Implementation Guide
for the
LTCare Encounter Reporting
Data Collection & Validation Utility

October 12, 2007

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Introduction

The Encounter Reporting Data Collection and Validation Utility

The encounter reporting application provides a consistent data collection and validation utility to gather data for:

- Updating and evaluating service costs for business or operation management
- Calculating capitation payment rates
- Providing a source of data for federal reporting
- Monitoring program integrity (i.e., service utilization, access to care)
- Quality of care monitoring
- Contract monitoring
- Research

In summary, this data collection and verification utility:

- Accepts claims, spenddown and cost share data directly from business systems.
- Allows for transfer of compressed files via SSL Web site for secure transmission.
- Provides diagnostic feedback to MCOs regarding quality of transmitted data.
- Assists MCOs in achieving and maintaining HIPAA data compliance.
- Allows MCOs to correct data anomalies either by resubmission or through adjustment transactions.
- Includes QA summary verification to ensure local and State databases remain synchronized.

The current encounter reporting data collection and verification utility is used by Family Care, Wisconsin PACE/Partnership, and SSI programs. The utility is designed to accept non-claims encounter data, and will accommodate "lines of business" other than those MCOs currently using the system.

Description of Encounter Transactions

Encounter records are detailed records of services that have been provided to members under the responsibility of the managed care organization (MCO). Encounter reporting requires a separate and unique record for each service.

Multiple encounters may occur between a single provider and a single recipient on a day. For example, when a therapy service, personal care services, and care management are all provided on a given day, the MCO will report three encounter records. These services may or may not be provided by the same provider, but they are three distinct encounters.

Overview of Transaction Types, Record Types, Claims Types, and Adjustment Types

Encounter data contains detailed records of services that have been provided to patients under the responsibility of the MCO. The source of most of the encounter data is the MCO claims systems but encounter data can have other sources. In addition to reporting service encounters, MCOs are required to report collections of member share and voluntary contributions. For managed care programs, the two types of transactions are Encounter transactions and Member Share transactions.

Transaction Types

Encounter transactions include the following:

- A service or item provided to a member through the benefit plan. Some examples are transportation services covered by the benefit plan, durable medical equipment, specific Case Management, etc.
- A service not directly provided by the MCO but for which the MCO is financially responsible, such as an emergency service provided by an out-of-network provider or facility.
- A service not directly provided by the MCO, but for which the MCO holds professional or administrative responsibility.

Member Share transactions include:

- A Cost Share amount due the MCO.
- A Voluntary Contribution.
- Room & Board.
- Spenddown amount.

The terms “service” and “item” as used above include those services and items not routinely covered by the benefit plan, but which the MCO chooses to provide as part of its managed care product. Examples may include educational services, certain over-the-counter drugs, and delivered meals.

Record Types

After determining the type of transaction, either Encounter or Member Share, the type of record must be identified. Encounter transactions and Member Share transactions have a record type of either “original” or “change”. The record type identifies whether the record being processed is an original record, or a change to a previous record.

Adjustment Types

A record type that identifies a change must further identify the adjustment type as a “reversal” or a “new” record. When changes are made to existing records, the changes are made in two steps; the first to reverse the previous transaction and the second to replace the record with a new record.

Claim Types

The claim type identifies whether the claim is “paid” or “denied”. Original, reversal, and new records must have one of these two claim types.

Diagram of Record Type Relationships

An overview of the relationship of transaction type, record type, claims type, and adjustment type is illustrated in the following diagram.

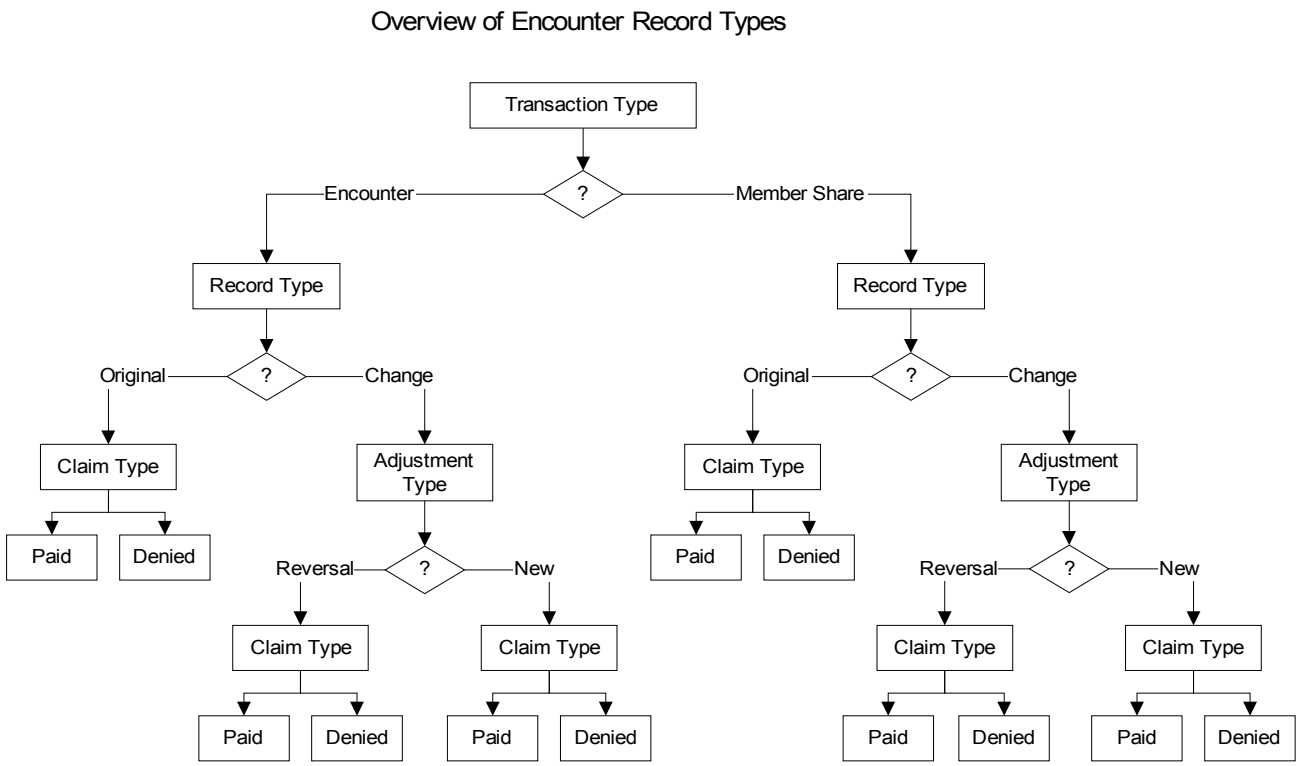

Figure 1. Encounter Record Types

Overview of the Encounter Reporting Process

The current MCO encounter reporting process consists of monthly data transfers from each management care organization. These monthly data transfers provide timely information for reporting and analysis. All file submissions, report viewing, and administration is done from a standard web browser.

Each MCO initiates a monthly data transfer submission file. The submission file contains an extract of data from the submitter's business (claims history) system. The data in the submission file is provided in an XML format.

Once submitted, the data transfer files are processed through a series of edits. Differing levels of error checking are used within the application to verify the submission. Edits are used to verify the submission file structure, the submission file content, and the content of each detailed record within the submission file.

It is possible that an entire submission is rejected when certain critical errors are found. This is referred to as a "batch reject error". When batch reject errors occur, the file must be corrected and resubmitted in its entirety.

Most often, a submission is accepted (i.e., no batch reject errors occurred), although it may contain individual records with errors found during the editing process. These errors are

referred to as “Batch Accept “errors and consist of items that can be fixed through an adjustment process.
Upon completion, feedback reports on the success of the data transfer are returned to the submitter. These feedback reports outline specific details of batch reject errors, batch accept errors, and other warnings that may be in place to assist the MCO in managing their data.

All accepted records (meaning records without errors) are sent to a data repository. This submitted data remains in the repository, and is used to load into the appropriate universe in the DSS data warehouse (DSS/DW) on a monthly basis. New programs may need to request the creation of a specific universe to house their data within the warehouse.

Encounter Reporting Process Flow

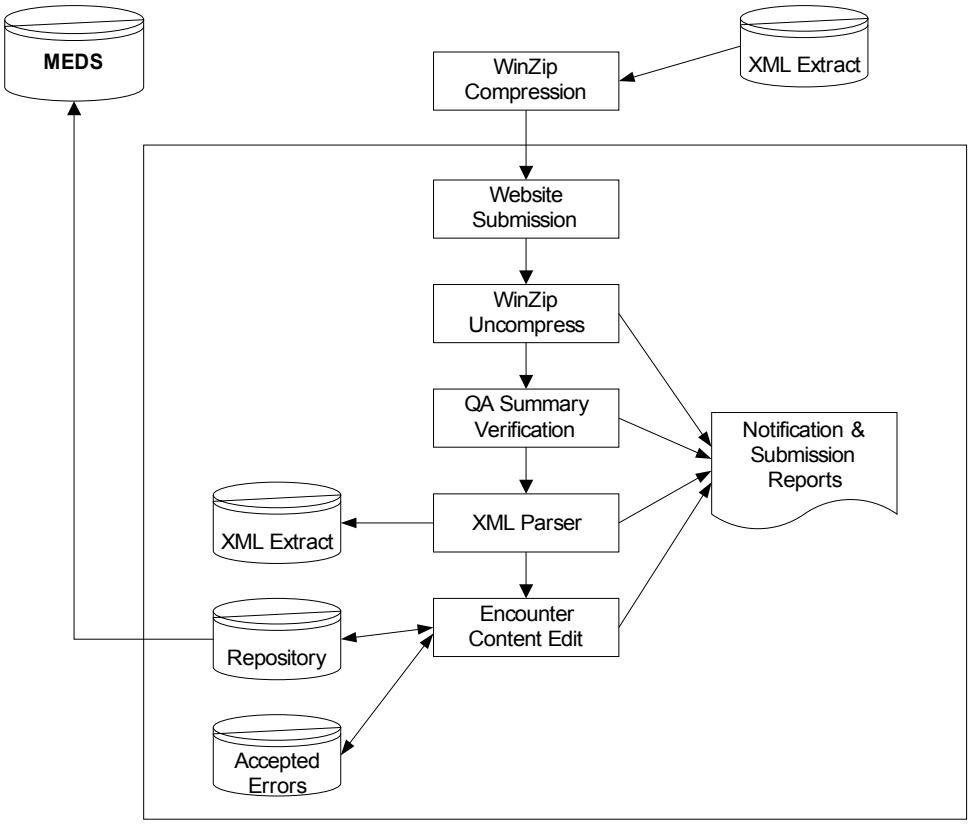

Figure 2. Encounter Reporting Process Flow

Local Business System Requirements

General Claims Processing Requirements of the Submitting Organization

MCOs must have a claim processing system that is robust enough to meet encounter reporting data requirements. The system must have the ability to supply required encounter data elements, and the required elements must pass data edits for encounter business rules.

The system must be able to generate an original claim transaction; any claims adjustments necessary and accurately to process the transaction and any member share encounters.

The claims system must adhere to Generally Accepted Accounting Principles (GAAP). Adjustments are expressed as debit/credit transaction pairs. Revenue is expressed as a negative amount, expense as a positive amount.

The claims system must be able to receive claims in a variety of mediums, including paper and electronic formats from various sources including service providers, billing services, Medicare carriers, and intermediaries. The system must accept additional claim inputs and use data from claims attachments including claims for Medicare coinsurance and deductible, attachments required for claims adjudication, coordination of benefits and explanation of Medicare benefits (EOMB), and non-claim-specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts.

The MCO claims system must be able to reconcile, coordinate, and pay claims. The system must be able to process "special" claims, including late billing, recipient retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class action suit, and any other State-defined situation, in accordance with State instructions.

The MCO must be able to produce and provide an explanation of benefits (EOB).

Effectively, to manage the claims processing function, the MCO system must be able to identify existing and potential Coordination of Benefits (COB) opportunities (including Medicare). This includes the ability to deny a claim when it is for a service covered under another member benefit resource, and deduct TPL amounts, as appropriate, when adjudicating claims. The system must be able to identify the allowable reimbursement according to date-specific pricing data and reimbursement methodologies for the date of service on the claim including Medicare coinsurance and/or deductible crossover claims and adjustments. (i.e., pay the Medicare deductible in full, pay Medicare coinsurance so as not to exceed the Medicaid maximum allowable fee, deduct Medicaid co-pay where appropriate, etc.). Any claims payments involving subrogation need to be credited back to the original claim (with the exception of re-insurance)

The MCO must also be able to manage member contributions for services according to cost share policies set by the State, including the ability to collect member cost share and coordinate it with claims payments, track remaining balances, and invoice recipients for the remaining monthly amount due.

Effective claims adjudication requires the MCO to perform adjustments to original and adjusted claim records. The process must prevent multiple adjustments to a single claim record (i.e., ensure successive adjustments are applied to the most current version of the claim record). The MCO must have the ability to identify a claim's disposition (i.e., paid,

denied, adjusted, etc.), including the ability to track all claim records from receipt to final disposition, and track (update) the claims inventory (to be processed, suspense, etc.) after each claims processing cycle.

Managed Care Organization must report room and board separately according to s.1915(c)(1) of the Social Security Act [42 U.S.C. 1396n(c)(1)].

Encounter reporting requires the ability to track and report on the original calculated claim amount allowed, any manually priced amount, and the actual payment amount in the claim history, including current and historical cost share data.

For purposes of illustration, the details presented in this document assume each claim contains a single service. In the event a claim contains multiples services, then each service within the claim becomes a separate claim line (transaction).

Each claim submitted for processing is classified as one of the following:

- **Paid:** Covered person / service for which payment is generated or an internal service paid amount is posted. Zero pay is part of paid. Zero pay is a covered/valid service for which the MCO liability was paid in full by other coverage. This is considered a paid claim for encounter reporting purposes.
- **Denied:** Valid claim (covered person/service) but nothing is paid (i.e. deny) because no amount is payable under these circumstances (exceeds authorized units, no authorization, duplicate, etc.).
- **Suspended / Pending:** Claims that are not yet finalized. Further processing is required to determine the final status of these claims.
- **Rejected:** Incomplete claim. Not a valid member/client. Not a valid vendor/provider. Outside the benefit package. Insufficient data to determine liability (e.g., no EOB or EOMB). For situations that involve insufficient data to determine liability, you do not need to enter these claims / services. If you do elect to control/enter these claims you should reject them.

Only paid and denied claims are reported to the encounter reporting system. The data collection and validation utility will not accept rejected or suspended/pending claims transactions.

Balancing Considerations

As with any reversal process, it is important, to accurately balance cash accounts with claims history. The following are recommendations to consider when implementing a reversal process.

Non-cash debits must always equal non-cash credits. Any claims payments involving subrogation need to be credited back to the original claim (with the exception of re-insurance)

- Claims history records must always balance against A/R records. All cash transactions should have a corresponding record within claims history to allow for accurate reporting, research, and auditing.
- Statistical information should not be inflated. For example, Provider X submitted a claim for $1000 for services rendered on 10 units of procedure ABC. This same

provider now requires an additional $200 due to incorrect billing. A supplemental payment can be issued but the units of 10 should not be reflected on the new claim for $200 (i.e., 20 units paid at a rate of $1200 of services when the true amount is 10 units paid at a rate of $1200).

- Supplemental payments require special consideration when balancing. If a supplemental payment is generated from the claims system, it is important that previous paid amounts be accounted for and handled accordingly. By not tracking any previous paid amounts, the supplemental payment claim risks being denied as a duplicate claim. If a supplemental payment is not generated from the claims system then an offsetting A/R must be created to account for any past amounts paid on the claim. In both cases, the Explanation of Benefits (EOB) should reflect the paid and previous amounts paid.
- As a rule, generally, voluntary transactions initiate the A/R. For example, if a provider refunds cash, then the entry of the refund into the system triggers the reversal.
- Requested (non-voluntary) transactions are initiated by the A/R system. For example, if a stop payment were issued on a check, the A/R needs to be satisfied prior to the reversal process.
- Lastly, when doing reversals it is important to account for service and/or dollar limits. Units used, visits allowed, deductible amounts, etc. are all totals or limits that should be recognized and documented when doing a reversal.

Ad Hoc Reporting

Each MCO must have the ability to generate ad hoc reports from the source data used to generate monthly encounter data extracts. Various tools are available to help with this including (but not limited to):

- MS Access
- FOCUS
- Crystal Reports
- Business Objects
- Cognos

Reporting tools are vital to the organization, and may be used for a variety of purposes. MCOs are asked to generate ad hoc reports to ensure the source data is synchronized with the data stored in the DSS data warehouse. MCOs may also use a variety of ad hoc reports to aid in testing any changes made to the system or to the extract programs.

Implementation Planning

To take advantage of the features of the data collection and validation utility, organizations must consider the current requirements of the encounter reporting process and evaluate these requirements against their own current systems capability. This document is intended to provide an overview of the encounter reporting process, and to provide basic instruction and recommendations for claims processing and reporting. Because this document cannot anticipate all implementation

and processing scenarios, it is advisable for the MCO to contact DHS Bureau of Information (BIS) staff to discuss their particular situation.

Planning Guidelines

In addition to the business system requirements listed above, some fundamental principles must be considered when planning for the implementation of encounter reporting.

- Organizations must be able to generate encounter records for both provider-based and internally provided services. In addition, for medical services, the National Provider ID (NPI) must be included.
- Encounter data must conform to claims and service reporting requirements for HIPAA.
- Organizations must have sufficient resources available to analyze and correct problems with data submitted to the encounter application.
- Organizations must be able to extract encounter data in XML file format for transmission.
- Organizations must be able to generate QA summary reports to verify historical data has not been altered.

Organizations must evaluate the capability of their existing business system and determine any functional gaps between their system and the requirements of encounter reporting. Additionally, MCOs must consider each of the following items and develop an implementation plan to address any conflicts that may relate to them.

- data dictionary elements
- definitions of paid and denied claims
- definitions of full cash, partial cash, and non-cash transactions
- COB processes
- adjustment processes
- XML file extracts
- test data sets
- processes for tie out to financial data

Encounter Reporting Transaction Information

Required Data Elements

Thirteen fields fully qualify an encounter record. Only the first seven fields in this list are required on every record. Depending on the type of transaction, additional fields may be required. For example, original records require all thirteen and others as indicated in the Data Dictionary (provided in Appendix A). Adjustments have different requirements, as do corrective transactions. Requirements for both adjustments and corrections are discussed in detail in their respective sections.

The thirteen fields are summarized here. More complete descriptions including valid data values for each field are provided in Appendix O.

1. Service Delivery Type; refers to the service deliver mechanism, which can be program contract providers or non-program contract providers.
2. Submitter Organization ID; refers to the Medicaid Provider ID assigned by the Wisconsin Medicaid Management Information System (MMIS).
3. Data Source; identifies the source of the data submitted in the encounter record.
4. Record ID; a unique identifier assigned by the MCO, which must have a sequencing property to provide the ability to identify whether a given record precedes or follows another record.
5. Record Type; identifies the type of encounter transaction. An "original" record is an unadjusted encounter transaction. A "credit/debit adjustment" to an original that is usually, but not always, submitted as a pair of records. The credit reverses the transaction being adjusted and the debit replaces the transaction being adjusted.
6. Claims Status; identifies the status of the claim as either paid or denied.
7. Posting Date; identifies the date the record was finalized in the MCO business system (paid or denied with EOB).
8. Parent Record ID; references the transaction being adjusted. In a credit/debit adjustment, both the credit and debit transactions reference the same transaction. This number is assigned by the MCO.
9. Original ID; the record ID of the original encounter or the first ancestor record, as assigned by the MCO. This is only used on adjustments.
10. Adjustment Type; identifies the type of adjustment and is only applicable to transactions that are adjusting a previous transaction. This field is assigned by the MCO for credit/debit transactions. This is required for credit/debit adjustments only.
11. Adjustment Type Detail; specifies the type of adjustment, which can be full cash, partial cash, or non-cash. Full cash identifies an adjustment that fully reverses the most recent existing transaction (e.g., to record monies paid back to the MCO from the Provider). Partial cash identifies an adjustment that partially reverses the most recent existing transaction resulting (e.g., to record some monies paid back to the MCO from the Provider). Non-cash identify an adjustment that has no financial impact but changes demographic or other related information. This field is assigned by the MCO.
12. Support Indicator; identifies services that are either self-directed by the MCO member; services that are directed by the MCO; or non-service items.
13. Member Share; identifies the type of revenue received from the member related to cost share, room and board, or voluntary contributions made by the member or on behalf of the member.

Record Edits

Each record within a submission is validated by a series of edits or business rules. Some of these rules require a field to contain correct values. Edits validate a variety of circumstances, from well-formed submission file and its data elements to specific content edits.

Data type checking is done for all populated fields, both required and optional. When a field contains a value, data type checking is conducted on that field.

All populated fields must have correct values. Domain checking is limited to those fields where the domains are specified in the data dictionary. Reference tables are also used to validate populated fields (e.g., procedure codes, diagnosis codes) in accordance with the National Code Set which may or may not align with the Medicaid Code sets.

Relationships are also verified. When fields contain data, all relationships between those fields are validated. For example, when a Billing Provider ID Qualifier is provided, it must be within the set (24, 34, XX, CO) and there must be values in other fields associated to the Billing Provider field. This does not check the validity of the values in the Billing Provider ID field or any other related fields. It does however; confirm the existence and data type based on the qualifier and/or the definition field(s). For example, if the Billing Provider ID qualifier is set to XX, then there must be an associated NPI value in the Billing Provider ID field.

DDES recommends that each MCO implement a set of edits for each encounter record in their own business system or process prior to extracting data to minimize errors in their file submissions. Errors identified through the edit process contain the unique record identifier supplied by the MCO. This identifier can be used to evaluate the errors and correct the appropriate transactions. The MCO is required to correct the errors and re-submit the complete file or the corrected transactions, as appropriate, in the next submission depending on the type of errors.

Edits may change over time as business rules or requirements from Federal or State entities change.

Each edit is assigned to an organization by the encounter application edit-manager for the edit to identify erroneous data in the submission file. The severity of the edit level depends upon the documented business rules for the organization's specific line of business.

Error Messages

There are three types of edit error messages:

- Batch Reject Error; a message regarding critical errors that cause the entire submission to be rejected. The file must be corrected and resubmitted in its entirety.
- Batch Accept Error; a message regarding critical errors contained in individual records within the file. The "error" records are flagged and consist of items that can be fixed in subsequent submissions through an adjustment process.
- Warning; a message regarding potential errors. These records are processed; corrections to these records must be made where possible in future submissions. These messages are provided to assist the MCO in managing their information systems and data. Warning messages are sometimes used to assist in the implementation and 'at a later date', may become error messages.

Requirements for Encounter Records

General Requirements for All Transaction Types

There are two types of transactions, as previously defined: encounters and member share transactions. Each of these types of transactions follows the same rules for reporting, correcting and adjusting. These rules are:

- The first appearance of an encounter or a member share is considered the original.
- If an adjustment is needed, it must be made to the original. Subsequent adjustments must always be made to the most recent prior encounter record.
- Adjustments must link to the original and to the transaction being adjusted.
- Adjustments must follow a credit/debit methodology. (See the section on Requirements for Reversals and Adjustments for details.)

Requirements for Member Share Transaction Types

Member share transactions are used to track cost share, voluntary contributions, and room and board. Cost Share transactions have a Member Share Value of C, Voluntary Contributions transactions have a Member Share of V, and Room and Board transactions have a Member Share of R. Each of these transaction types provide a record of an amount received from the member or on behalf of the member.

In general, all of these member-share transaction types must follow these rules:

- Changes to any of these transaction types must use the standard rules for adjustments. It is imperative that any encounters do not subtract these amounts from any particular service.
- The amounts for these transaction types must be reflected in these transactions regardless of who collects the member share, the MCO or the Provider.
- The standard rules for negative/positive dollar amounts must be reversed for member share transactions to appropriately record monies received, rather than those paid as in a standard transaction.
- The Paid Amount is the amount paid by the member. This is a negative amount when submitting an original record (Record Type of O).
- The Support Indicator must equal N.
- The Charges and Allowed Amount fields are NULL. Allowed Amount is also an optional field.
- The Quantity and Unit or Basis for Measurement Code fields are NULL.
- All TPL fields including Medicare Paid Amount and Other Payer Amount Paid fields must equal zero.
- The Claim Status must be ‘Paid’.
- The MA Billing Provider ID and the MA Rendering Provider ID fields contain the Submitter Organization ID.

- The From/To Dates of Service are relevant to the date for which the specific member share transaction applies.
- Remaining fields are their defaults.

A few rules apply to specific member share transaction types.

- When Room and Board transactions are provided, the corresponding facility transactions must be a gross cost that includes the Room and Board amounts. (If only the net amount is provided, then cost is understated, since Room and Board is used as a credit to decrease the service costs from facilities.)
- The SPC for cost share transactions must equal 095.01.
- The SPC for voluntary contribution transactions must equal 095.02.
- The SPC for room and board transactions must equal 095.03.
- The SPC for spenddown transactions must equal 095.04.

Record Type Business Rules

The Record ID for all record types must be unique. Replacements records are allowed for error records using the same record ID.

For original record types:

- Quantities and amounts are positive.
- The Parent ID and the Original ID must be NULL.
- No other previous record may have this Record ID stored in the Parent ID or Original ID fields.

For change record types:

- The Parent ID must have a value. The current Parent ID must be equal to the Record ID of an original record or the previous record of the same Record Type as provided on the current record.
- The Original ID must have a value. The Original ID must be that of a previously reported original record.

Adjustment Type Business Rules

Valid adjustments are reversals, and new replacement records. All adjustment records have the same criteria as the original records, with the addition of those criteria mentioned above regarding change record types.

- A reversal adjustment must provide an exact reversal of the transaction being adjusted.
- Confirm every field provided; numeric quantities and dollars must be negated; non-numeric fields must have the exact value as the transaction being adjusted.

Requirements for Paid Claim Type

Paid records include standard claim records where there is no member share component, and they are either an original or an adjustment record (member share is N and the record type is O or the adjustment type is N). The following rules apply to paid encounter transactions:

- Changes in the reported encounter transaction are reported by using the standard rules for adjustments.
- Required and situational fields are indicated in the data dictionary.
- The sign (positive/negative) for Charges, Allowed Amount, Medicare Paid Amount, and other Payer Amount Paid fields must be the same, when they exist on the same encounter record. Allowed amount is also an optional field.
- Charges and Paid Amount are required.
- The Quantity must reflect the same sign as the dollar fields.
- Self-Directed Support Services transactions must have a Support Indicator of S and Member Share of N.
- CMO-Directed Support Services transactions must have a Support Indicator of C and Member Share of N.
- Claim adjustment reason codes are required when the Paid Amount is not equal to the Billed Amount.
- Either the MA Billing Provider ID or the Billing Provider ID is required.
- From/To Dates of Service are required.
- Receipt Date is required.
- SPC may not begin with 095.

Requirements for Denied Claim Type

Denied records have a claim status of D. Only original encounters and adjustments may be denied (a standard claim where there is no member share component). When adjustments are denied, only the new adjustment line reflects the denied status. Fields required for a denied transaction are:

- Service Delivery Type
- Submitter Organization ID
- Data Source
- Claim Status
- Record Type
- Paid Amount, which must be equal to zero
- Posting Date
- Claim Adjustment Reason Codes
- Support Indicator

- Member Share

Claims that have a status of D (denied) may not be adjusted.

Basic Assumptions Regarding Fields

Nulls and Blanks:

- When only spaces or NULLs appear in any field, it is considered NULL.
- When space(s) appear among other characters within an alpha or an alphanumeric field, it is treated as a space. If the spaces are either leading or trailing, they are removed from the data. It is assumed that these trailing and leading blanks are not to be counted when determining the max length of a field.
- When a field is populated with a value of zero, it is treated as a valid value and carries through all edits and calculations.

The Data Source and SPC fields have a fixed length. When a value less than the maximum length is used in these fields, the data must be left-padded with zeros in the submission file.

Requirements for Correcting Errors and Making Changes

Requirements for Reversals and Adjustments

Reversal records completely reverse a previously submitted record. Adjustments are made using a credit/debit pair of records to reverse a record and replace it with the correct data, effectively adjusting the record. Reversal records may be submitted alone, or as the first of a pair of adjusting records.

Reversal records must contain these required fields:

- Record ID
- Record Type
- Posting Date
- Parent Record ID
- Original ID

These additional rules apply to reversal records:

- The Post Date must reflect the posting date of the reversal.
- All non-numeric fields must exactly match the corresponding field of the record being adjusted, as indicated by the value in the Parent ID. All numeric fields must be the exact negative amount of the corresponding field of the record being adjusted.

Errors in the reversing transaction cause the batch submission to be rejected.

When a reversal occurs, it may only be followed by a new record. Once an encounter has been adjusted by a reversal record, it may not be adjusted any further unless the adjustment record is to submit a new encounter record.

For example, in the table below transactions 5, 7, and 9 are valid.

ID	Type	Parent ID	Quantity	Amount
5	O		200	5
7	CR	5	-200	-5
9	CN	5	200	5

The Parent Record ID in a reversal record reflects the original record that it is reversing.

An acceptable reversal transaction sequence is:

- Original encounter record
- Credit Reversal record
- Credit New record (optional)

An **invalid** reversal transaction sequence is:

- Original encounter record
- Credit Reversal record
- Credit Reversal record
- Credit New record

Adjustment Protocols

MCOs must use the credit/debit method for submitting adjustments. Adjustments using the credit/debit method require two records for each encounter, unless the type of adjustment is a complete reversal of the parent record. Full reversals are reported as a single reversing record.

The first of the two records in a credit/debit pair is the reversal, which backs out or cancels the record being adjusted. This record has the following differences from its original record:

Record ID	Must be a unique Record ID
Record Type	C
Adjustment Type	R
Parent ID	The Record ID of the record being adjusted
Original ID	The Record ID of the original encounter record
Posting Date	The posting date of this adjustment
Remaining numeric fields	The corresponding value from the record being adjusted multiplied by -1
Remaining non-numeric fields	The corresponding value from the record being adjusted

The second of the two records in a credit/debit pair is the new record, which replaces the record being adjusted. This record has the following differences from its original record:

Record ID	Must be a unique Record ID
Record Type	C
Adjustment Type	N

Parent ID	The Record ID of the record being adjusted
Original ID	The Record ID of the original encounter record
Posting Date	The posting date of this adjustment

When an MCO provides data that is inconsistent with these rules, the data collection and validation utility flags these inconsistencies as Batch Reject Errors and rejects the file submission. These criteria define those additional edits for the new transaction for an adjustment. The remaining fields are populated to contain values consistent with an original encounter.

The encounter application processes the records as they are presented in the submission file by the MCO. The following examples represent the data at the MCO and the DDES levels. The lightly shaded fields are the various identifiers, the non-shaded fields are encounter information, and the fields with darker shading are the Record Types, Adjustment Types and related.

Adjustment Examples

The following examples illustrate the adjustment process using full cash adjustments, partial cash adjustments, non-cash adjustments, and records for multiple adjustments.

Full Cash Adjustment

A full cash adjustment negates a previous record. Record 123 was incorrectly billed and never should have been billed. The MCO creates a record (127) that nullifies the original.

Record ID	Record Type	Adjustment Type	Quantity	Procedure Code	Charges	Paid Amount	Parent Record ID	Original ID
123	O		1	XYZ	50	50		
127	C	R	-1	XYZ	-50	-50	123	123

Record 123 is the original encounter. Record 127 is the adjustment that completely reverses the original.

Partial Cash Adjustment

A partial cash adjustment is actually an adjustment that results in a change to a portion of the cash amounts on the record. Record 123 was correctly billed but incorrectly paid. The co-pay ($10.00) was forgotten. The MCO creates a record (127) that nullifies the original. Finally, the MCO creates a new record (134) correctly to pay the claim.

Record ID	Record Type	Adjustment Type	Quantity	Procedure Code	Charges	Paid Amount	Parent Record ID	Original ID
123	O		1	XYZ	50	50		
127	C	R	-1	XYZ	-50	-50	123	123
134	C	N	1	XYZ	50	40	123	123

Record 123 is the original encounter. Record 127 is the adjustment that completely reverses the original. Record 134 is the adjustment, or replacement, of the original.

Non-Cash Adjustment

A non-cash adjustment is used to adjust the components of the record that are not related to cash amounts. Record 123 was incorrectly billed with an incorrect procedure code. There is no pricing difference; therefore, there is no financial impact. The MCO creates a record (127) that nullifies the original. Finally, the MCO creates a new record (134) to correctly pay the claim.

Record ID	Record Type	Adjustment Type	Quantity	Procedure Code	Charges	Paid Amount	Parent Record ID	Original ID
123	O		1	XYZ	50	50		
127	C	R	-1	XYZ	-50	-50	123	123
134	C	N	1	ABC	50	50	123	123

Record 123 is the original encounter. Record 127 is the adjustment that completely reverses the original. Record 134 is the adjustment or replacement of the original.

Multiple Adjustments

Record ID	Record Type	Adjustment Type	Quantity	Procedure Code	Charges	Paid Amount	Parent Record ID	Original ID
123	O		1	XYZ	50	50		
127	C	R	-1	XYZ	-50	-50	123	123
134	C	N	1	ABC	50	40	123	123
168	C	R	-1	ABC	-50	-40	134	123
199	C	N	1	CDE	50	40	134	123

Record 123 is the original encounter. Record 127 is an adjustment that completely reverses the original. Record 134 is the adjustment or replacement of the original. Record 168 is an adjustment that completely reverses Record 134. Record 169 is the adjustment or replacement of Record 134.

Correcting Submission Errors

There are two types of errors; ‘batch reject’ and ‘batch accept’. Batch reject errors are those errors that cannot be corrected by the MCO’s normal operating procedures. When any record or submission has any batch reject errors, the complete batch is rejected and the MCO must correct the records and resubmit the entire data file. Batch Accept errors are those errors that can be corrected by the MCO’s normal operating procedures. These errors are “accepted” but held in suspense until the MCO sends correcting transactions.

There are two methods for correcting erroneous transactions. The two methods are to correct a batch with errors and resubmit or to adjust individual transactions.

To resubmit, the MCO makes the appropriate corrections in their system and resubmits the XML file with the same Record ID and Record Types.

When correcting by adjustment, the MCO creates another individual record transaction (or adjustment) that reverses the erroneous record and resubmits a new replacement transaction. This process is treated like a Credit/Debit Adjustment at the MCO but is treated

like a resubmission by the DDES encounter process. The process accepts the credit record to reverse the erroneous transaction and records the debit record as the encounter. The erroneous record remains in the error file as fixed but never reaches the final encounter data set.

In the example below, an original transaction supplies an erroneous SPC code.

Record ID	Record Type	Adjustment Type	Quantity	SPC Code	Charges	Paid Amount	Parent Record ID
123	O		1	198	50	50	

The correction to the erroneous SPC as an adjustment is specified below.

Record ID	Record Type	Adjustment Type	Quantity	SPC Code	Charges	Paid Amount	Parent Record ID
187	C	R	-1	198	-50	-50	123
188	C	N	1	503	50	50	123

This adjustment method assumes the MCO is able to reverse out the offending transaction and enter a correcting transaction.

When an error is classified as a batch reject, the complete batch is rejected and the MCO is expected to correct the error(s) and resubmit the batch within three business days. When an error is classified as batches accept error, the batch is accepted but the offending record is held in an error status. The MCO is expected to correct the offending record(s) using an adjustment submitted in the next monthly submission. When the correcting adjustments are submitted, an error reconciliation process occurs within the encounter application.

Making Changes and Maintaining Integrity of Data

The overall business goal of Encounter Reporting is for DDES to maintain a database of encounter transactions that exactly match the data in the MCO.

Note these requirements:

- All changes to certified data must be made using the encounter adjustment process **exclusively**. This is the only way the MCO source claims data and the DDES encounter data repository will remain synchronized. Data that are not synchronized because of various problems from audit exceptions to “false positive” edit errors, particularly, when evaluating adjustments.
- Ensure the MCO claims history records are not linked (or hard coded) to master tables, which contain provider, member, or demographic information. The MCO claims history records must be a snapshot of the data at a point in time. When historical records are linked to tables and those tables are updated, the historical claims information no longer matches the encounter data that has been reported to DDES. This causes a variety of tie-out and verification problems.
- The encounter audit procedures include regular quality assurance (QA) checks to verify the repository is synchronized with the MCO business system. When discrepancies are found, the MCO is asked to re-extract all the months since the last QA tie-out.

Submitting Encounter Data

Monthly Submission Process

Encounter reporting is a monthly submission for encounters posted in the prior month. Encounters posted are claims that are finalized (paid or denied with a corresponding EOB). Once claims have been finalized, there are no changes to these records, although you may alter an encounter through an adjustment process. Adjustments are treated as an encounter record with similar rules as the original.

Encounter submissions are expected to be monthly and contain a complete month of data. Partial month submissions are not supported. The Begin Posting Date must always be the beginning of the month and the End Posting Date is the last day of the month. The previous month's submission must be accepted before any new submission is accepted. (Note: This does not apply to the initial data submission, as a prior submission does not exist.)

Each program or line of business is assigned a monthly submission due date. Certified encounter reporting submissions are due no later than the assigned date, or on the first business day following the due date, in the event the due date falls on a non-working day. The accepted files must be certified before they will be loaded into the ODS universes. In the event the assigned due date falls on the weekend or a holiday, the submission is due on the next business day. For example, Family Care encounter data with posting dates in January must be submitted no later than February 15. If February 15 is a Saturday, the data must be submitted and certified by Monday, the 17.

DDES recommends that organizations send the encounter submissions prior to the assigned due date to allow time to make corrections should the submission fail the edits. To meet the assigned deadline, the encounter submission must pass all critical edits in the encounter validation program. When the MCO is satisfied that the data transmitted is representative of the business transacted in the previous month, the MCO must certify each submission attesting to its accuracy.

Extracting Data and the XML File Format

An XML file layout template is provided in Appendix B. The template is designed to accompany the Data Dictionary, which is found in Appendix A, and includes both header record and detail record fields. The maximum field lengths are illustrated in this template with the exception of those with AAAAAAAAAA. See the Data Dictionary for specific details of each data element, including the maximum length of these fields.

Issues to consider in creating the XML file include:

- Comments use the following syntax: <!-- This is a comment -->
- Do not generate XML tags for fields that do not contain data. For example, if there is no cmo_reason_code, then omit this line from the XML file for that record.
- There is currently no support for the NIL attribute.
- It is very important that the first line of the XML file is exactly as provided here. There must not be any characters before this line in the file.

<? xml version="1.0" encoding="UTF-8" standalone="no"?>

- The last line of the XML file must be a proper end of file. Do not end the file with a single Line Feed (LF) without a Carriage Return (CR). Do not end the file with any extraneous characters.
- Issue a line break after each line of XML code. When this is not done, the file is read as one (very long) line. This is difficult to parse, and causes difficulty in issuing meaningful error references.
- A few special characters (< > & ‘ or “) confuse the XML parser. The XML parser is used to strip the data from the XML file. Each occurrence of these special characters must be issued with a specific escape sequence (or character string). These characters are often found in provider names but they may exist in other fields as well. The following table illustrates the escape sequence mapping.

Character	Escape Sequence
< (less than)	<
> (greater than)	>
& (ampersand)	&
' (apostrophe)	'
" (quotation mark)	"

For example:
<billing_provider_last_name>Jones & Smith</billing_provider_last_name>
Becomes:
<billing_provider_last_name>Jones & Smith</billing_provider_last_name>

Notice that the semi-colon is part of the sequence.

Submission File Edits for Header and Details

Preamble and header edits impose the domain and format for each field contained in the file header. There must be a single header record per file. Each submission must contain a header record. Header edits include, but are not limited to:

- Submission Date >= Ending Posting Date.
- Beginning Posting Date <= Ending Posting Date.
- Number of Records transmitted = Number of Detail Records contained in the file.

A submission file may contain only header information, and not contain any detail records. For example, various business circumstances may force claims payment to be suspended for a given month, where this type of file submission may be needed to maintain a proper reporting sequence.

Detail edits are used to impose the domain and format for each individual field contained in the file submission. The number of detail records in the file must equal the number or records transmitted specified in the header. Edits used to validate detail records are specified in the appendices.

Implementation and Testing

Submitting Data Using the Encounter Web Site

The encounter application development-team recommends users access the application through one of the following browsers, Microsoft Internet Explorer 5.0 for Windows (optimal) or Microsoft Internet Explorer 6.0 for Windows.

These browser versions provide the broadest access to the features and functionality of the application while also presenting the user interface in the most consistent and easy to use manner. While both versions 5.0 and 6.0 of Internet Explorer work well, version 5.0 provides the optimal support for the application at this time.

File extensions must be either .XML or .ZIP. The encounter application development-team recommends submitting the file in a standard zipped format to accelerate the upload process.

The following instructions outline the steps to access the submission application.

1) Enter the URL https://www.wisconsinedi.org/cmoencounter/secureLogin.html

2) The following screen is displayed.

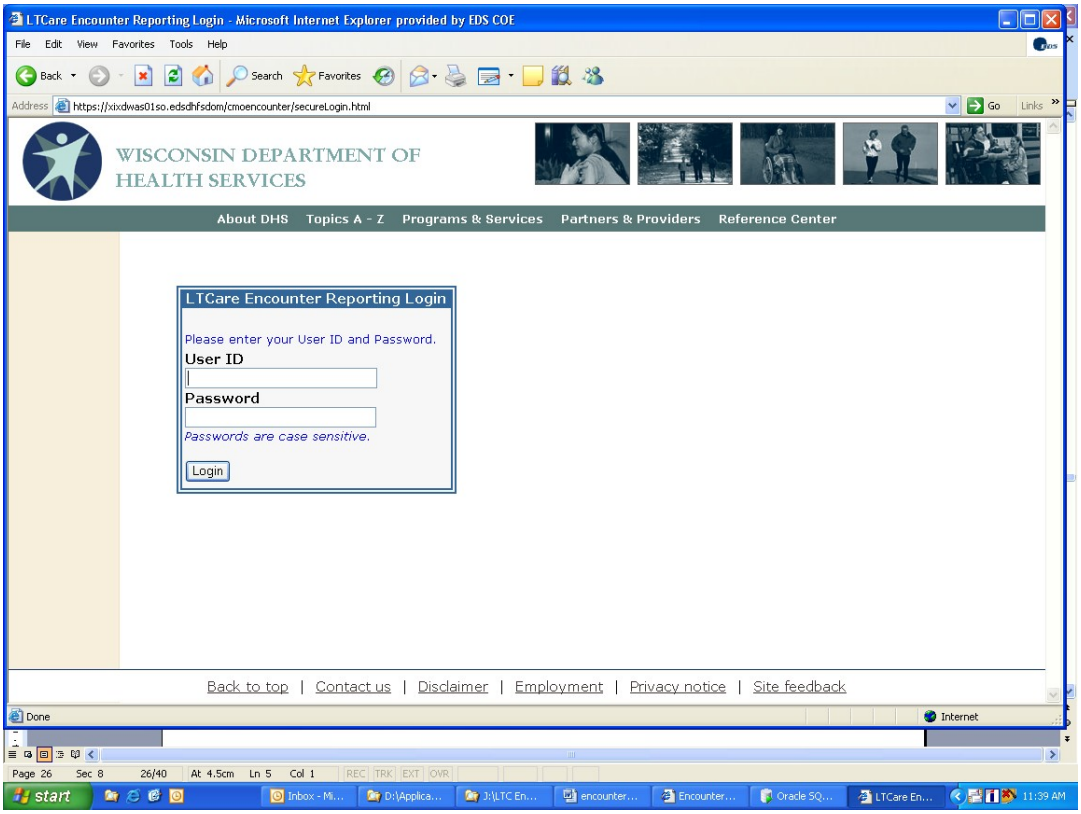

Figure 3. MCO Encounter Login

3) Enter the user ID and Password. Press the “Login” button.

You are now logged onto the Encounter Reporting Application.

4) The following screen is displayed.

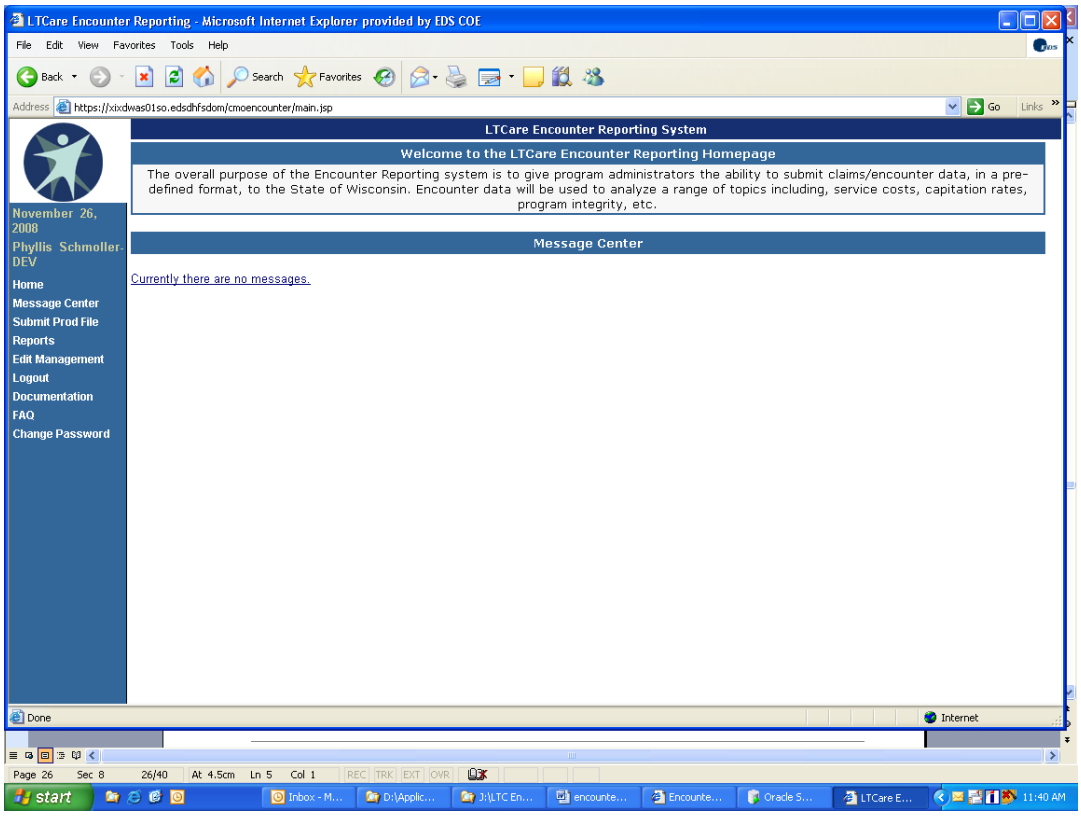

Figure 4. Encounter Welcome Homepage

Note: When you initially log on, you get a view that shows both the Home Page and the Message Center. This is to ensure that you see your messages for the day. For example, New Encounter Password Feature hyperlink.

To Change User Password

1. On the left-hand side of the Message Center Page, you see nine options. In order to change the user password to the system, please click on the hyperlink that says **"Change Password"**.

2. After clicking the **"Change Password"** hyperlink, the following screen is displayed.

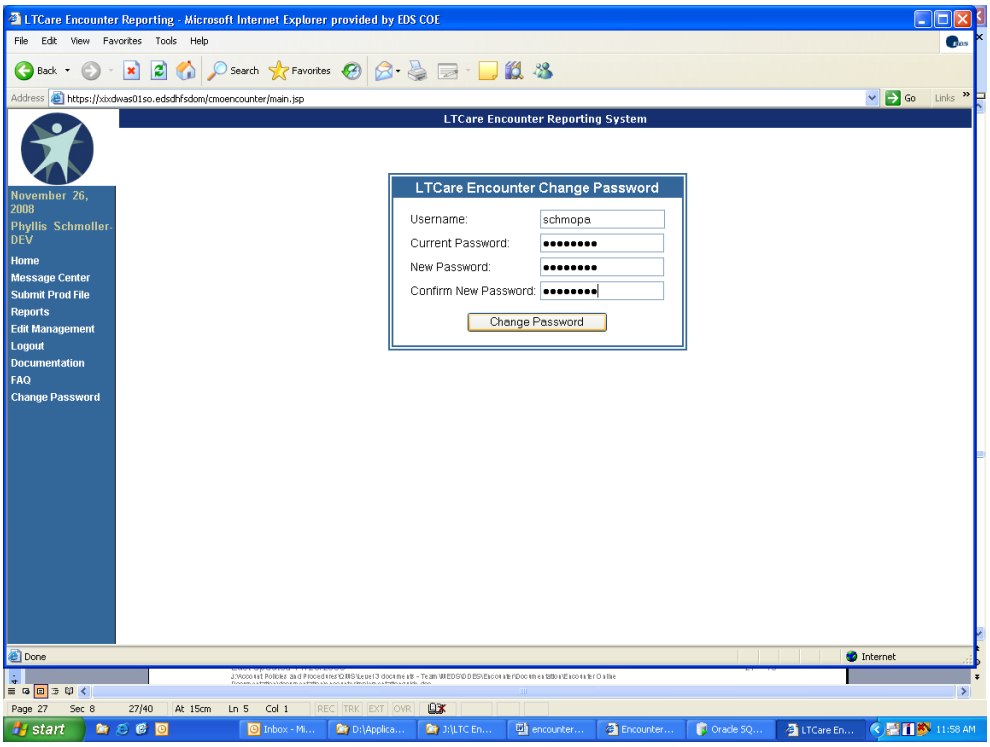

Figure 5. New Encounter Change Password Feature

3. Enter the **"User name"** and **"Current Password"**, and then type the **"New Password"** and now confirm the **"New Password"** by retyping it.

4. After clicking the **"Change Password"** button, the following screen is displayed.

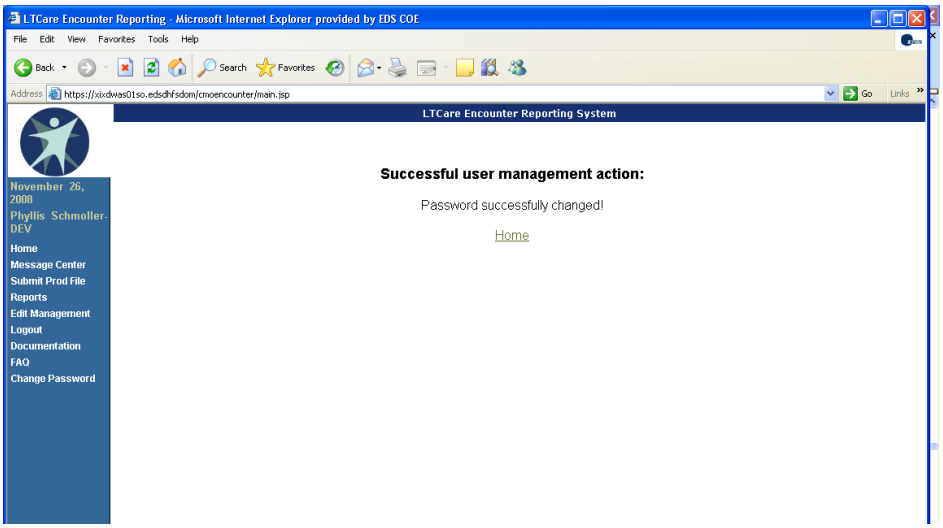

Figure 6. User Management Action – Password Changed

User password successfully changed.

5. Click the **"Home"** hyperlink to return to the main screen.

6) Several options are displayed along the left side of the main screen. Select the "Submit Prod File" option.

7) A new window is displayed containing a pop message with the following text; 'A new window is being opened for you to upload your file'. Select "OK" to continue.

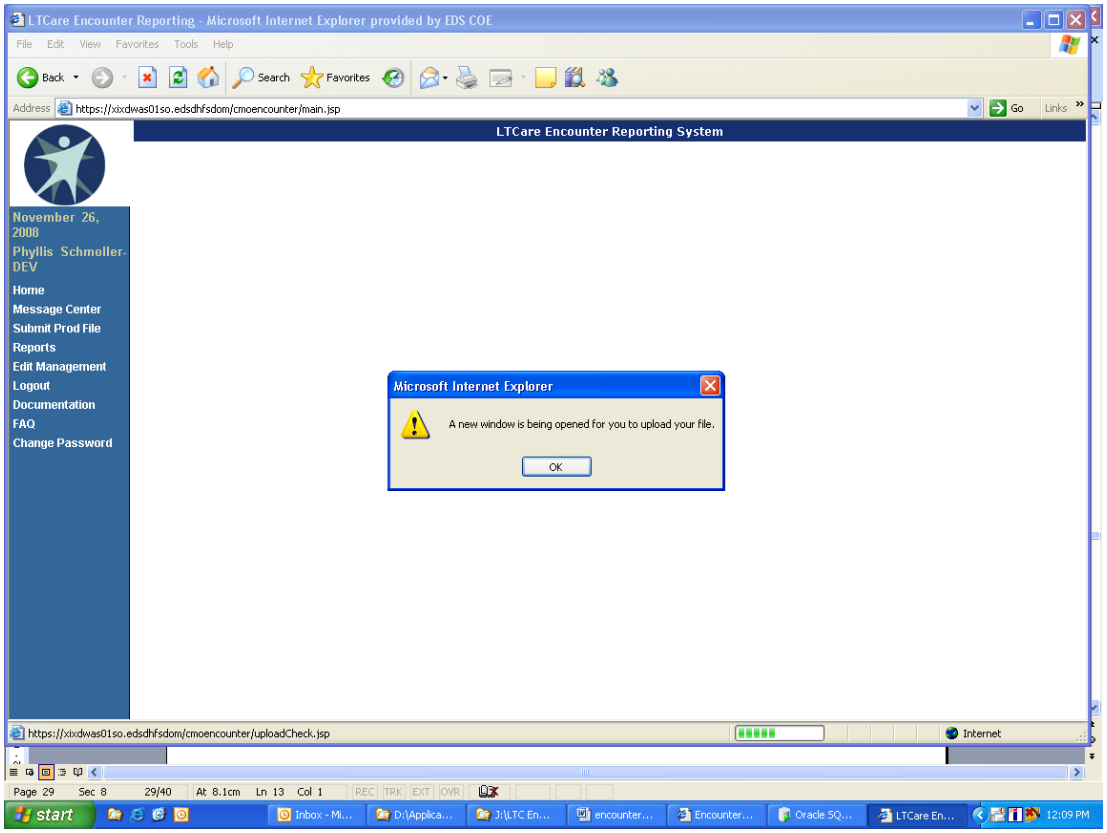

Figure 7. Submit Prod File Window

The XML file upload window is displayed. Note the following in the “Select Organization” drop down field.

- When the user ID is associated with only one organization, the organization field contains the appropriate Submitter Organization ID for that user ID.
- When the user ID is associated with multiple organizations, choose the appropriate organization from the drop down menu.

8) Select the “Browse” button to choose an XML file to upload.

- This displays a window that provides access to all directories that are normally available to this user ID.

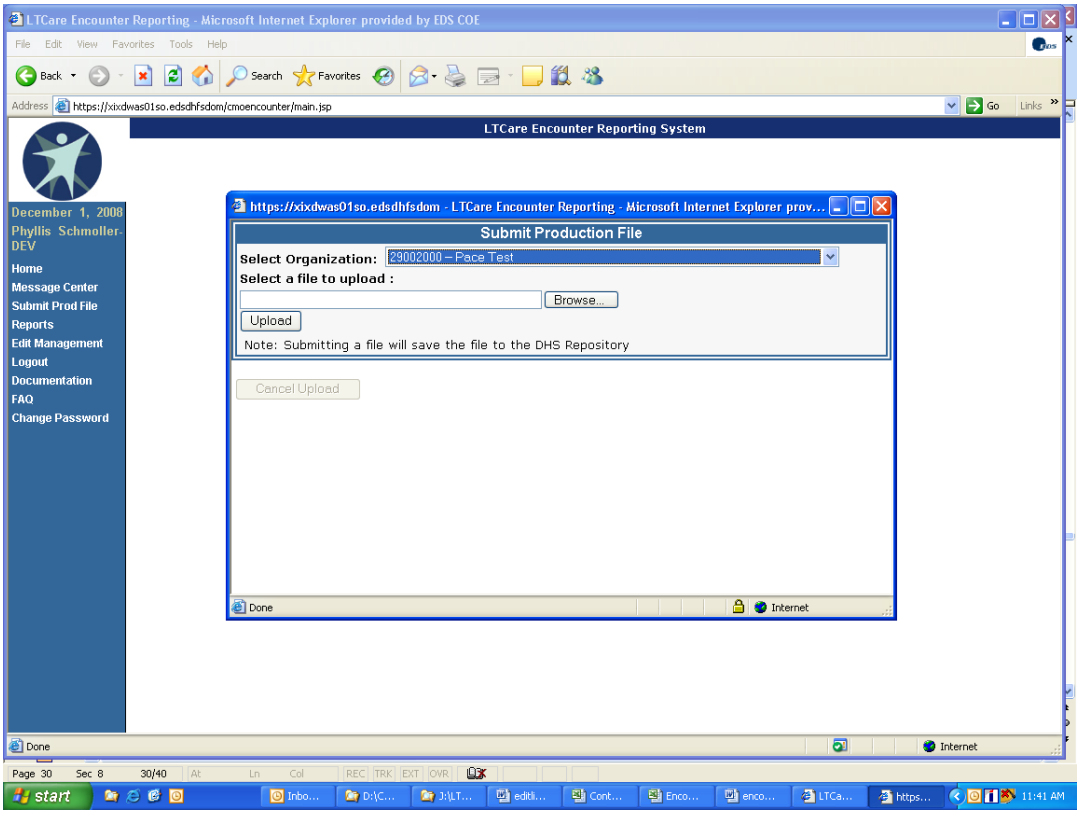

Figure 8. Encounter XML File Upload

9) Browse through the available folders as needed, and select the file to submit.

- When the file is selected, the file name is placed in the “File Name” field in the pop-up window.

10) Select “Open”. In the example below, the file, “XML_2.7_001_S03_2.7_S03_3.xml” has been chosen from the D directory, folder CMO Completed Tests – WPP.

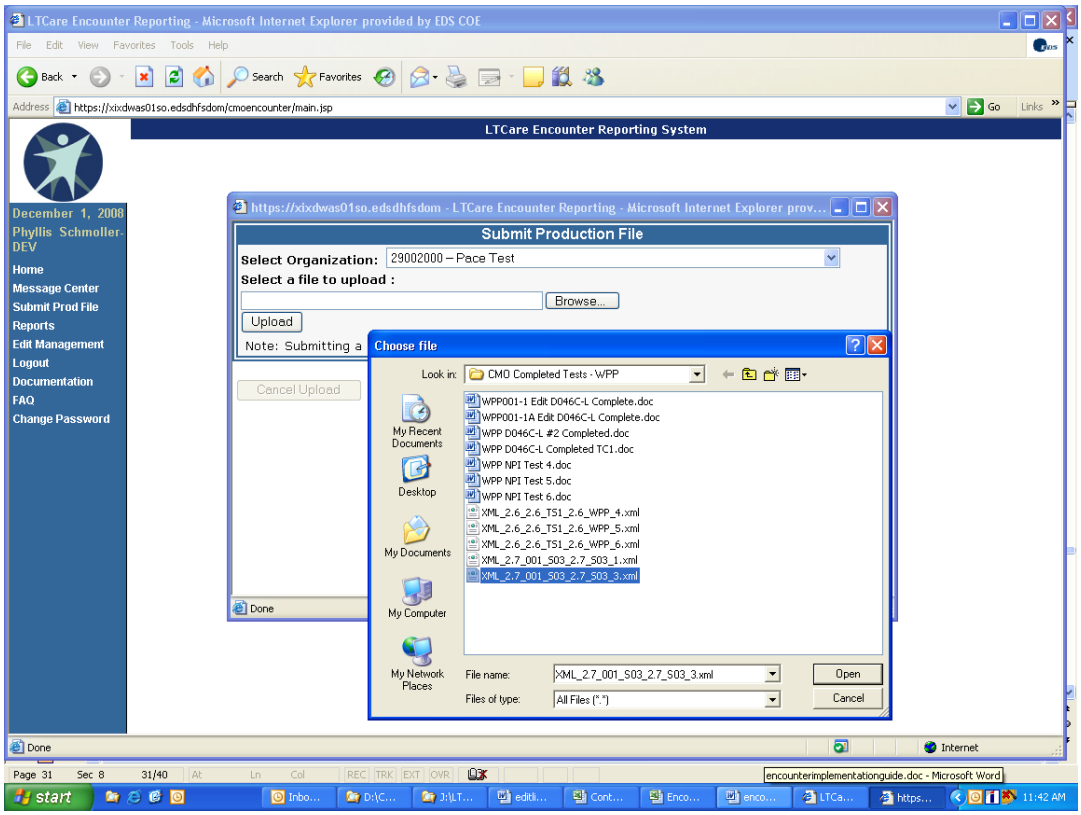

Figure 9. Select Production File

11) This returns to the previous screen, now containing the chosen file name.

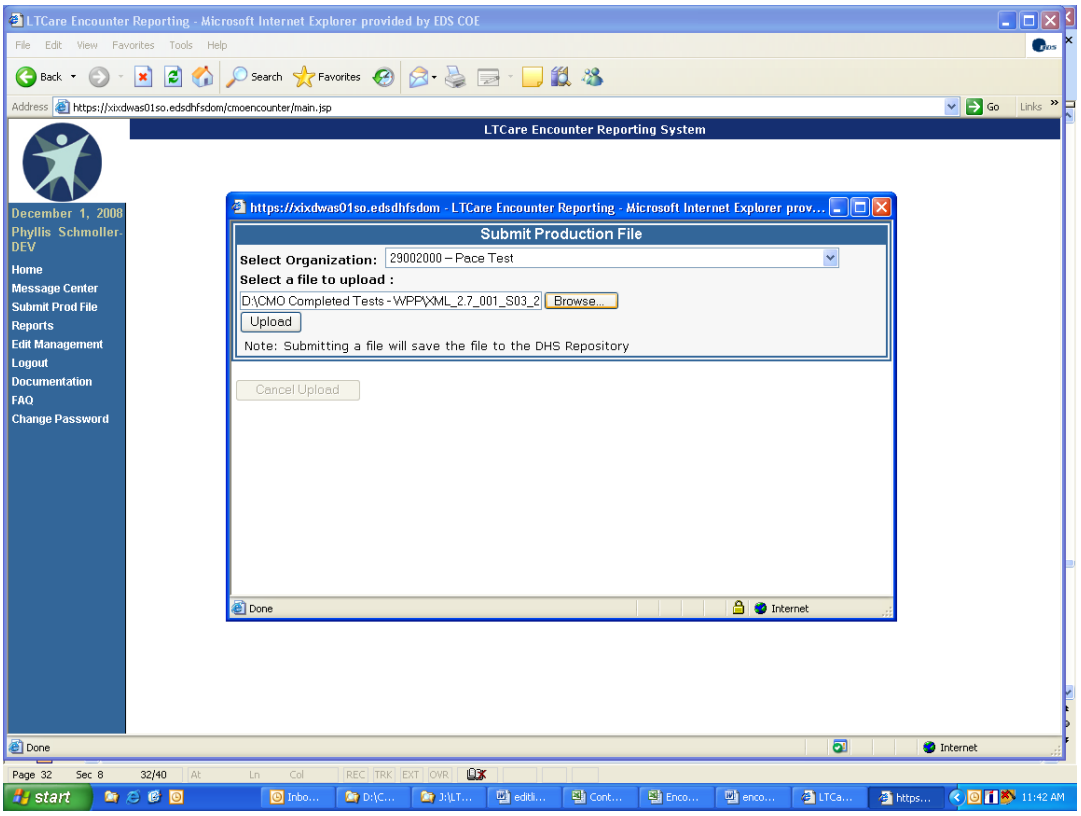

Figure 10. Submit Production File

12) The file can now be submitted. Select “Upload” to begin the file transmission process. A “percentage complete” icon is displayed. When the percentage reaches 100%, the submission status screen is displayed.

13) When the file has completed its upload process, the following message appears on the submission status screen.

The submission ID that is referenced on this screen is the number used to certify the submission.

The XML file is successfully submitted to the encounter application.

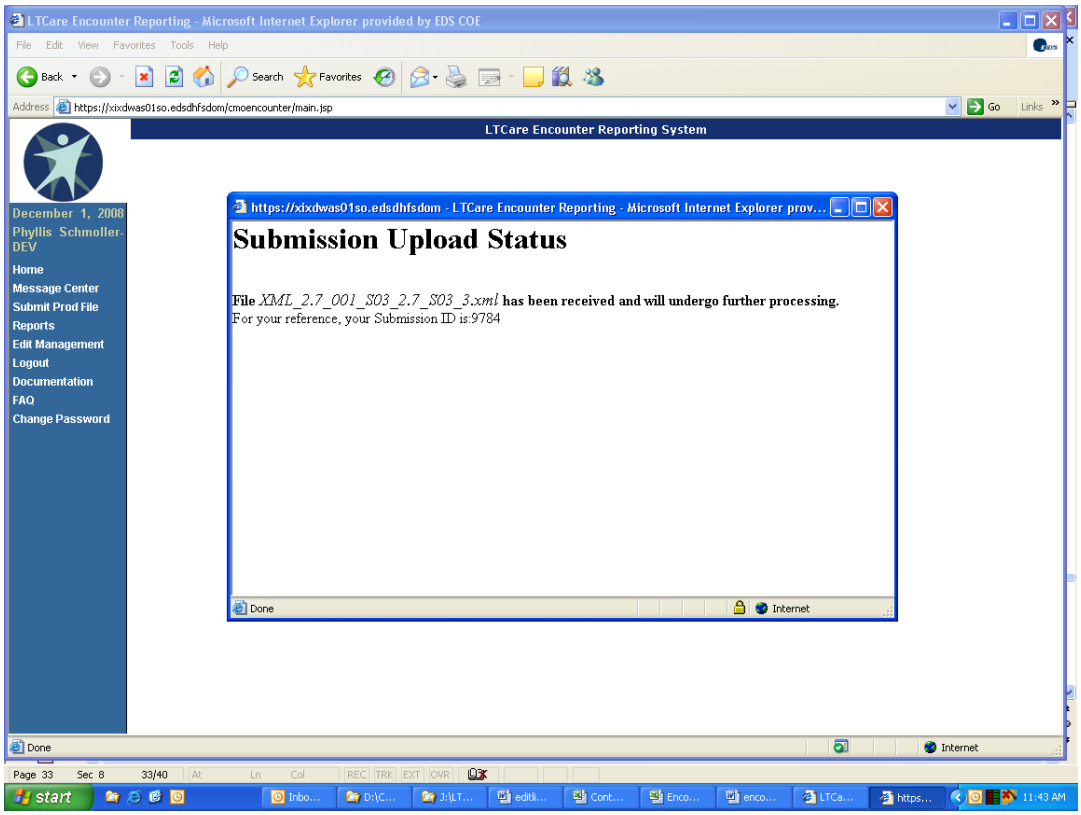

Figure 11. Submission Upload Status

14) To view the submission report:

- Close the window that was opened during the file upload process.
- Select the “Reports” option from the options displayed on the left side of the screen.

The following screen is displayed.

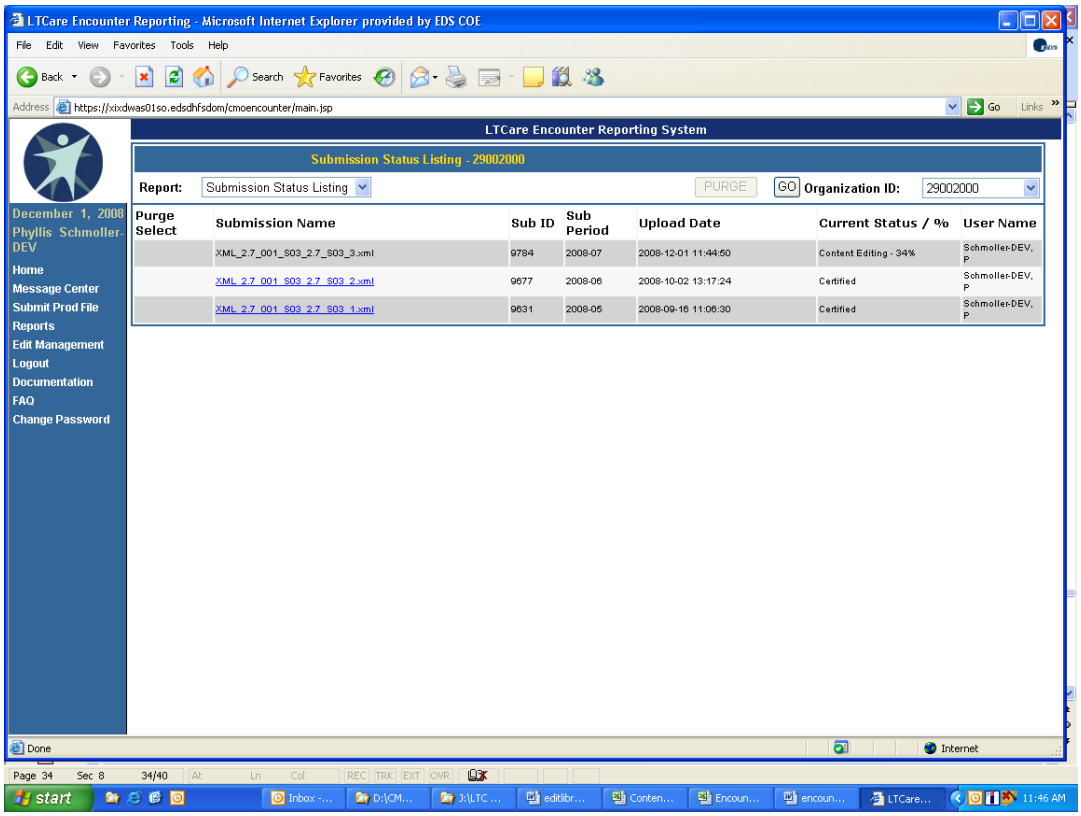

Figure 12. Submission Status Reports Listing

15) To log out:

- Close the window opened during the file upload.
- Select “Logout” from the options listed on the left side of the screen.
- Close the window to the encounter application.

Testing Encounter Submissions with BIS

When an MCO is ready to generate an encounter XML file for processing, they must contact the Bureau of Information Systems (BIS) to schedule a series of test to verify the structure of the file and the quality of the data. BIS leads the MCO through the test process detailed below:

- The MCO submits an XML file for test processing using the Internet submission application.
- BIS reviews the results of the edit verification and provides feedback to the MCO regarding XML construction and/or data issues.
- The MCO makes appropriate changes to their business system or XML extract program as needed, and resubmits the encounter XML file.
- When the submission is processed without serious edit errors, BIS requests the MCO produce a report of summary data from their claims file for the period of the XML extract to assure the accuracy of the file received.
- When the summary report reconciles with the data received in the XML submission, the MCO is ready to submit encounter data on a regular basis.

Final Tie-Out and Data Certification

A series of short reports are required to reconcile the submitted encounter data to the MCO data source. Summary data is all that is required for each of these reports. Each report should include data for all months in the tie-out period, unless otherwise instructed. A description of each of these reports follows.

Claim Status Summary Report

Columns to display include Claim Status, Paid Amount, and Record Count. Summarize the Paid Amount and Record Count by Claim Status.

For example:

Claim Status	Paid Amount	Record Count
D	0	20
P	1,000,000	20,000

Posting Month Summary Report

Columns to display include Posting Month, Paid Amount, and Record Count. Summarize the Paid Amount and Record Count by Posting Month.

For example:

Posting Month	Paid Amount	Record Count
08/02	10,000	900
09/02	20,000	899
10/02	20,000	850
etc.		

Record Type Summary Report

Columns to display include Record Type, Paid amount, and Record Count. Summarize the Paid Amount and Record Count by Record Type.

Record Type	Paid Amount	Record Count
O	10,000	900
CR	20,000	899
CN	20,000	850

Appendices

The following appendices are provided as reference documents for MCOs.

A. Header Record Edits (all programs)

http://dhs.wisconsin.gov/ltcare/encounter/docs/headeredits.pdf

B. FC Encounter Reporting Data Dictionary

http://dhs.wisconsin.gov/ltcare/encounter/docs/datadictionaryviewforfamilycare.pdf

C. FC XML File Layout for Encounter Reporting Data Submissions

http://dhs.wisconsin.gov/ltcare/encounter/docs/xmllayoutforfamilycare.pdf

D. FC Encounter Data Edits of the Detail Records

http://dhs.wisconsin.gov/ltcare/encounter/docs/contenteditsforfamilycare.pdf

E. WPP Encounter Reporting Data Dictionary

http://dhs.wisconsin.gov/ltcare/encounter/docs/datadictionaryviewforwpp.pdf

F. WPP XML File Layout for Encounter Reporting Data Submissions

http://dhs.wisconsin.gov/ltcare/encounter/docs/xmllayoutforwpp.pdf

G. WPP Encounter Data Edits of the Detail Records

http://dhs.wisconsin.gov/ltcare/encounter/docs/contenteditsforwpp.pdf

H. SSI Encounter Reporting Data Dictionary

http://dhs.wisconsin.gov/ltcare/encounter/docs/datadictionaryviewforssi.pdf

I. SSI XML File Layout for Encounter Reporting Data Submissions

http://dhs.wisconsin.gov/ltcare/encounter/docs/xmllayoutforssi.pdf

J. SSI Encounter Data Edits of the Detail Records

http://dhs.wisconsin.gov/ltcare/encounter/docs/contenteditsforssi.pdf

K. MH Encounter Reporting Data Dictionary

http://dhs.wisconsin.gov/ltcare/encounter/docs/datadictionaryviewformh.pdf

L. MH XML File Layout for Encounter Reporting Data Submissions

http://dhs.wisconsin.gov/ltcare/encounter/docs/xmllayoutformh.pdf

M. MH Encounter Data Edits of the Detail Records

http://dhs.wisconsin.gov/ltcare/encounter/docs/contenteditsformh.pdf

N. AODA Encounter Reporting Data Dictionary

http://dhs.wisconsin.gov/ltcare/encounter/docs/datadictionaryviewforaoda.pdf

O. AODA XML File Layout for Encounter Reporting Data Submissions

http://dhs.wisconsin.gov/ltcare/encounter/docs/xmllayoutforaoda.pdf

P. AODA Encounter Data Edits of the Detail Records

http://dhs.wisconsin.gov/ltcare/encounter/docs/contenteditsforaoda.pdf

Q. Edit Library

http://dhs.wisconsin.gov/ltcare/encounter/docs/editlibrary.pdf

R. Transaction Adjustment Scenarios Worksheet

http://dhs.wisconsin.gov/ltcare/encounter/docs/transactionadjustmentscenarios.pdf

S. Answers to Transaction Adjustment Scenarios

http://dhs.wisconsin.gov/ltcare/encounter/docs/answerstoadjustmentscenarios.pdf

T. Data Source Mapping Worksheet

http://dhs.wisconsin.gov/ltcare/encounter/docs/datasourcemappingworksheet.pdf

U. Required Data Elements

http://dhs.wisconsin.gov/ltcare/encounter/docs/requiredfields.pdf

CHANGE LOG

Date	Changes	Changed By	Remarks/Reason
06/30/07	Document is baselined at version 6. From now on, all changes will be implemented into the baseline document, and documented into the change log.	Syed Aziz	One time document baselining.
07/25/07	Update: Table of content, Table of figures, doc format changes: align and resize images.	Ramona Johnson	Documentation updates.
10/02/07	Page 29, item 7 of the implementation guide removed, as well as the screen shot for this instruction.	Ramona Johnson	Documentation updates.
10/12/07	Addition: Document the new user password functionality: New Encounter Password Feature which allows you to change your password.	Ramona Johnson	UID and password login procedure: Uuser management new password functionality.
10/24/2007	Addition: included MH and AODA LOBs in the appendices.	Ramona Johnson	Web page: LOB links/locations.
11/02/07	Addition: Required MCO R&B Statement.	Ramona Johnson	Documentation updates.
06/27/08	Change DHFS to DHS	Sven P. Ahlstrom	Documentation updates.
08/27/08	Page 19 both parent record ids changed to 5. Page 22 the both parent record ids changed to 123	Sven P. Ahlstrom	Documentation updates.
12/01/08	Replaced the screen images with revised ones showing the new logo (pages 26-34).	Phyllis Schmoller	Changes made per Bugzilla 2382.