ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ENCOUNTER MANUAL

(Revised Date: 10/31/2024)

Effective Date: 10/1/2022

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Encounter Manual

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

Definitions

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

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

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

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

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

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