	32	
Total Charges	N(13)V99	33	47	Zeros
BBA Attestation	X(35)	48	82	
Filler	X(16)	83	98	
Record Type	X(2)	99	100	Value "T9"

EXHIBIT 4C

Comment File Record Layout

100 Column Format

T0 Record

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Record Type	X(2)	01	02	"T0"
Filler	X(14)	03	16	
Transmission Submitter Number (TSN)	X(3)	17	19	
Date File Created	X(8)	20	27	'YEARMMDD'
Filler	X(73)	28	100	

C6 Record

One Per Encounter

Data Name	Picture	Actual Positions		Remarks
		From	To	
Record Type	X(2)	01	02	"C6"
CRN	X(15)	03	16	
Health Plan Identifier	X(6)	17	22	
Comment	X(68)	23	90	
Filler	X(10)	91	100	

Comment File Record Layout

100 Column Format

T9 Record

One Per File

Data Name	Picture	Actual Positions From	Actual Positions To	Remarks
Record Type	X(2)	01	02	"T9"
Filler	X(14)	03	16	
Transmission Submitter Number (TSN)	X(3)	17	19	
Date File Created	X(8)	20	27	'YEARMMDD'
Total Number of Records	N(7)	28	34	
Filler	X(66)	35	100	

Exhibit 4D

Field Information (ECFLD.TXT)

<ftp://shareinfo/reference/prod/out/ecfld.txt>

ECFLD.TXT Record Layout

Data Name	Picture	Actual Positions		Remarks
		From	To	
Form Type	X(01)	01	01	
Internal Field Number	X(03)	02	04	
Internal Field Name	X(15)	05	19	
Internal Table Name	X(15)	20	34	
Internal Field Length	N(03)	35	37	
Form Field Name	X(15)	38	54	
Date Record Added	X(08)	53	60	
Last Modified Date	X(08)	61	68	
Last Modified Time	X(08)	69	76	
Last Modified User	X(03)	77	79	
Field Type	X(01)	80	80	

Exhibit 4E

Error-to-Field Relationship (ECERRFLD.TXT)

<ftp://shareinfo.reference.prod/out/ecerrfld.txt>

ECERRFLD.TXT Record Layout

Data Name	Picture	Actual Positions		Remarks
		From	To	
Error Code	X(04)	01	04	
Internal Field Number	X(03)	05	07	
Begin Date	X(08)	08	15	
End Date	X(08)	16	23	
Encounter CCL Indicator	X(01)	24	24	
Claim CCL Indicator	X(01)	25	25	
Form Type	X(01)	26	26	
Date Record Added	X(08)	27	34	
Last Modified Date	X(08)	35	42	
Last Modified Time	X(08)	43	50	
Last Modified User	X(03)	51	53	

Exhibit 4F

Error Information (ECERR.TXT)

<ftp://shareinfo/reference/prod/out/ecerr.txt>

ECERR.TXT Record Layout

Data Name	Picture	Actual Positions		Remarks
		From	To	
Error Number	X(04)	1	4	
Error Description	X(70)	5	74	

CHAPTER 5 – PROVIDER AND REFERENCE FILES

I. INTRODUCTION

This chapter contains a description and examples of files generated by AHCCCS for the Contractor. These Files contain information and coding pertaining to provider, reference and encounter data intended to assist the Contractor 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 in place to routinely update their systems with this information in order to replicate the editing logic needed to “pre” adjudicate claims to efficiently achieve approved encounter status. These files will help insure that the Contractor meets AHCCCS encounter editing criteria resulting in timely encounter adjudication.

II. PROVIDER FILES

On a weekly basis AHCCCS produces two provider files:

Provider Profile (filename = profile.zip). The file layout attached as Exhibit 5A

Provider File (filename = provider.zip). The file layout attached as Exhibit 5B

These files are available for download from the AHCCCS FTP server:

ftp\\shareinfo\provider\prod\out\profile.zip
ftp\\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. This provider type drives encounter editing to ensure that the Contractors reimburse registered providers only for services for which they are appropriately licensed/certified and which are approved by AHCCCS.

1. Provider Profile- (exhibit 5A)

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, this file contains six (6) date sensitive record types-P1-P6 that indicate:

- **P1 – Provider Type Profile** - 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 (PR090)

- **P2 – Provider Type/COS/Licensing Agency**– 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, effective dates and which COS are related to this license/certification. (RF607)
- **P3 – Provider Type Rate Schedule** - Service rates for provider type for covered services ; lists multiple payment schedules (RF618)
- **P4 – Category of Service (COS)** - COS is a grouping of services by AHCCCS defined category; records provide COS codes and description (RF603)
- **P5 – Provider Type** –provides provider type coding and description (RF612)
- **P6 – Provider Type to Form Type** - Provider type code relationship to form type. Certain provider types like Dental and Residential treatment Centers may use more than one form type for claims and encounters. (RF639)

2. **Provider File-(exhibit 5B)**

The Provider File (Exhibit 5B) gives the Contractor 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 a 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** - provider type code, National Provider Identifier(NPI) and 340B drug pricing indicators (PR010)
- **P2 – Provider Enrollment Status** - coding indicating the provider’s current and historical enrollment status with AHCCCS (PR070)
- **P3 – Category of Service** - multiple records indicating approved COS for date spans; indicates which agency issues the license or certification and effective dates (PR035)

- **P4 – Payment Rates** - coded information and values related to AHCCCS provider specific fee schedule payment rates to be used as default payment rates for certain types of providers unless Contractors have other rates established by contract with the provider. (PR050)
- **P5 – License** - date sensitive coding of license/certification records relevant to the provider (PR020)
- **P6 – Specialty** - Date sensitive AHCCCS proprietary provider specialty coding segments. Also includes special date and coding related to current Federal PCP Rate Parity Program (PR030) (see AHCCCS website) <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/PCPParity.html>
- **P7 – Medicare Data** - data related to the provider’s participation with Medicare programs and assigned Medicare Identification Numbers (PR060)
- **P8 – Exception** – 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** (PR055)
- **P9 – Billing Associations – No longer in use**-records linking the provider to AHCCCS provider ID “ 01 group payment” records (PR045)

Address records type codes- (PR015)

- C=correspondence
- S= service site
- P= Pay to

- **R1 – Address record** - Correspondence/mailing addressing information; each provider has one (PR015)
- **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** – 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. (PR082)
- **R5 – Provider File Taxonomy Record (PR021)**- Provides provider taxonomy codes associated with provider. One provider may have many R5 records.

III. REFERENCE FILES

On the 1st and 15th of the month AHCCCS produces multiple reference files with data used to adjudicate encounters. Six (6) of these files and their layouts are included in this section and attached as Exhibits 5C-5I. These files are available for download from the AHCCCS FTP server filenames= refer01.zip through refer06.zip (e.g.- ftp\shareinfo\reference\prod\out\refer01.zip).

Each file contains Header (T0) and trailer (T9) records along with multiple records carrying codes and values needed to efficiently adjudicate AHCCCS claims for encounter acceptance.

Exhibit 5C

Reference File 01 (Refer01.zip) informational records include:

- **H1 – Procedure Demographics** – basic procedure code information including maximum and minimum age limitations (RF113)
- **H2 – FFS and CMDP Max Allowed Charge** – 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) (RF112)
- **H3 – AHCCCS Coverage** – indicates AHCCCS coverage parameters for a procedure code. (RF123) (see Coverage code listing Chapter 7-4)
- **H4 – AHCCCS Medical Category of Service** – provides date sensitive revenue code, UB Bill Type, HCPCS code and NDC codes to COS. Indexed by service type code. (RF769)

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** – used for relational editing between Revenue codes and UB bill type codes
- **H6 – Revenue Code to Procedure Code** – provides valid, date sensitive revenue code to procedure code relationships. (RF773)

- **H7 – Status Code B** - 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. (RFC25)
- **H8 – Benefit Package Limits** – provides service benefit limitations on services such as inpatient days, physical therapy visits and respite hours by effective plan year. (RFC31)
- **H9 – Benefit Package Limit exceptions - TABLE NOT CURRENTLY USED-** provides the criteria for benefit limit exceptions. (RFC32)
- **N1 – Multiple Surgery** – (RF724) Extract of HCPCS codes to which multiple procedure discounting rule applies
- **N2 – PCP Specialty Rates** - New PCP Parity rate table providing special rates for applicable effective dates by Place of Service (POS) for qualified providers (RF144)
- **N3 – PCP Special Modifier Rate-** - provides valid modifier rates, as applicable, for Parity eligible codes with the SL modifier for vaccine administration codes. (RF147)

EXHIBIT 5D

Reference File 02 (Refer02.zip) informational records include:

- **M1 – Procedure** - procedure code specific indicators and values e.g. family planning, TPL applicable, sterilization indicator, min-max age, etc...(RF113)
- **M2 – FFS valid modifiers** – 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 (RF122)
- **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 – Pharmacy Procedure codes – TABLE NOT CURRENTLY USED** lists CPT/HCPCS codes that require an NDC code when billed on HCFA or UB.
- **M6 – ICD-10 with family Planning indicator = “Y”** – extract of ICD-10 procedure and diagnosis codes indicated as Family Planning related.

EXHIBIT 5E

Reference File 03 (Refer03.zip) informational records include various table information related to AHCCCS specific Outpatient Fee Schedule Pricing rules: for more information on the entire AHCCCS Outpatient Fee Schedule pricing methodology see:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/outpatientfees.html>

- **N1 – Procedure OPFS (Outpatient Fee Schedule) Indicators and Values** – OPFS procedure code specific indicators and values e.g. family planning, TPL applicable, EPSDT, sterilization indicator, min-max age,etc... (RF127)
- **N2 – OPFS Price** – provides procedure code specific price for OPFS services (RF126)
- **N3 – OPFS Bundled Driver** - provides procedure code values and value ranges for services that drive bundled OPFS pricing (RF797)
- **N4 – Bundled Revenue Codes** – provides a listing of Revenue codes that are subject to bundled payment for OPFS (RF796)
- **N5 – CCI codes** - lists Correct Coding relationships that indicate bundled and unbundled services editing required by AHCCCS. **Note:** CCI editing is not limited to OPFS (RF128)
- **N6 – Multiple Surgery Exemption Table** – Lists procedure codes that are exempted from the OPFS Multiple surgery pricing rules (RF789)
- **N7 – Limit Override Modifiers** – 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 **Note:** editing is not limited to OPFS (RF723)
- **N8 – Override Action Codes-** the 2 digit code values for modifier override of various rules (RF725)

See table RF 725 Override Action Codes values below:

- 01 OVERRIDE MULTIPLE SURGERY DISCOUNT
- 02 OVERRIDE FREQUENT SERVICE LIMIT
- 04 OVERRIDE CCI EDITS
- 05 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** - provides relationship of procedure code to valid OPFS modifiers indicating amount (A) or percent (P) payment values (RF121)

- **P1 – Limit Override Procedures** - lists relationship of procedures to override action codes that allow override of various types of edit rules (see override action code table above) (RF739)
- **P2 – MUE Units of Service - 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 is part of the National Correct Coding Initiative (NCCI) to address coding methodologies. **Note:** not limited to OPFS only. (RF129)
- **P3 – NCCI Associated Modifiers-** lists modifier values that are valid for National Correct Coding Initiative (NCCI) editing. (RF131)
- **P4 – Procedure OPFS Clinic Price RCF** - 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. (RF133)
- **P5 – Secondary OPFS Bundled Rate Driver Codes OBS** – lists 2 codes G0378 and G0379 as additional bundled rate drivers for OPFS pricing as defined in the OPFS pricing flow. (RFC97)

EXHIBIT 5F

Reference File 04 (Refer04.zip) informational records include:

- **TA – Medicare Covered Part B Therapeutic Classes-** Medicare Part B covered drug classification using a therapeutic class grouper. (RF350)
- **T2 – Link Multiple Service Types** – 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. (RF771)
- **T3 – VFC Procedure Codes** – 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. (RF729)
- **T4 – Medicare Primary Payer Error Bypass** – lists encounter pend codes where related encounter editing is bypassed when Medicaid secondary claims are submitted to AHCCCS as encounters. (RF799)
- **T5 – Medicaid Covered Therapeutic Classes** – Lists Therapeutic Class Codes not covered by Medicare Part D or B. (RF347)
- **T6 – ASC Rate Schedule** – Statewide date sensitive ASC rates.

- **T7 – Dental Procedures** – provides indicators by dental code related to tooth number, surface and quadrant reporting requirements. (RF103)
- **T8 – Procedure Place of service** – provides valid, date sensitive procedure code to Place of Service (POS) relationships (RFC23)

EXHIBIT G AND H RATE FILES NOTE

Reference files 05 and 06 both contain the maximum allowed charge and modifier records similar to those found in the Reference 01 and 02 files. 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

EXHIBIT 5I

Reference File 07 (Refer07.zip) informational record

- **M1 – Co-pay to service** – Date sensitive data related to recipient copay requirements for service codes, includes other information relevant to the service type and copay amount e.g. POS, provider type, age etc. (RF7A7)

**Exhibit 5A1
Provider Profile Record Layout
\\ftp\shareinfo\provider\prod\out\profile.zip**

Header (T0)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(58)	21	78	
Record Type	X(02)	79	80	"T0"

Provider Type Profile (P1) (PR090)

Data Name	Picture	Actual Positions		Remarks	
		From	To		
Provider Type	X(02)	01	02		
Category of Service	X(02)	03	04		
Mand/Opt	X(01)	05	05	M	Mandatory
				O	Optional
Category Description	X(30)	06	35		
Service From	X(11)	36	46		
Service To	X(11)	47	57		
Service Type	X(01)	58	58	B	Bill Type
				H	HCPCS
				P	Pharmacy Item
				R	Revenue Code
				S	ICD9 Proc. Code
				T	Therapeutic Class
				D	Diagnosis Code
				X	Unspecified
Begin Date	X(08)	59	66		CCYYMMDD
End Date	X(08)	67	74		CCYYMMDD
Plc-ser	X(02)	75	76		Place of service
Proc-mod	X(02)	77	78		Procedure modifier
Record Type	X(02)	79	80		P1

Provider Type COS to Licensing Agency (P2) (RF607)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider Type	X(02)	01	02	
Category of Service	X(02)	03	04	
Mand/Opt	X(01)	05	05	M Mandatory O Optional
Agency ID	X(03)	06	08	
Agency Name or Description	X(40)	09	48	
Federal State Indicator	X(01)	49	49	F Federal S State
Licensing/Certification Indicator	X(01)	50	50	L Licensing C Certification
State	X(02)	51	52	
Agency Mand/Opt Indicator	X(01)	53	53	M Mandatory O Optional
Begin Date	X(08)	54	61	CCYYMMDD
End Date	X(08)	62	69	CCYYMMDD
Filler	X(09)	70	78	
Record Type	X(02)	79	80	P2

License Certification Indicator Values

(RF655)

License Certification Indicator Values		
L	=	License
C	=	Certification
C1	=	CLIA Registration
C2	=	CLIA Regular Certification
C3	=	CLIA Certification Accreditation
C4	=	CLIA Waiver
C5	=	CLIA Microscopy

CHAPTER 5 – PROVIDER AND REFERENCE FILES

Provider Type Rate Schedule (P3) (RF618)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider Type	X(02)	01	02	
Rate Schedule	X(03)	03	05	
Payment Type	X(01)	06	06	P A Percent Amount
Amount	N(7.4)	07	17	
Service Type	X(01)	18	18	B Bill Type H HCPCS P Pharmacy Item R Revenue Code S ICD9 Proc. Code T Therapeutic Class D Diagnosis Code X Unspecified
Service From Code	X(11)	19	29	
Service To Code	X(11)	30	40	
Procedure Modifier	X(02)	41	42	
Place of Service	X(02)	43	44	
Begin Date	X(08)	45	52	CCYYMMDD
End Date	X(08)	53	60	CCYYMMDD
Filler	X(18)	61	78	
Record Type	X(02)	79	80	P3

Category of Service Code (P4) (RF603)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Category of Service	X(02)	01	02	
Category of Service Description	X(40)	03	42	
Begin Date	X(08)	43	50	CCYYMMDD
End Date	X(08)	51	58	CCYYMMDD
Filler	X(20)	59	78	
Record Type	X(02)	79	80	P4

Provider Type Code (P5) (RF612)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider Type	X(02)	01	02	
Provider Type Description	X(40)	03	42	
Begin Date	X(08)	43	50	CCYYMMDD
End Date	X(08)	51	58	CCYYMMDD
Filler	X(20)	59	78	
Record Type	X(02)	79	80	P5

Provider Type To Form Type (P6) (RF639)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider Type	X(02)	01	02	
Form Type	X(01)	03	03	
State Code	X(01)	04	04	A Arizona B Both (Arizona and Hawaii)
Form Type Description	X 40)	05	44	
Begin Date	X(08)	45	52	CCYYMMDD
End Date	X(08)	53	60	CCYYMMDD
Filler	X(18)	61	78	
Record Type	X(02)	79	80	P6

Trailer (T9)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(70)	21	78	
Record Type	X(02)	79	80	"T9"

**Exhibit 5A2
Provider Profile Record Layout
\\ftp\shareinfo\provider\prod\out\profile2.zip**

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(138)	21	158	
Record Type	X(2)	159	160	T0

Taxonomy Code/Description (P1) (RF648)

Many to one Taxonomy Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
Taxonomy Code	X(10)	01	10	RF648 Code Values
Taxonomy Description	X(120)	11	130	RF648 Code Description
Begin Date	X(08)	131	138	CCYYMMDD
End Date	X(08)	139	146	CCYYMMDD or '99999999'
Status Code	X(1)	147	147	Record Status: A – Active H - History
Filler	X(11)	148	158	
Record Type	X(02)	159	160	P1

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(138)	21	158	
Record Type	X(2)	159	160	T9

**Exhibit 5B
Provider File Record Layout
ftp\share\info\provider\prod\out\provider.zip**

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(58)	21	78	
Record Type	X(02)	79	80	"T0"

Demographic (P1) (PR010)

One Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Provider Name	X(25)	07	31	
Provider Type	X(02)	32	33	
NPI Indicator	X(01)	34	34	Y or N
Provider 340B Indicator	X(01)	35	35	Y or N
Filler	X(43)	36	78	
Record Type	X(02)	79	80	P1

Provider Enrollment Status(P2) (PR070)

One to Many Per Provider

Data Name	Picture	Actual Positions		Remarks	Sort Sequence
		From	To		
Provider ID	X(06)	01	06		1
Provider Status Type	X(01)	07	07	A = Active P = Pended T = Terminated S = Suspended D = Denied	
Provider Status	X(02)	08	09		
Begin Date	X(08)	10	17	CCYYMMDD	2
End Date	X(08)	18	25	CCYYMMDD	
Replacement Provider ID	X(06)	26	31		
Filler	X(47)	32	78		
Record Type	X(02)	79	80	P2	

Category of Service (P3) (PR035)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Category of Service	X(02)	07	08	
Begin Date	X(08)	09	16	CCYYMMDD
End Date	X(08)	17	24	CCYYMMDD
Filler	X(54)	25	78	
Record Type	X(02)	79	80	P3

CHAPTER 5 – PROVIDER AND REFERENCE FILES

Payment Rate (P4) (PR050)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Service Type	X(01)	07	07	
Service From	X(11)	08	18	
Service To	X(11)	19	29	
County	X(02)	30	31	
CRN Date	X(08)	32	39	CCYYMMDD
Begin Date	X(08)	40	47	CCYYMMDD
End Date	X(08)	48	55	CCYYMMDD
Rate Schedule	X(03)	56	58	
Payment Type Values	X(01)	59	59	A = Amount; Payment format is 9(7)V99 or P = Percent; Payment format is 9V9999
Amount	N(07)v(04)	60	70	
Place of Service	X(02)	71	72	
Procedure Modifier	X(02)	73	74	
Filler	X(04)	75	78	
Record Type	X(02)	79	80	P4

License (P5) (PR020)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Agency	X(03)	07	09	
License ID	X(15)	10	24	
License Cert Ind	X(02)	25	26	
Begin Date	X(08)	27	34	CCYYMMDD
End Date	X(08)	35	42	CCYYMMDD
Filler	X(36)	47	78	
Record Type	X(02)	79	80	P5

CHAPTER 5 – PROVIDER AND REFERENCE FILES

Specialty (P6) (PR030)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Specialty	X(03)	07	09	
Begin Date	X(08)	10	17	CCYYMMDD
End Date	X(08)	18	25	CCYYMMDD
Attest Type	X(01)	26	26	PCP Specialty included in relationship to B = Board Certified - Attested 6 = 60% qualified 7 = 60% qualified for new provider (less than 1 year) (B or 6 qualifies for specialty PCP Pricing) N = Not Qualified C = Vendor Board Certified - Not Attested “ “ = Does Npr010ot apply
Attest Date	X(08)	27	34	CCYYMMDD
Filler	X(44)	35	78	
Record Type	X(02)	79	80	P6

Medicare Data (P7) (PR060)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Medicare Coverage	X(01)	07	07	A – Medicare A B – Medicare B
Medicare ID	X(10)	08	17	
Carrier Code	X(05)	18	22	
Intermediary Code	X(05)	23	27	
Begin Date	X(08)	28	35	CCYYMMDD
End Date	X(08)	36	43	CCYYMMDD
Filler	X(35)	44	78	
Record Type	X(02)	79	80	P7

Exception (P8) (PR055)

**Zero to Many Group Identifiers Per Provider
One to Many Services per Group Identifier**

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Service Type	X(01)	07	07	
Service From	X(11)	08	18	
Service To	X(11)	19	29	
Begin Date	X(08)	30	37	CCYYMMDD
End Date	X(08)	38	45	CCYYMMDD
Exception Type	X(02)	46	47	01 – Provider Prohibited 02 – Medical Review Required 03 – PA Required 04 – Allowed Service
Agency ID	X(03)	48	50	
Group Type	X(05)	51	55	
Group Identifier	X(04)	56	59	
Procedure Modifier	X(02)	60	61	
Place of Service	X(02)	62	63	
Filler	X(28)	64	78	
Record Type	X(02)	79	80	P8

NOTE: Table not auto read by Encounters for exception type 04, plans must submit override request to encounter unit

Billing Associations (P9) (PR045)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Group ID	X(06)	07	12	
Begin Date	X(08)	13	20	CCYYMMDD
End Date	X(08)	21	28	CCYYMMDD
Filler	X(50)	29	78	
Record Type	X(02)	79	80	P9

NOTE: not currently being used for encounter processing.

Addressses (PR015) A group of R1, R2, R3

One to Many Per Provider

R1

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Address Type	X(01)	07	07	C –Correspondence
Location Code	X(02)	08	09	
Street Line 1	X(25)	10	34	
Street Line 2	X(25)	35	59	
Begin Date	X(08)	60	67	CCYYMMDD
End Date	X(08)	68	75	CCYYMMDD
Claims-Brand	X(02)	76	77	01 – I.H.S 02 – Tribal 638
Filler	X(01)	78	78	
Record Type	X(02)	79	80	R1

CHAPTER 5 – PROVIDER AND REFERENCE FILES

**Addresses (PR015) A group of R1, R2, R3
R2**

One to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Address Type	X(01)	07	07	S - Service
Location Code	X(02)	08	09	
Pay-To Location Code	X(02)	10	11	
City	X(25)	12	36	
County	X(02)	37	38	
State	X(02)	39	40	
Zip Code	X(09)	41	49	
Country Code	X(02)	50	51	01 – USA must be USA
Business Phone	X(10)	52	61	
Emergency Phone	X(10)	62	71	
Filler	X(07)	72	78	
Record Type	X(02)	79	80	R2

**Addresses (PR015) A group of R1, R2, R3
R3**

One to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Address Type	X(01)	07	07	P – Pay To
Location Code	X(02)	08	09	
Tax ID	X(20)	10	29	
Attention To	X(25)	30	54	
Filler	X(24)	55	78	
Record Type	X(02)	79	80	R3

Alternate ID (R4) (PR082)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Provider Alt ID	X(15)	07	21	
Alt ID Type	X(02)	22	23	NP=NPI;MA=Medicare A; MB=Medicare B; PC=program contractor ID
Begin Date	X(08)	24	31	CCYYMMDD
End Date	X(08)	32	39	CCYYMMDD or '99999999'
Filler	X(39)	40	78	
Record Type	X(02)	79	80	R4

CHAPTER 5 – PROVIDER AND REFERENCE FILES

Provider Taxonomy (R5) (PR021)

Zero to Many Per Provider

Data Name	Picture	Actual Positions		Remarks
		From	To	
Provider ID	X(06)	01	06	
Taxonomy Code	X(10)	07	16	RF648 Code Values
Begin Date	X(08)	17	24	CCYYMMDD
End Date	X(08)	25	32	CCYYMMDD or '99999999'
Status	X(1)	33	33	Record Status: A = Active H = History
Filler	X(45)	34	78	
Record Type	X(02)	79	80	

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Total Records	N(10)	21	30	
Total Providers	N(06)	31	36	
Filler	X(42)	37	78	
Record Type	X(02)	79	80	"T9"

**Exhibit 5C
Reference File 01 Record Layout
Refer01.zip**

\\ftp\shareinfo\reference\prod\out\refer01.zip

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(58)	21	78	
Record Type	X(02)	79	80	"T0"

**ProcedureDemographic (H1)
(RF113)**

One Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Description	X(65)	06	70	
Minimum Age Limitations	X(03)	71	73	
Minimum Age Type	X(01)	74	74	Y=Year ; M=Month; D=day
Maximum Age Limitations	X(03)	75	77	
Maximum Age Type	X(01)	78	78	Y=Year ; M=Month; D=day
Record Type	X(02)	79	80	H1

**FFS and CMDP Max Allowed
Charge (H2) (RF112)**

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
County	X(02)	06	07	
Begin Date	X(08)	08	15	CCYYMMDD
End Date	X(08)	16	23	CCYYMMDD
MAC	N(9)V99	24	34	
CRN Date	X(08)	35	42	CCYYMMDD
Place of Service	X(02)	43	44	
Filler	X(34)	45	78	
Record Type	X(02)	79	80	H2

AHCCCS Coverage (H3) (RF123)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Coverage Code	X(02)	06	07	
Replacement Proc Code	X(05)	08	12	
Begin Date	X(08)	13	20	CCYYMMDD
End Date	X(08)	21	28	CCYYMMDD
Filler	X(50)	29	78	
Record Type	X(02)	79	80	H3

AHCCCS Medical Category of Service (H4) (RF769) One to Many per Category of Service

Data Name	Picture	Actual Positions		Remarks
		From	To	
Category of Service	X(02)	01	02	
Category of Type	X(01)	03	03	
Category of Service From	X(11)	04	14	
Category of Service To	X(11)	15	25	
Begin Date	X(08)	26	33	CCYYMMDD
End Date	X(08)	34	41	CCYYMMDD
Filler	X(37)	42	78	
Record Type	X(02)	79	80	H4

AHCCCS Revenue Codes to Bill Types (H5) (RF774) One to Many per Revenue Code Range

Data Name	Picture	Actual Positions		Remarks
		From	To	
Revenue Code From	X(04)	01	04	
Revenue Code To	X(04)	05	08	
Bill Type From	X(03)	09	11	
Bill Type To	X(03)	12	14	
Error Code	X(04)	15	18	
Revenue 4th Digit Indicator	X(01)	19	19	
Coverage Indicator	X(01)	20	20	
Units Indicator	X(01)	21	21	
PA Code	X(01)	22	22	
Medical Review Indicator	X(01)	23	23	
MAN Price Indicator	X(01)	24	24	
Proc Indicator	X(01)	25	25	R=Required; O=Optional; N=Not Required
Begin Date	X(08)	26	33	CCYYMMDD
End Date	X(08)	34	41	CCYYMMDD
Filler	X(37)	42	78	
Record Type	X(02)	79	80	H5

AHCCCS Revenue Codes to Procedure Code (H6) (RF773) One to Many per Revenue Code Range

Data Name	Picture	Actual Positions		Remarks
		From	To	
Revenue Code From	X(04)	01	04	
Revenue Code To	X(04)	05	08	
Procedure Code From	X(05)	09	13	
Procedure Code To	X(05)	14	18	
Begin Date	X(08)	19	26	CCYYMMDD
End Date	X(08)	27	34	CCYYMMDD
Filler	X(44)	35	78	
Record Type	X(02)	79	80	H6

Status Code B (H7) (RFC25)

One Per Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
CPT-HCPCS Code	X(05)	01	05	
CPT-HCPCS Description	X(40)	06	45	
Begin Date	X(08)	46	53	CCYYMMDD
End Date	X(08)	54	61	CCYYMMDD
Filler	X(17)	62	78	
Record Type	X(02)	79	80	H7

Benefit Package Limits (H8) (RFC31)

One to One Benefit Limit Type

Data Name	Picture	Actual Positions		Remarks
		From	To	
Benefit Limit Type	X(02)	01	02	
Benefit Limit Description	X(24)	03	26	
Contract Year	X(04)	27	30	
Contract Limit	X(04)	31	34	
Begin Date	X(08)	35	42	CCYYMMDD
End Date	X(08)	43	50	CCYYMMDD
Claim Receipt Date	X(08)	51	58	CCYYMMDD
Filler	X(20)	59	78	
Record Type	X(02)	79	80	H8

Benefit Package Limit Exception (H9) (RFC32)

One Code Per Contract Year

Data Name	Picture	Actual Positions		Remarks
		From	To	
Exception Criteria Code	X(03)	01	03	
Description	X(23)	04	26	
Limit Type	X(02)	27	28	
Contract Year	X(04)	29	32	
Begin Date	X(08)	33	40	CCYYMMDD
End Date	X(08)	41	48	CCYYMMDD
Filler	X(30)	49	78	
Record Type	X(02)	79	80	H9

Multiple Surgery (N1) (RF724)

One Code Per Date Range

Data Name	Picture	Actual Positions		Remarks
		From	To	
Service Type	X(01)	01	01	
Entity Type	X(03)	02	04	
Service Code Billable From	X(11)	05	15	
Service Code Billable To	X(11)	16	26	
Entity Indicator	X(01)	27	27	
Begin Date	X(08)	28	35	CCYYMMDD
End Date	X(08)	36	43	CCYYMMDD
Filler	X(35)	44	78	
Record Type	X(02)	79	80	N1

PCP Specialty Rates (N2) (RF144)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
County	X(02)	06	07	
Begin Date	X(08)	08	15	CCYYMMDD
End Date	X(08)	16	23	CCYYMMDD
MAC	N(9)V99	24	34	
CRN Date	X(08)	35	42	CCYYMMDD
Place of Service	X(02)	43	44	
Filler	X(34)	45	78	
Record Type	X(02)	79	80	N2

MCO PCP SPECIAL MODIFIER RATE (N3) (RF147)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Procedure Modifier	X(02)	06	07	
Payment Type	X(01)	08	08	A=Amount, P=Percentage
Amount	N(7)V9(4)	09	19	Amount or percentage allowed
Begin Date	X(08)	20	27	CCYYMMDD
End Date	X(08)	28	35	CCYYMMDD
CRN Date	X(08)	36	43	CCYYMMDD
Place of Service	X(02)	44	45	
Filler	X(33)	46	78	
Record Type	X(02)	79	80	N3

BHS Standard Service Set (N4) (RF724)

One Code Per Date Range

Data Name	Picture	Actual Positions		Remarks
		From	To	
Service Type	X(01)	01	01	
Entity Type	X(03)	02	04	BHS
Service Code Billable From	X(11)	05	15	
Service Code Billable To	X(11)	16	26	
Entity Indicator	X(01)	27	27	
Begin Date	X(08)	28	35	CCYYMMDD
End Date	X(08)	36	43	CCYYMMDD
Filler	X(35)	44	78	
Record Type	X(02)	79	80	N4

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Total Records	N(10)	21	30	
Total Procedures	N(06)	31	36	
Filler	X(42)	37	78	
Record Type	X(02)	79	80	"T9"

**Exhibit 5D
Reference File 02 Record Layout
Refer02.zip
*ftp\share\info\reference\prod\out\refer02.zip***

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(98)	21	118	
Record Type	X(02)	119	120	"T0"

Procedure (M1) (RF113)

One Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Description	X(13)	06	18	
Start Date	X(08)	19	26	
End Date	X(08)	27	34	
Maximum Units	X(06)	35	40	
1 st Frequency Value	X(03)	41	43	
1 st Frequency Code	X(01)	44	44	
Anesthesia Maximum	X(04)	45	48	Anesthesia Unit Maximum *Limited use, see Anesthesia policy
Anesthesia Value	N(3.1)	49	52	Anesthesia Base Units
Maximum Allowable Charge (MAC)	N(9.2)	53	63	
Follow Up Period	X(03)	64	66	
Sex	X(01)	67	67	
Minimum Age	N(03)	68	70	
Minimum Age Qualifier	X(01)	71	71	Y=Years, M=Months, D=Days
Maximum Age	N(03)	72	74	
Maximum Age Qualifier	X(01)	75	75	Y=Years, M=Months, D=Days
Medicare Coverage Indicator	X(01)	76	76	Y=Covered by Medicare
Place of Service	X(02)	77	78	
1 st Limit	X(03)	79	81	
Abortion Indicator	X(01)	82	82	
Confidential Services Indicator	X(01)	83	83	
EPSDT Indicator	X(01)	84	84	
Family Planning Indicator	X(01)	85	85	
2nd Limit	X(03)	86	88	
2nd Frequency Value	X(03)	89	91	
2nd Frequency Code	X(01)	92	92	
Procedure Status	X(01)	93	93	
Sterilization Indicator	X(01)	94	94	
Third Party Liability Indicator	X(01)	95	95	
Laboratory Indicator	X(01)	96	96	
Filler	X(22)	97	118	
Record Type	X(02)	119	120	M1

FFS and CMDP Modifier (M2) (RF122)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Procedure Modifier	X(02)	06	07	
Payment Type	X(01)	08	08	A=Amount, P=Percentage
Amount	N(7.4)	09	19	Amount or percentage allowed of MAC
Begin DOS	X(08)	20	27	
End DOS	X(08)	28	35	
Claim Receipt	X(08)	36	43	
Place of Service	X(02)	44	45	
Filler	X(73)	46	118	
Record Type	X(02)	119	120	M2

NDC with Family Planning = 'Y' (M3)

One Per NDC

Data Name	Picture	Actual Positions		Remarks
		From	To	
National Drug Code	X(11)	01	11	
Family Planning	X(01)	12	12	"Y"
Filler	X(106)	13	118	
Record Type	X(02)	119	120	M3

ICD9 with Family Planning = 'Y' (M4)

One Per ICD9

Data Name	Picture	Actual Positions		Remarks
		From	To	
ICD9 Code	X(07)	01	07	
ICD9 Code Type	X(01)	08	08	D" ICD9 Diagnosis Code "P" ICD9 Procedure Code
Family Planning	X(01)	09	09	"Y"
Filler	X(109)	10	118	
Record Type	X(02)	119	120	M4

Pharmacy Procedure Codes (M5)

One Per Procedure

NOT CURRENTLY USED

Data Name	Picture	Actual Positions		Remarks
		From	To	
CPT\HCPCS Code	X(05)	01	05	
Description	X(40)	06	45	
Begin Date	X(08)	46	53	
End Date	X(08)	54	61	
Filler	X(57)	62	118	
Record Type	X(02)	119	120	M5

CHAPTER 5 – PROVIDER AND REFERENCE FILES

ICD10 with Family Planning = 'Y' (M6)

One Per ICD-10

Data Name	Picture	Actual Positions		Remarks
		From	To	
ICD-10 Code	X(07)	01	07	
ICD-10 Code Type	X(01)	08	08	"I" ICD-10 Diagnosis Code "J" ICD-10 Procedure Code
Family Planning	X(01)	09	09	"Y"
Filler	X(109)	10	118	
Record Type	X(02)	119	120	M6

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Total Records	N(10)	21	30	
Total Procedures	N(06)	31	36	
Filler	X(82)	37	118	
Record Type	X(02)	119	120	"T9"

**Exhibit 5E
Reference File 03 Record Layout
Refer03.zip
*ftp\share\info\reference\prod\out\refer03.zip***

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X (12)	01	12	
Date Created	X (08)	13	20	CCYYMMDD
Filler	X (58)	21	78	
Record Type	X (02)	79	80	"T0"

OPFS Indicators (N1) (RF127)

One Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X (05)	01	05	
Effective Begin Date	X (08)	06	13	CCYYMMDD
Effective End Date	X (08)	14	21	CCYYMMDD
Medicare Coverage Indicator	X (01)	22	22	Y=Yes, N=No
Third Party Liability Indicator	X (01)	23	23	Y=Yes, N=No
Confidential Services Indicator	X (01)	24	24	Y=Yes, N=No
Family Planning Indicator	X (01)	25	25	Y=Yes, N=No
Sterilization Indicator	X (01)	26	26	Y=Yes, N=No
Abortion Indicator	X (01)	27	27	Y=Yes, N=No
EPSDT Indicator	X (01)	28	28	Y=Yes, N=No
Procedure Daily Maximum	X (06)	29	34	
Gender	X (01)	35	35	M=Male, F=Female or blank
Minimum Age Group				
Minimum Age Duration	X (03)	36	38	'000' – '999'
Minimum Age Type	X (01)	39	39	Y=Years, M=Months, D=Days
Maximum Age Group				
Maximum Age Duration	X (03)	40	42	'000' – '999'
Maximum Age Type	X (01)	43	43	Y=Years, M=Months, D=Days
1 st Limit	X (03)	44	46	'000' – '999' or blank
1 st Frequency Group				
1 st Frequency Value	X (03)	47	49	'000' – '999' or blank
1 st Frequency Code	X (01)	50	50	C=Contract Year, D=Day, L-Lifetime M=Month, W=Week, Y=Year or blank
2 nd Limit	X (03)	51	53	'000' – '999' or blank
2 nd Frequency Group				
2 nd Frequency Value	X (03)	54	56	'000' – '999' or blank
2 nd Frequency Code	X (01)	57	57	C=Contract Year, D=Day, L-Lifetime M=Month, W=Week, Y=Year or blank
Filler	X (21)	58	78	
Record Type	X (02)	79	80	N1

OPFS Price (N2) (RF126)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
County	X (02)	06	07	
Effective Begin Date	X (08)	08	15	CCYYMMDD
Effective End Date	X (08)	16	23	CCYYMMDD
OPFS Price	N(9)V99	24	34	
Receipt Date	X (08)	35	42	CCYYMMDD
Filler	X (36)	43	78	
Record Type	X (02)	79	80	N2

OPFS Bundled Driver (N3) (RF797)

One Per Procedure Code Range

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code From	X (05)	01	05	
Procedure Code To	X (05)	06	10	
Effective Begin Date	X (08)	11	18	CCYYMMDD
Effective End Date	X (08)	19	26	CCYYMMDD
Filler	X (52)	27	78	
Record Type	X (02)	79	80	N3

OPFS Bundled Revenue Codes (N4) (RF796)

One Per Revenue Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
Revenue Code	X (04)	01	04	
Revenue Description	X (40)	05	44	
Effective Begin Date	X (08)	45	52	CCYYMMDD
Effective End Date	X (08)	53	60	CCYYMMDD
Filler	X (19)	61	78	
Record Type	X (02)	79	80	N4

CCI Codes (N5) (RF128)

One to Many Per Procedure Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Primary	X (05)	01	05	
Procedure Component	X (05)	06	10	
Procedure Modifier Indicator	X (01)	11	11	
Source Code	X (03)	12	14	MDC (Medicaid) MCR (Medicare) or AHC (AHCCCS specific)
Edit Type	X (03)	15	17	VEN (Ventilator Management) DIS (Discharge Management) PRA (Practitioner/ASC NCCI Edits) OPH (Outpatient Hospital NCCI Edits)
Effective Begin Date	X (08)	18	25	CCYYMMDD
Effective End Date	X (08)	26	33	CCYYMMDD
Filler	X (44)	34	78	
Record Type	X (02)	79	80	N5

CHAPTER 5 – PROVIDER AND REFERENCE FILES

Multiple Surgery Exemption Table (N6) (RF789)

One Per Procedure Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X (05)	01	05	
Source Indicator	X (01)	06	06	'A' =AHCCCS; 'M'=Medicare
Effective Begin Date	X (08)	07	14	CCYYMMDD
Effective End Date	X (08)	15	22	CCYYMMDD
Filler	X (56)	23	78	
Record Type	X (02)	79	80	N6

Limit Override Modifiers (N7) (RF723)

One Per Modifier

Data Name	Picture	Actual Positions		Remarks
		From	To	
Modifier	X (02)	01	02	
Action Code	X (02)	03	04	
Effective Begin Date	X (08)	05	12	CCYYMMDD
Effective End Date	X (08)	13	20	CCYYMMDD
Filler	X (58)	21	78	
Record Type	X (02)	79	80	N7

Override Modifier Action Codes (N8) (RF725)

One Per Action Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
Action Code	X (02)	01	02	
Effective Begin Date	X (08)	03	10	CCYYMMDD
Effective End Date	X (08)	11	18	CCYYMMDD
Code Description	X (40)	19	58	
Filler	X (20)	59	78	
Record Type	X (02)	79	80	N8

Valid OPFS Procedure Modifiers (N9) (RF121)

One to Many Per Procedure Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X (05)	01	05	
Procedure Modifier	X (02)	06	07	
Payment Type	X (01)	08	08	'P'=Percent 'A'=Amount
Amount	N(7.4)	09	19	
Effective Begin Date	X (08)	20	27	CCYYMMDD
Effective End Date	X (08)	28	35	CCYYMMDD
Claim Receipt Date	X (08)	36	43	CCYYMMDD
Filler	X (35)	44	78	
Record Type	X (02)	79	80	N9

Limit Override Procedures (P1) (RF739)

One Per Procedure Range

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure From	X (05)	01	05	
Procedure To	X (05)	06	10	
Action Code	X (02)	11	12	
Effective Begin Date	X (08)	13	20	CCYYMMDD
Effective End Date	X (08)	21	28	CCYYMMDD
Filler	X (58)	29	78	
Record Type	X (02)	79	80	P1

CHAPTER 5 – PROVIDER AND REFERENCE FILES

MUE Units of Service (P2) (RF129)

One Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X (05)	01	05	
Maximum Units	X (06)	06	11	
Publication Indicator	X (01)	12	12	0 = Not published -confidential - do not share - for CMS and CMS contractors only (currently no MUEs have an indicator = 0) 1 = Published - OK to share 9 = Not Applicable
Source Code	X (03)	13	15	MDC (Medicaid) MCR (Medicare) or AHC (AHCCCS specific)
MUE Type	X (03)	16	18	PRA (Practitioner) OPH (Outpatient Hospital) DME (Durable Medical Equipment)
Effective Begin Date	X (08)	19	26	CCYYMMDD
Effective End Date	X (08)	27	34	CCYYMMDD
Filler	X (44)	35	78	
Record Type	X (02)	79	80	P2

NCCI Associated Modifiers (P3) (RF131)

One Per Modifier

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Modifier	X (02)	01	02	
Effective Begin Date	X (08)	03	10	CCYYMMDD
Effective End Date	X (08)	11	18	CCYYMMDD
Filler	X (60)	19	78	
Record Type	X (02)	79	80	P3

Procedure OPFS Clinic Price RCF (P4) (RF133)

One To Many Per Procedure Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
CPT/HCPCS Code	X(05)	01	05	
County Code	X(02)	06	07	
Claim Receipt Date	X(08)	08	15	CCYYMMDD
OPFS Amount	9(9)V2	16	26	
Begin Date	X(08)	27	34	CCYYMMDD
End Date	X(08)	35	42	CCYYMMDD
Filler	X(36)	43	78	
Record Type	X(02)	79	80	P4

**Secondary OPFS Bundled Rate Driver Codes OBS (P5) (RFC97)
Range**

One To Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
CPT/HCPCS Code From	X(05)	01	05	
CPT/HCPCS Code To	X(05)	06	10	
Begin Date	X(08)	11	18	CCYYMMDD
End Date	X(08)	19	26	CCYYMMDD
Filler	X(52)	27	78	
Record Type	X(02)	79	80	P5

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X (12)	01	12	
Date Created	X (08)	13	20	CCYYMMDD
Total Records	N(10)	21	30	
Filler	X (48)	31	78	
Record Type	X (02)	79	80	T9

**Exhibit 5F
Reference File 04 Record Layout
Refer04.zip
ftp\share\info\reference\prod\out\refer04.zip**

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Creation Date	X(08)	13	20	CCYYMMDD
Filler	X(58)	21	78	
Record Type	X(02)	79	80	T0

Medicaid Covered Part B Therapeutic Classes (TA) (RF350)

One Class

Data Name	Picture	Actual Positions		Remarks
		From	To	
Therapeutic Class Code	X(06)	01	06	
Therapeutic Class Description	X(40)	07	46	
Begin Date	X(08)	47	54	CCYYMMDD
End Date	X(08)	55	62	CCYYMMDD
Filler	X(16)	63	78	
Record Type	X(02)	79	80	TA

Link Multiple Service Types (T2) (RF771)

One to Many

Data Name	Picture	Actual Positions		Remarks
		From	To	
Code Type	X(02)	01	02	
Service Type From	X(01)	03	03	H=HCPCS, R=Revenue, D=Diagnosis
Service From Start	X(11)	04	14	
Service From End	X(11)	15	25	
Service Type To	X(1)	26	26	H=HCPCS, R=Revenue, D=Diagnosis
Service To Start	X(11)	27	37	
Service To End	X(11)	38	48	
Begin Date	X(08)	49	58	CCYYMMDD
End Date	X(08)	57	64	CCYYMMDD
Filler	X(12)	65	78	
Record Type	X(02)	79	80	T2

VFC Procedure Codes (T3) (RF729)

One to Many

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(02)	01	05	
Indicator	X(01)	06	06	A = Administration Code, T = Toxoid Code
Maximum Administration Fee	N(7.4)	07	17	
Begin Date	X(08)	18	25	CCYYMMDD
End Date	X(08)	26	33	CCYYMMDD
Filler	X(45)	34	78	
Record Type	X(02)	79	80	T3

CHAPTER 5 – PROVIDER AND REFERENCE FILES

Medicare Primary Payer Error Bypass (T4) (RF799)

One Error

Data Name	Picture	Actual Positions		Remarks
		From	To	
Error Message Code	X(04)	01	04	
Error Message Text	X(40)	05	44	
Begin Date	X(08)	45	52	CCYYMMDD
End Date	X(08)	53	60	CCYYMMDD
Filler	X(18)	61	78	
Record Type	X(02)	79	80	T4

Medicaid Covered Therapeutic Classes (T5) (RF347)

One Class

Data Name	Picture	Actual Positions		Remarks
		From	To	
Therapeutic Class Code	X(06)	01	06	
Therapeutic Class Description	X(40)	07	46	
Begin Date	X(08)	47	54	CCYYMMDD
End Date	X(08)	55	62	CCYYMMDD
Filler	X(16)	63	78	
Record Type	X(02)	79	80	T5

ASC Rate Schedule (T6) (RFC23)

One Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Status Code	X(01)	01	01	A = Active
Procedure Code	X(05)	02	06	
County Code	X(02)	07	08	
ASC Fee Schedule	N(9)V99	09	19	
Begin Date	X(08)	20	27	CCYYMMDD
End Date	X(08)	28	35	CCYYMMDD
ASC Group ID	X(05)	36	40	
Filler	X(38)	41	78	
Record Type	X(02)	79	80	T6

Dental Procedure (T7) (RF103)

One to Many

Data Name	Picture	Actual Positions		Remarks
		From	To	
Dental Procedure Code	X(05)	01	05	
Tooth Number Required	X(01)	06	06	
Tooth Quadrant Required	X(01)	07	07	
Tooth Surface Required	X(01)	08	08	
Max Teeth per Quadrant	X(01)	09	09	
Max Surface per Tooth	X(01)	10	10	
Begin Date	X(08)	11	18	CCYYMMDD
End Date	X(08)	19	26	CCYYMMDD
Filler	X(52)	27	78	
Record Type	X(02)	79	80	T7

CHAPTER 5 – PROVIDER AND REFERENCE FILES

Procedure Place of Service (T8) (RF115)

One to Many

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Place of Service	X(02)	06	07	
Begin Date	X(08)	08	15	CCYYMMDD
End Date	X(08)	16	23	CCYYMMDD
Place of Service Description	X(40)	24	63	
Filler	X(15)	64	78	
Record Type	X(02)	79	80	T8

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Creation Date	X(08)	13	20	CCYYMMDD
Total Records	X(10)	21	30	
Total Groups	X(10)	31	40	
Filler	X(38)	41	78	
Record Type	X(02)	79	80	T9

**Exhibit 5G
Reference File 05 Record Layout
Refer05.zip
ftp\share\info\reference\prod\out\refer05.zip
80 Column Format**

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(58)	21	78	
Record Type	X(02)	79	80	T0

LTC MCO Max Allowed Charge (M1) (RF142)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
County	X(02)	06	07	
Begin Date	X(08)	08	15	CCYYMMDD
End Date	X(08)	16	23	CCYYMMDD
MAC	9(9)V99	24	34	
CRN Date	X(08)	35	42	CCYYMMDD
Place of Service	X(02)	43	44	
Filler	X(34)	45	78	
Record Type	X(02)	79	80	M1

LTC MCO Modifier (M2) (RF132)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Procedure Modifier	X(02)	06	07	
Payment Type	X(01)	08	08	A=Amount, P=Percentage
Amount	N(7.4)	09	19	Amount or percentage allowed
Begin Date	X(08)	20	27	CCYYMMDD
End Date	X(08)	28	35	CCYYMMDD
Claim Receipt	X(08)	36	43	CCYYMMDD
Place of Service	X(02)	44	45	
Filler	X(33)	46	78	
Record Type	X(02)	79	80	M2

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Total Records	9(10)	21	30	
Filler	X(45)	31	78	
Record Type	X(02)	79	80	T9

**Exhibit 5H
Reference File 06 Record Layout
Refer06.zip
ftp\shareinfo\reference\prod\out\refer06.zip**

80 Column Format

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(58)	21	78	
Record Type	X(02)	79	80	T0

Acute MCO Max Allowed Charge (M1) (RF142)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
County	X(02)	06	07	
Begin Date	X(08)	08	15	CCYYMMDD
End Date	X(08)	16	23	CCYYMMDD
MAC	9(9)V99	24	34	
CRN Date	X(08)	35	42	CCYYMMDD
Place of Service	X(02)	43	44	
Filler	X(34)	45	78	
Record Type	X(02)	79	80	M1

Acute MCO Modifier (M2) (RF132)

One to Many Per Procedure

Data Name	Picture	Actual Positions		Remarks
		From	To	
Procedure Code	X(05)	01	05	
Procedure Modifier	X(02)	06	07	
Payment Type	X(01)	08	08	A=Amount, P=Percentage
Amount	N(7.4)	09	19	Amount or percentage allowed
Begin Date	X(08)	20	27	CCYYMMDD
End Date	X(08)	28	35	CCYYMMDD
Claim Receipt	X(08)	36	43	CCYYMMDD
Place of Service	X(02)	44	45	
Filler	X(33)	46	78	
Record Type	X(02)	79	80	M2

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Total Records	9(10)	21	30	
Filler	X(45)	31	78	
Record Type	X(02)	79	80	T9

**Exhibit 51
Reference File 07 Record Layout
Refer07.zip
*ftp\share\info\reference\prod\out\refer07.zip***

120 Column Format

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(58)	21	118	
Record Type	X(02)	119	120	T0

Co-Pay to Service (M1) (RF7A7)

Data Name	Picture	Actual Positions		Remarks
		From	To	
Co-Pay Level	X(02)	01	02	
Form Type	X(01)	03	03	
Service Type	X(01)	04	04	
Service Code From	X(11)	05	15	
Service Code To	X(11)	16	26	
Begin Date	X(08)	27	34	CCYYMMDD
End Date	X(08)	35	42	CCYYMMDD
Related Service Type (1)	X(01)	43	43	
Related Service Code From (1)	X(11)	44	54	
Related Service Code To (1)	X(11)	55	65	
Related Service Type (2)	X(01)	66	66	
Related Service Code From (2)	X(11)	67	77	
Related Service Code To (2)	X(11)	78	88	
Place of Service	X(02)	89	90	
Provider Type	X(02)	91	92	
Admit Type	X(01)	93	93	
Member Age From	X(03)	94	96	
Member Age To	X(03)	97	99	
Co-Pay Amount From	N(5)V99	100	104	
Filler	X(14)	105	118	
Record Type	X(02)	119	120	M1

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Total Records	N(10)	21	30	
Filler	X(88)	31	118	
Record Type	X(02)	119	120	T9

**Exhibit 5J
Reference File 08 Record Layout
Refer08.zip
*ftp\share\info\reference\prod\out\refer08.zip***

Header (T0)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(208)	21	228	
Record Type	X(02)	229	230	"T0"

RF-ICD10-Procedures (L1) (RF161)

One per ICD-10 Procedure Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
ICD-10 Procedure Code	X(07)	01	07	
- Procedure Category				Pos 1-3 of Procedure Code
- Procedure Detail				Pos 4-7 of Procedure Code
End Date	X(08)	08	15	CCYYMMDD
Begin Date	X(08)	16	23	CCYYMMDD
Classification Code	X(03)	24	26	
Description	X(50)	27	76	
Technical Description	X(50)	77	126	
Procedure Coding Method	X(01)	127	127	
Procedure Code Status	X(01)	128	128	
Family Planning Indicator	X(01)	129	129	
Maximum Age Duration	X(03)	130	132	
Maximum Age Type	X(01)	133	133	Y=Years, M=Months, D=Days
Minimum Age Duration	X(03)	134	136	
Minimum Age Type	X(01)	137	137	Y=Years, M=Months, D=Days
Sex	X(01)	138	138	
Third Party Liability Indicator	X(01)	139	139	
Confidential Services Indicator	X(01)	140	140	
Sterilization Indicator	X(01)	141	141	
Abortion Indicator	X(01)	142	142	
Header/Detail Indicator	X(01)	143	143	
Filler	X(85)	144	228	
Record Type	X(02)	229	230	"L1"

RF-ICD10-CVG (L2) (RF163)

One per ICD-10 Procedure Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
ICD-10 Procedure Code	X(07)	01	07	
- Procedure Category				Pos 1-3 of Procedure Code
- Procedure Detail				Pos 4-7 of Procedure Code
AHCCCS Coverage Code	X(02)	08	09	
Begin Date	X(08)	10	17	CCYYMMDD
End Date	X(08)	18	25	CCYYMMDD
Filler	X(203)	26	228	
Record Type	X(02)	229	230	"L2"

RF-ICD10-DIAG (L3) (RF223)

One per ICD-10 Diagnosis Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
ICD-10 Diagnosis Code	X(07)	01	07	
- Category				Pos 1-3 of Diagnosis Code
- Etiology				Pos 4-6 of Diagnosis Code
- Extension				Pos 7 of Diagnosis Code
End Date	X(08)	08	15	CCYYMMDD
Begin Date	X(08)	16	23	CCYYMMDD
Classification Code	X(03)	24	26	
Technical Description	X(80)	27	106	
Diagnosis Coding Method	X(01)	107	107	
Diagnosis Code Status	X(01)	108	108	
Family Planning Indicator	X(01)	109	109	
Maximum Age Duration	X(03)	110	112	
Maximum Age Type	X(01)	113	113	Y=Years, M=Months, D=Days
Minimum Age Duration	X(03)	114	116	
Minimum Age Type	X(01)	117	117	Y=Years, M=Months, D=Days
Sex	X(01)	118	118	
Third Party Liability Indicator	X(01)	119	119	
Description	X(80)	120	199	
Confidential Services Indicator	X(01)	200	200	
Sterilization Indicator	X(01)	201	201	
Abortion Indicator	X(01)	202	202	
Header/Detail Indicator	X(01)	203	203	
Filler	X(25)	204	228	
Record Type	X(02)	229	230	"L3"

RF-I10-DIAG-CVG (L4) (RF221)

One per ICD-10 Diagnosis Code

Data Name	Picture	Actual Positions		Remarks
		From	To	
ICD-10 Diagnosis Code	X(07)	01	07	
- Category				Pos 1-3 of Diagnosis Code
- Etiology				Pos 4-6 of Diagnosis Code
- Extension				Pos 7 of Diagnosis Code
AHCCCS Coverage Code	X(02)	08	09	
Begin Date	X(08)	10	17	CCYYMMDD
End Date	X(08)	18	25	CCYYMMDD
Filler	X(203)	26	228	
Record Type	X(02)	229	230	"L4"

Trailer (T9)

One Per File

Data Name	Picture	Actual Positions		Remarks
		From	To	
Filler	X(12)	01	12	
Date Created	X(08)	13	20	CCYYMMDD
Filler	X(208)	21	228	
Record Type	X(02)	229	230	"T9"

CHAPTER 6 – “HOW TO...”

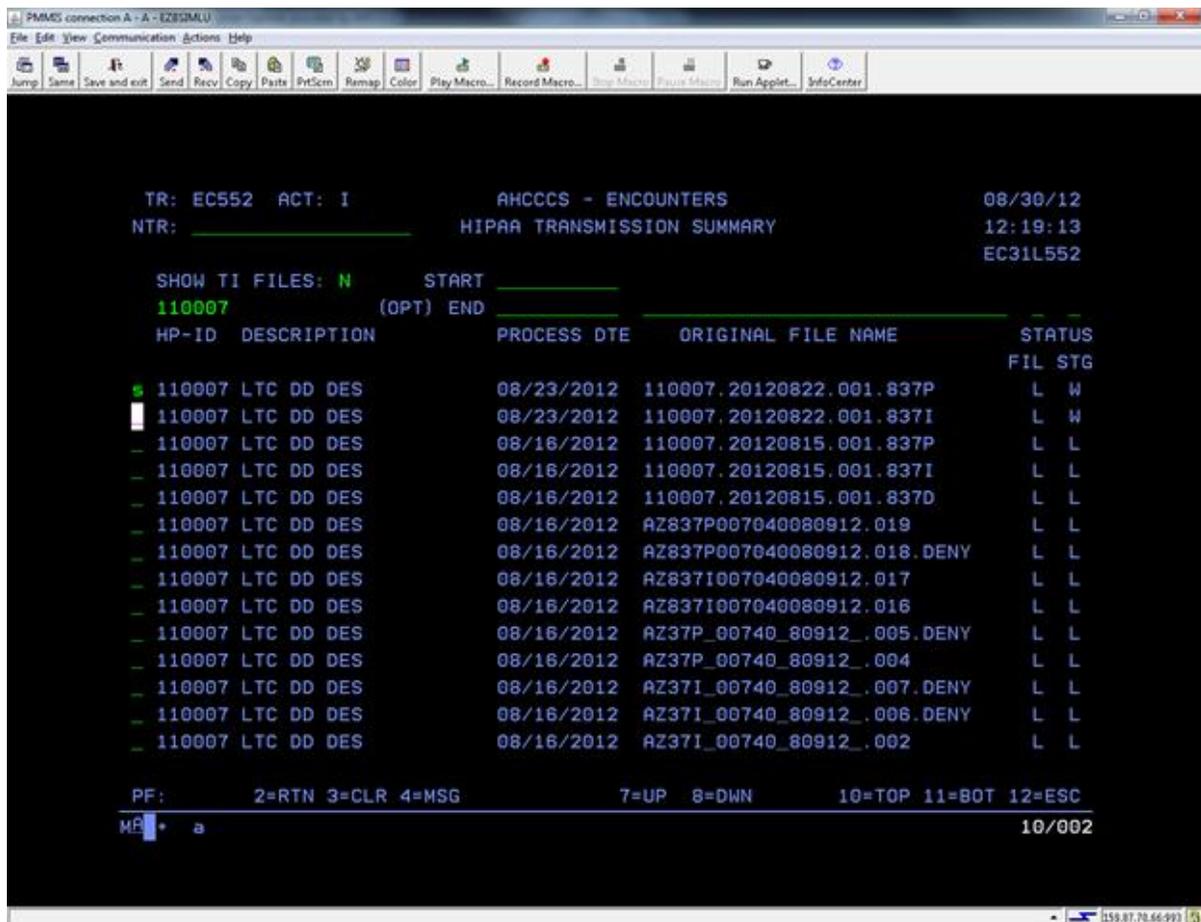
I. INTRODUCTION

The purpose of this chapter is to provide additional clarification of those common questions presented to AHCCCS from the Contractors regarding encounter processing. This section will cover a variety of topics is updated quarterly as issues/questions are presented 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 unless otherwise specified (where allowable) in written contract between the Contractor and the provider. Therefore, the billing requirements and coding standards and instructions reflected in that manual are the general guidelines for editing of encounters.

II. CHECK STATUS OF ENCOUNTER FILE SUBMISSION

Mainframe availability for the inquiry of encounter files status is listed on this HIPAA TRANSMISSION SUMMARY screen EC552.

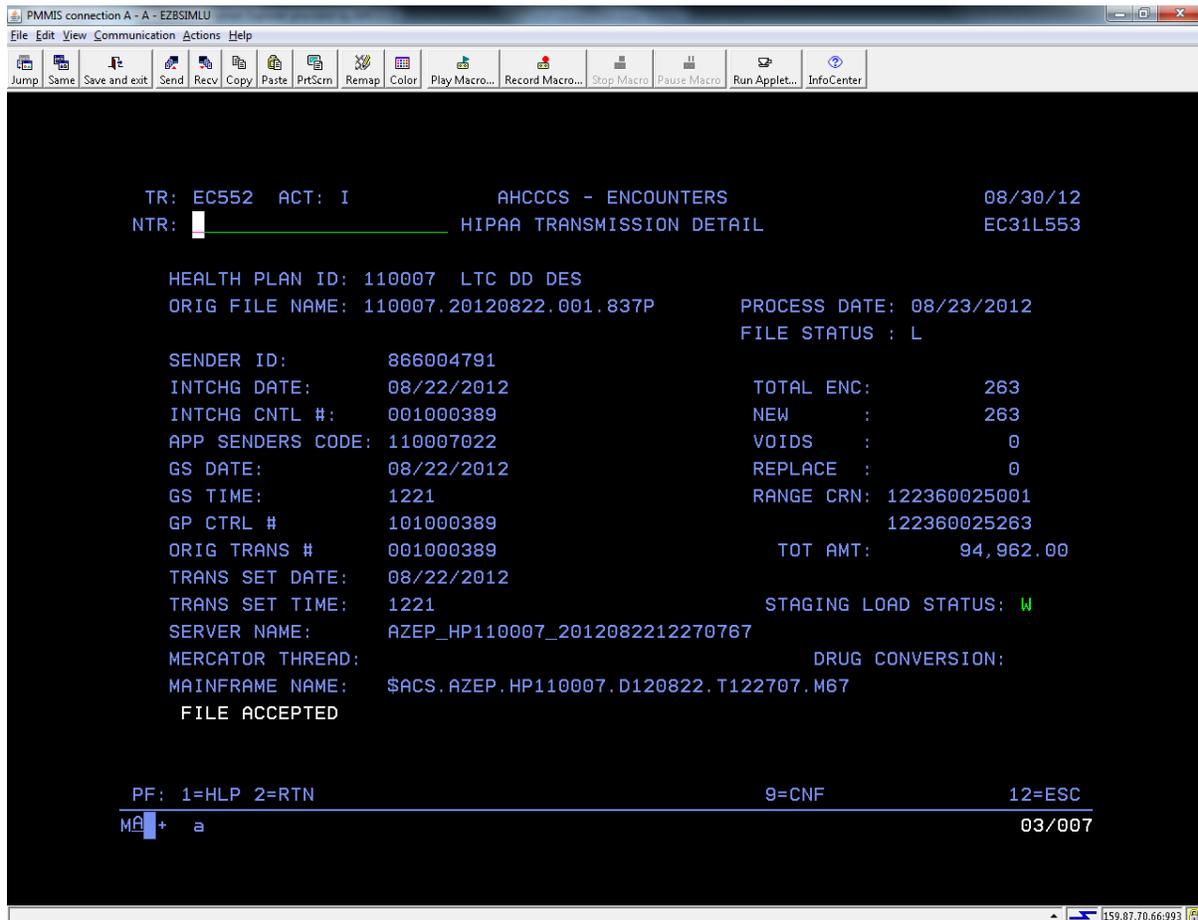


STG = Staging Load Status – “STG” on EC552 Summary screen is the same as “Load Status” on EC552 Detail screen.

(Staging) Load Status: W = Waiting, H = Hold, L = Loaded, E = Exclude.

Fil – File Processing Status: U = Unprocessed, L = Loaded, F = Failed

To get to the next screen to view the file, you must put an “s” to select the file then hit “enter”. You will then see the HIPAA Transmission Detail screen below.



STG = Staging Load Status – “STG” on EC552 Summary screen is the same as “Load Status” on EC552 Detail screen.

(Staging) Load Status: W = Waiting, H = Hold, L = Loaded, E = Exclude.

Fil – File Processing Status: U = Unprocessed, L = Loaded, F = Failed

III. ALLOWED AND NET ALLOWED (APPROVED) AMOUNT MATRIX FOR (NON-BHS PLANS)

With v5010, the 2320 COB approved and 2320 COB allowed amount segments were removed from the 837 transactions. 5010 includes guidance on how to calculate the approved amount. The process with which to select the appropriate values for AHCCCS to calculate the Health plan approved amount has been challenging. Detailed direction is available on the website at the following link:

http://www.azahcccs.gov/commercial/Downloads/EDIchanges/Non-BHSPlans_ApprovedAmountMatrixv20120928.pdf

IV. REPORTING INPATIENT COVERED DAYS

General reminders related to the reporting of Covered Days

- This data element is critical to the tracking of 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 *actual number of days they covered* for that encounter. If the length of stay is 20 days, but the Contractor only reimburses 15, for whatever reason, the covered days reported should be 15.
- Covered days *cannot exceed the actual length of stay* on the encounter. If the length of stay is 4 days, the contractor cannot report covered days greater than 4.
- 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, the Contractor 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, page 94-95 (FL 39-41) to report the following value codes:

- ‘80’ Covered Days
- ‘82’ Co-insurance Days
- ‘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

```

....

V. REPORTING OF NON-COVERED CHARGES/PARTIAL DENIALS

Reporting Non-Covered Charges

- It is important that Contractors 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 itself 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 Three (3).

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-VI.

VI. IMPLANT CARVE OUT ENCOUNTERS CONSIDERATION FOR REINSURANCE

Implant carve-out Implants (VAD) are to be carved out of UB charges and reported as non-covered charges on the encounter. The implant itself is supposed to be submitted/encountered on a 1500 claim form.

For acute care cases where 1500's are not auto-associated to Reinsurance (RI), submit a Reinsurance Action Request form (RAR) to the RI Unit and they will manually associate/recognize it through the RAR.

In the event that a Contractor's provider contract designates carve out and separate payment of Implants, Biological items, etc. the Contractor must reflect this processing on Encounters as follows:

- **Inpatient Claim**
Do not alter the billed charges or claim detail. Billed charges and detail should include the implantable or biological as well as the associated charges and the associated charges should be non-covered with an appropriate reason code. Health Plan Allowed and Paid should reflect that the associated charges were non-covered and separately reimbursed.

- **1500 Claim**

This form must be used to report the carve out item under an appropriate HCPCS code and include the applicable Billed Charges and Health Plan Allowed/Paid. To be considered for Reinsurance the charges must be substantiated by contract/invoice/etc. and the Plan must request Reinsurance consideration.

VII. 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. Contractor’s 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 1/1/2014 outpatient physical therapy for adults (age 21 years and older) is limited to the following:

- A. 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
- B. 15 visits per contract year to 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 time of service.

Duplicate or Near Duplicate Service Encounters from Different Contractors

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

There are circumstances where the principle diagnosis on the claim determines which plan should be eligible for the service payment, i.e. where contracted Health Plans and a CRS or BHS Contractor must coordinate payment of services as determined by benefit responsibility. For example: a health plan is responsible for CRS covered services for CRS-eligible members unless and until the Contractor has received confirmation from AHCCCS that the member has transitioned to the CRS Contractor. Coordination between the plan and the special needs Contractor may involve reversal of payment and voiding of the encounter as appropriate.

VIII. ENCOUNTER/REFERENCE TABLE UPDATE COMMUNICATION

AHCCCS endeavors to keep all reference/code tables in PMMIS up to date with issuing agency regular 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 the website go to (<http://listserv.azahcccs.gov>) and follow 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 give you first notice of items and issues, including Encounter Manual changes, which may require Contractor system and encounter reporting remediation. If you want to be added to e-mail distribution related to encounters contact your health plan’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 Contractor’s received by e-mail since last newsletter issue. Current and historical issues are available on the Web at: <https://www.azahcccs.gov/PlansProviders/HealthPlans/encounterkeysnewsletter.html>

Provided as current encounter requirements, Contractors are held responsible to incorporate 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 and EDI technical interface changes and other clarification that needs to be shared with Contractor IT staff.

AHCCCS Fee-for-Service Provider Manual

As stated in section I of this Chapter, AHCCCS contract requires that Contractors follow claims processing guidelines, applicable to managed care, that are maintained within the AHCCCS FFS provider manual, unless otherwise specified (where allowable) in provider subcontract. Therefore, the billing requirements and coding standards and instructions reflected in that manual are the general guidelines for editing of encounters. This manual is located on the web 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 adjunct to the AHCCCS FFS Provider manual. As such it is also very useful 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
- 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.

AHCCCS staff issue monthly update Memos to Contract Compliance Officers for internal distribution. (Note: ACOM update memos are also available by Listserv). These memos are intended to alert Contractors to a summary of changes. It is, however, incumbent on every Contractor to fully review all policy changes and assess impact on claims processing and encounter reporting.

<https://www.azahcccs.gov/shared/ACOM/>

AHCCCS Medical Policy Manual (AMPM)

This Manual contains information regarding services that are covered within the AHCCCS program. The AMPM is applicable to both Managed Care and Fee-for-Service members. Relevant to encounter reporting, this manual defines covered services and their limitations, including special maternal and child health programs and services. 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 on-line <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. A revision history is available at bottom of manual webpage.

IX. 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 5

Outside Maricopa County: 1-800-794-6862

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, the Contractor has determined that it is industry standard to provide that service in that POS and a RTRU is submitted and approved, the table maintenance will allow all of the related pends to clear 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 of the pended encounters.

Contractors are encouraged to thoroughly research their issues before submitting a 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: AHCCSEncounters@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 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 make the final determination on the appropriate start 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 medical determination. Whether approved or not Contractors will receive feedback on submitted requests.

Because of the multiple unit review process, turn around time on these RTRU requests may take up to 30 days.

X. CONTRACTOR ON-LINE VOIDS AND REINSURANCE PAYMENT CYCLE

The timing of Contractor entered PMMIS pend corrections/voids can adversely effect 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, starting at 5pm until the following Wednesday morning. **Online voids cannot be performed during this time.**

Contractor compliance with this policy will insure accurate disbursement of RI funds and prevent misallocation to closed RI years and RI payment recoupments.

XI. 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 of 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 of 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

AHCCCS DIVISION OF HEALTHCARE MANAGEMENT (DHCM) ENCOUNTER MANUAL

CHAPTER 6 – “HOW TO...”

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		<p>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</p> <p>FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported</p> <p>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</p>
2320	CAS04	Adjustment Quantity		Expect Adjustment Qty
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

XII. INPATIENT HOSPITAL DRG ENCOUNTER EDITING

On October 1, 2014 AHCCCS implemented Inpatient Hospital APR-DRG payment methodology. The technical and policy aspects of this payment methodology were developed in collaboration with existing AHCCCS Contractors, Arizona Hospitals and other stakeholders statewide. Detailed specifications and policy requirements can be accessed on the AHCCCS website

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html>

Additional information regarding claims and coding has been included in AHCCCS FFS Provider Billing Manual

https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap11.pdf

New encounter editing related to APR-DRG pricing was implemented and included in encounter keys issue Sept/OCT 2014 as follows:

A956 DRG - DOES NOT MEET CRITERIA FOR ANY DRG

This edit information was also posted in the October 2014 updated web version of the Encounter edit status report:

<https://www.azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/EncounterEditStatusList.pdf>

XIII. 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 cancelled. **(Voided)**
- 4 Adjusted - Code indicating that the previous transaction was changed. **(Replaced)**

XIV. SAME DAY ADMIT DISCHARGE ENCOUNTER REPORTING

Effective October 1, 2014 AHCCCS implemented APR-DRG inpatient claims payment methodology. Inpatient claims with an admission date equal to the date of the discharge 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 a same date of admission and date of death will be reimbursed a full DRG payment.

The DRG edit A956 DRG - DOES NOT MEET CRITERIA FOR ANY DRG will apply if encounter financial fields do not match AHCCCS DRG calculation.

For detailed information on DRG billing requirements see AHCCCS Fee for Service provider manual addendum Chapter 11 on the web:

https://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 prior to 10-01-2014. Billing information for that methodology is available in FFS Provider M chapter 11.

AHCCCS WEBSITE RESOURCE LINKS FOR ENCOUNTER RELATED INFORMATION

Throughout this manual you will find links to on-line resource information necessary or helpful to the understanding of requirements and processes related to AHCCCS encounter reporting and error resolution. Most of this information is available on the AHCCCS website in various site locations.

<http://www.azahcccs.gov/>

This listing is meant to provide a single page quick reference link for manual users:

GENERAL SITE INFORMATION:

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

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitation.html>

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/>

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html>

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html>

<https://www.azahcccs.gov/shared/MedicalPolicyManual/>

<https://www.azahcccs.gov/PlansProviders/HealthPlans/purchasing.html>

HIPAA TECHNICAL RESOURCES:

AHCCCS Technical specification Companion guides:

<https://www.azahcccs.gov/Resources/EDI/EDITEchnicalDocuments.html>

5010 Consortiums and Documentation:

<https://www.azahcccs.gov/Resources/EDI/consortium.html>

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

Technical interface guidelines:

<https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/>

ENCOUNTER SPECIFIC:

Accessing PMMIS encounter system:

<https://www.azahcccs.gov/PlansProviders/ISDresources.html>

<https://www.azahcccs.gov/PlansProviders/HealthPlans/encounters.html>

<https://azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/DeskLevelInstructionsForAccessingPMMIS.pdf>

Data validation guide:

<https://azahcccs.gov/PlansProviders/Downloads/Encounters/EncounterValidationTechnicalDocument.pdf>

http://en.wikipedia.org/wiki/National_Correct_Coding_Initiative

CN1 TO SUBCAP CODE CROSSWALK

CN1	DEFINITIONRCP EXP	SUB CAP	DESCRIPTION
Blank		00	No subcapitated payment arrangement. Used to report services paid on a fee-for-service basis. When subscriber exception code is 25, subcap code is 05.
01	Diagnosis Related Group (DRG)	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
02	Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
03	Variable Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
04	Flat	00	Full Subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
05	Capitated	01	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
06	Percent	00	Partial subcapitation arrangement. Used to report services provided by a subcapitated provider that are excluded from the subcapitated payment arrangement. When subscriber exception code is 25, subcap code is 05
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, when subscriber exception code is not 25.
09	Other	04	Contracted transplant service (covered under AHCCCS catastrophic reinsurance) Used to report covered transplant services paid via catastrophic reinsurance, when subscriber exception code is 25.
	Identified by Filename	06	Denied claim used to report valid AHCCCS services that are denied. For example, if a claim was denied for untimely submission.

COUNTY CODES

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

County Codes				
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			

CATEGORY OF SERVICE (COS)

AHCCCS has developed a two-digit coding definition called a Category Of Service (COS). The COS is determined based on an encounter’s procedure code, bill type, revenue code, or pharmacy National Drug Code (NDC). Contractors do not provide the COS, and it cannot be changed on the pending encounter correction file. The COS is determined by AHCCCS.

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 table.

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. A provider’s provider type is assigned by the AHCCCS Provider Registration Unit 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.

CHAPTER 7 – SUPPLEMENTAL INFORMATION

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
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

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 for AHCCCS FFS claims, but may be reported for encounters
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
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

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. The Julian date of receipt of a New Day Encounter File is incorporated into the Control Reference Number (CRN) that is 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