

State of Connecticut
Encounter Submission and Reporting Guide
Introduction and Encounter Definition — Section 1.1

Introduction

This manual serves as guide for the reporting of encounter data for Connecticut's Medicaid managed care program. Encounter data provides the State with vital information for the management and monitoring of the HUSKY program. Encounter data will be used in conjunction with other information to:

- update and set capitation rates,
- evaluate program effectiveness,
- monitor quality of care,
- monitor utilization levels and patterns,
- monitor access to care, and
- perform other ad hoc analyses as needed.

The vendor data reporting guide outlines for Connecticut's vendors the encounter export process, the data layouts, and any reports that are available. Any questions regarding the guide or information contained within the guide should be directed in writing to Connecticut's Department of Social Services (DSS).

Encounter Definition

Encounters are records of health care services rendered to a Connecticut Medicaid managed care member enrolled in an MCO. Medically related services include, but are not limited to:

- physician visits,
- nursing visits,
- surgical services,
- anesthesia services,
- laboratory tests,
- radiology services,
- durable medical equipment (DME),
- outpatient hospital services,
- dialysis centers,
- inpatient hospital services,
- nursing home services,
- long term care services,
- pharmacy services, or
- dental services.

MCOs must all report all encounters for all covered services, which include the following:

- fee-for-service claims for which the MCO incurred a direct financial liability,
- all covered capitated services,
- all adjustments to previously reported services, and
- covered bundled services where financial liability is met under an accompanying service.

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In general, the services are completed and the provider's claim or encounter fully adjudicated by the MCO prior to submitting the encounter to DSS.

Services that should *not* be submitted are as follows:

- do *not* submit denied claims (regardless of the reason for the denial), and
- do *not* submit pended claims.

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Data Processing Vendor Information — Section 1.2

Encounter Data Vendor Information

DSS contracts with an encounter data vendor to collect, validate, and report encounter data. DSS' agent will be responsible for:

- maintaining the Encounter Submission and Reporting Guide;
- collecting the encounter data from the MCOs, validating the data for quality, completeness, and timeliness of submissions;
- creating and sending encounter data feeds for DSS approved vendors; and
- providing DSS with utilization and program management reports on a regular basis.

DSS Agent for Encounter Data Processing

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Data Submission Process — Section 1.3

Data Submission Guidelines

- Each MCO is responsible for extracting all the necessary data from their respective computer systems and submitting the data to DSS in a timely fashion.
- It is imperative that *all* encounter data for each MCO is submitted and accepted into DSS' encounter system. Therefore, it is important that each MCO develop a timely and consistent process by which the necessary data can be collected and analyzed in an efficient manner.
- Data should be submitted based on the date the claim or encounter was paid/adjudicated. Each subsequent submission should contain dates of payment/adjudication that immediately follow those in the previous submission ensuring that no dates are missed. If both a paid date and adjudication date exists for a claim, the claim should be submitted based on its paid date. Adjudication date should be used only for those claims that are not paid, such as capitated services.
- The data extract should be in the format as described in Section 2.3.
- For any alphanumeric data elements not available, please fill the field with spaces; if numeric, please fill the field with zeroes.

Media

The preferred media for submitting encounter data and receiving error files and other reports is via a secure FTP site. DSS' appointed agent will maintain a secure FTP site for MCOs to submit encounter data for processing.

To maintain the confidentiality and security of the encounter data, uploading encounter data to the secure FTP site will require each MCO to have an MCO specific ID and a password issued by DSS' agent. Additionally, MCO transmission can only take place from a computer with a TCP/IP address pre-registered with DSS' agent.

Each MCO will be required to complete an application form and be certified by DSS' agent as FTP ready. Once a completed application form has been received, the MCO will be provided a login ID, password, and the correct IP address to transmit and receive data files. Once the login ID has been issued, the MCO will be required to successfully transmit a test file prior to being allowed to submit encounter data.

FTP application forms can be requested through the DSS Agent for encounter data processing listed in Section 1.2.

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Other forms of acceptable media for submitting encounter data include:

- CD-ROM,
- Jaz diskette,
- Zip diskette, or
- 3.5” diskette.

Submission Timetables

- In accordance with DSS’ current contract language, each MCO shall provide the Department or its appointed agent with an electronic record of every encounter between a network provider and a member within fifteen (15) days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter.
- The system will be designed to allow the MCOs to submit encounter data daily, if needed. Only one encounter data file may be submitted per day.

Upon receipt of the encounter data, DSS’ appointed agent will process the file and perform edits to determine if the file has been submitted in the proper format and that all necessary information has been provided and is accurate and complete.

Edits/Data Quality Process

Once loaded, an in-depth data quality analysis will be performed on the submitted file. The data quality analysis will take place *prior* to accepting the data. The analysis will involve validating each record against the list of edits described in Section 4. Each record failing an edit will be flagged and subsequently reported to the submitting MCO. If the edit failure is considered critical, the MCO must resubmit a corrected record. Informational edit failures will be reported to the MCO, but a record that fails informational edits only will not need to be resubmitted.

If a record fails five (5) critical edits, no more critical edits will be performed on that record. All valid informational edits will be processed regardless of the number of failures that record experiences.

In general, the edits will be performed in a hierarchical order. Therefore, not all edits will be processed for each record. A particular edit will not be processed if:

- a) the edit is critical and the record has already failed five (5) critical edits; and
- b) based on the results of other edits that have already been run, the edit is deemed redundant.

The hierarchical structure of the edits will indicate that an edit is not needed for several reasons. For example, if a record is tested for the presence of a primary diagnosis and the diagnosis is found to be missing, the edit that tests for the validity of the diagnosis is redundant. Similarly, certain edits on date fields will be skipped if they are not needed. For example, all of the date fields are compared to one another in chronological order. On a “20” Professional/Ambulatory record, the Date of Birth (from the eligibility file) must be the same as or prior to the Beginning Date of Service, which in turn must be equal or prior to Ending Date Of Service and so on. However, since Claim Received Date is not a required field, the edits that will be run will change depending upon the presence of this date. If Claim Received date is present, it will be compared to Claim Paid Date and Ending Date of Service. If it is not present, Ending Date of Service will be compared to Claim Paid Date.

This hierarchy of edits eliminates unnecessary processing and, more importantly, it eliminates the possibility that an unnecessary number of edit failures will be reported back to the MCO.

Error Reports

Records failing critical and informational edits will be reported separately in an “Edit Failure Report.” Each report subtitle will indicate if the errors listed are critical or informational. Please see the sample reports in Section 4.7.

The reports will be distributed to the MCOs after each monthly submission. Each report will include a summary report totaling the number of record failures for each edit as well as the percentage of records affected by the edit failures. The summary report may be useful in identifying specific processes that may be causing a significant number of errors.

The reports will be sent to the contact person listed in each submission’s type “01” record. Therefore, it is imperative that this information is populated consistently.

Replacement Codes

Every submitted record *must* contain a valid replacement code indicating the type of operation to be performed on the record. Valid codes are:

- For records that are submitted for the first time:
 - N** — New record; no modification of existing record applicable

- For *previously accepted records* that require modification:
 - D** — Delete a previously submitted record
 - R** — Replace a previously submitted record
 - C** — Correct (Adjust) a previously submitted record

- For records that have been *rejected* and are being resubmitted:
 - 1** — Replace rejected record
 - 2** — Delete rejected record — erroneous submission
 - 3** — Delete rejected record — recipient ineligible
 - 4** — Delete rejected record — denied service
 - 5** — Delete rejected record — other (please submit a written document explaining the reason for deleting the encounter record)

The following section will describe use of the “D,” “R,” “C,” and “N” replacement codes only. For a detailed explanation of on replacement codes 1-5, see Section 1.6.

(N)ew:

All records submitted for the first time should have a value of “N” in the replacement code field. This is the only type of record that *cannot* contain the claim reference number, or claim reference number/line number combination, if applicable, of a previously submitted record. In the event that a duplicate claim reference number is submitted with an “N” replacement code, the record will be rejected.

(D)eletions:

For records that should be deleted or voided, please submit a record containing a “D” in the replacement code field. The claim reference number on this record should exactly match the claim reference number or claim reference/claim line number combination, if applicable, of the corresponding record that is to be deleted. After processing, both the original and newly submitted record will be deleted from the database. Edits will not be performed on (D)eleation records.

Please note that if a type “10” Inpatient/Hospital Header Record or a type “11” Outpatient/Hospital Record is being deleted, all associated “15” and “16” detail records will automatically also be deleted. It is not necessary to submit a (D)eleation record for the “15” and “16” records.

(R)placements:

A (R)replacement record may also be submitted should a previously submitted and accepted record contain inaccurate information that requires updating. The replacement record should contain a value of “R” in the replacement code field. As with a delete record, the claim reference number or claim reference/claim line number combination, if applicable, should correspond exactly to the existing record that is to be replaced. Once the (R)replacement record has passed the edit process, the original record will be deleted from the database and the (R)replacement record will be added. Therefore, the replacement record must have all fields appropriately populated.

Please note, unlike (D)eleletes, (R)placements are maintained separately for each record type. If a type “10” or type “11” record is being replaced, associated type “15” or “16” detail records will *not* be replaced. If modifications are needed on a type “15” or “16” record, separate replacement records must be submitted for each corresponding detail record.

(C)orrections:

Corrections can be made to the numeric data elements of any previously submitted record without replacing the entire record. Corrections may be either positive or negative. These numeric elements include the following:

- Quantity (Pharmacy only),
- Units of Service,
- Billed Amount,
- Allowed/Contracted Amount,
- COB/TPL/Other Paid Amount,
- Medicare Paid Amount,
- Paid Amount, and
- Days Supply (Pharmacy only).

When a (C)orrection is submitted, no non-numeric data elements within the record will be changed. Should additional elements require correction, please submit a (R)replacement record to completely replace the existing record. As the record is processed, the claim reference number contained on the (C)orrection record will be used to locate the corresponding record in the database. For each data element listed above, the numeric values in the original record will be summed with those in the correction record. The resulting values will then replace the values contained in the original record. Again, no other elements will be updated.

Like (R)replacement Records, if a (C)orrection is made to a “10” or “11” record, a correction must also be made to any affected detail records and vice versa.

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Adjustment Process — Section 1.5**

Submission Examples for Adjustments

The replacement codes have been developed to provide enough flexibility to accommodate the different systems and processes each MCO may have. The codes may be used in several different ways depending upon how the MCO's system processes and stores claim adjustments. The following are some examples of the various ways to correctly utilize the replacement code. Additional scenarios can be provided upon request. Requests can be made in writing to DSS or its appointed agent as identified in Section 1.2.

Scenario 1:

An additional amount has been paid on a previously submitted outpatient hospital record. \$1,000.00 had been paid on claim when it was previously submitted, now an additional \$500.00 has been paid. An abbreviated version of the originally submitted record looked like this:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount
11	N	123	...	000200000	000100000	000100000

Solution 1:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount
11	C	123	...	000000000	000050000	000050000

Submit a (C)orrection record containing the additional paid amount. The numeric fields will be summed. Please note that only the fields that needed to be changed contain values in the (C)orrection record. Billed Amount is unchanged from the original record, therefore, Billed Amount on the (C)orrection record must contain a zero. Below is the resulting record that will remain in the encounter system:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount
11	N	123	...	000200000	000150000	000150000

Solution 2:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount
11	D	123	...			

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount
11	N	126	...	000200000	000150000	000150000

In this scenario, a (D)eleation record is submitted along with a (N)ew record to indicate the adjustment. The original record will be deleted and the second will be processed as a new record, in effect replacing the original.

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Note that the only fields required in the (D)eflete record are Record Type, Replacement Code, and Claim Reference Number/Claim Line Number. For a deletion, the data contained in the other fields is irrelevant.

Solution 3:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount
11	R	123	...	000200000	000150000	000150000

In this scenario, a (R)eplacement record is submitted. This record replaces the previously submitted and accepted new record.

Scenario 2:

The same previously submitted outpatient hospital record presented in the first scenario is negatively adjusted. \$1,000.00 had been paid on claim when it was previously submitted, now \$500.00 of that payment has been recovered due to TPL recovery efforts. An abbreviated version of the originally submitted record looked like this:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	TPL Amount	Paid Amount
11	N	123	...	000200000	000100000	000000000	000100000

Solution 1:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	TPL Amount	Paid Amount
11	C	123	...	000000000	000000000	000050000	-00050000

A (C)orrection record is submitted. The numeric fields will be summed. Please note that only the fields that needed to be changed contained values in the (C)orrection record. Billed Amount and Allowed Amount remained unchanged from the original record, therefore Billed Amount and Allowed amount on the (C)orrection record must contain a zero. Below is the resulting record that will remain in the encounter system:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	TPL Amount	Paid Amount
11	N	123	...	000200000	000100000	000050000	000050000

Solution 2:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	TPL Amount	Paid Amount
11	D	123	...				

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	TPL Amount	Paid Amount
11	N	126	...	000200000	000100000	000050000	000050000

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In this scenario, a (D)eleation record is submitted along with a (N)ew record to indicate the adjustment. The original record will be deleted and the second will be processed as a new record, in effect replacing the original.

Note that the only fields required in the (D)eleate record are Record Type, Replacement Code, and Claim Reference Number. For a deletion, the data contained in the other fields is irrelevant.

Solution 3:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	TPL Amount	Paid Amount
11	R	123	...	000200000	000100000	000050000	000050000

In this scenario, a (R)eplacement record is submitted. This record replaces the previously submitted and accepted new record.

Processing Order for Replacement Codes

The monthly encounter files will be sorted and processed by replacement code. First, all (D)eleation records will be processed, followed by (C)orrections, then (R)eplacements; (N)ew records will be processed last. Therefore, it is very important that modifications to previously submitted records follow an identical order.

For example, if a (R)eplacement record and a (C)orrection record that is intended to correct values in the (R)eplacement occur within a single submitted encounter file, the records will *not* be processed in the correct order. Within the system, the (C)orrection will be processed first, followed by the (R)eplacement. As a result, the incorrect record will be identified as the “final” version, possibly skewing the encounter data.

Please note, however, that such an issue arises only when multiple modifications are made to the same record within one file submission. In the above example, the modifications would have been processed correctly had they been submitted in separate file submissions or by submitting just the (R)eplacement record. Therefore, timely and accurate encounter submissions have a direct impact on the quality and overall reliability of any reporting or information extracted from the encounter data set.

Resubmitting Rejected Records

Records that fail critical edits and are rejected will be sent back to the MCOs for resubmission. The rejected record will be identical to the submitted records except that up to five (5) critical error codes will be included on the record. The records will be returned in the same format in which they were received. A new header and trailer record containing plan information as well as control totals for the rejected records will be generated (see Section 4.6 for the Rejection Error File Layout).

The critical edit failure report described in Section 4.7 can be used to identify the errors experienced for each rejected record. The appropriate fields should be corrected and the record resubmitted within 30 days.

The resubmission of rejected records is critical to ensuring the completeness of the encounter data. All rejected records will be monitored and tracked against future submissions to ensure that they are resubmitted. An electronic copy of each rejected record will be maintained in a separate error log. Rejected records will be monitored for resubmission by comparing subsequently submitted records with appropriate replacement codes to the records in the error log. When a rejected record is resubmitted with corrected information *and* it passes all remaining edits, the new record will be accepted into the system. The error log will be updated to indicate that the rejected record has been successfully resubmitted. Please note, the error log will be monitored to ensure that encounter records are corrected and re-submitted in an accurate and timely manner.

An Aging Report (see Section 4.7 for sample report) will be sent to the MCOs monthly to show:

- number of originally rejected records;
- number of rejected records that have been corrected;
- total percentage of accepted and corrected records per month at 90 days and 120 days; and
- total number of rejected records outstanding.

The status field in the error log will be used to monitor overall completeness of data and resubmission compliance. The date of resubmission field will be used to monitor timely resubmission of rejected records. MCOs will be informed periodically about their resubmission compliance. A report will be compiled from the error log listing all outstanding rejected records.

At the time a record that was previously rejected is resubmitted, the record status and resubmission date will be updated in the error log. The results of these updates differ according to the outcome of the data edits on the resubmitted record as follows:

- When all the critical errors for a record are fixed, the status field will be updated to indicate that the record is clean and the resubmission date will reflect the date that the final corrected record was submitted. It will also be accepted into the encounter system and will no longer appear on error aging reports.

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- If a resubmitted record fails any critical edit the status will continue to indicate that an error is outstanding and the record will continue to age based on the original submission date, not the resubmission date. The record will again be rejected indicating the edits that it continues to fail as well as any additional edits failed.

Replacement Codes for Rejected Records

The replacement code on a record that is resubmitted after having been rejected *must* contain a valid value from the following list:

- 1** — Replace rejected record
- 2** — Delete rejected record — erroneous submission
- 3** — Delete rejected record — recipient was not eligible
- 4** — Delete rejected record — denied service
- 5** — Delete rejected record — other (please submit a written document explaining the reason for deleting the encounter record)

ALL rejected records must be resubmitted using one of the above codes. Do *not* use these codes on (N)ew records or on records intended to modify records that have already been accepted into the Connecticut Encounter System.

ReSubmission Examples

Scenario 1:

An outpatient hospital record was rejected because the Payment Indicator indicated an FFS claim and the Paid Amount was 0. An abbreviated version of the originally submitted record looked like this:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount	Payment Type
11	N	123	...	000200000	000100000	000000000	2

Solution 1:

If the encounter was for a capitated service rather than an FFS claim then the encounter should be resubmitted with a replacement code of “1” and the payment type should be corrected.

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount	Payment Type
11	1	123	...	000200000	000100000	000000000	1

Submit a corrected encounter record with the correct payment type indicating that the record was for a capitated service. The error log will be updated to reflect that the rejected record has been corrected. The clean record will now be accepted into the encounter system.

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Please note: If the Billed Amount had been incorrect, the same solution could be used except that the Billed Amount would have been changed to reflect the correct value.

Solution 2:

If the Payment Type or the Paid Amount was incorrect and the MCO's system created a delete record and then a new replacement record, the following solution should be used:

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount	Payment Type
11	2	123	...				

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount	Payment Type
11	N	345	...	000200000	000100000	000000000	1

In this scenario, a deletion record with a replacement code indicating erroneous submission should be submitted along with a new record. The error log will be updated to reflect that the rejected record has been corrected. The clean record will now be accepted into the encounter system.

Note that the only fields required for records with replacement codes of "2," "3," "4," and "5" are Record Type, Replacement Code, and Claim Reference Number/Claim Line Number. For a deletion, the data contained in the other fields is irrelevant.

Solution 3:

If the encounter was for a denied service and erroneously submitted, the encounter should be resubmitted with a replacement code of "4."

Rec. Type	Replace Code	Claim Ref #	...	Billed Amount	Allowed Amount	Paid Amount	Payment Type
11	4	123	...	000200000	000100000	000000000	2

The error log will be updated to reflect that the rejected record was submitted in error and that the service was denied by the MCO.

Please note: If the record was submitted erroneously for reasons other than ineligible member or denied service, a replacement code of "5" should be used and the MCO should submit an explanation in writing to DSS and its appointed agent as to the reason for the erroneous submission. The error log will not reflect that the error has been resolved until written documentation has been received and reviewed.

Non-Aging Critical Errors

The following edits do not age and consequently are not retained in our error logs:

Presence Edits

- PRS012-Claim Reference Number is null
- PRS045-Claim Line Number is null

Logic Edits

- LOG042-Replacement Code = 'D', 'R', or 'C' and no original record was found in the encounter system
- LOG043-Replacement Code = 'N' and duplicate claim number found in the encounter system or error log
- LOG045-Replacement Code = 'N' and claim with duplicate key fields found in the encounter system or error log
- LOG046-Replacement Code = 'N', 'R', 'C' or '1' and duplicate claim number exists with the same Replacement Code in the submitted file
- LOG049-Replacement Code = '1', '2', '3', '4', or '5' and no original record was found in the error log
- LOG052-Header rejected for critical error
- LOG054-All details rejected for critical error
- LOG066-Claim with duplicate key fields found in submitted file

Since encounters that fail these edits are records that may have been submitted erroneously, the MCOs are not required to resubmit these encounters. However, if the MCO chooses to resubmit these rejections, the encounter should be resubmitted with the original replacement code and not with the error correction replacement codes of 1, 2, 3, 4, or 5. Encounters submitted with replacement codes of 1, 2, 3, 4, or 5 are compared to the error log to see if there is a match. Since the above errors are not retained in the error log, a match would not be found, and the resubmission would be rejected with an error code of LOG049.

Provider Validation

In order to ensure that the encounter data contains accurate and complete provider data, the following methodology for transmitting provider information via the encounter data will be used.

Whenever available, the MCOs should submit the National Provider ID number (NPI). DSS recognizes that the NPI may not always be available and will accept Medicaid IDs or Tax ID numbers until an NPI becomes available.

- MCOs will provide DSS's agent with a provider file in accordance with the provider file layout in Section 2.4.

The provider ID numbers must be no more than 10 digits in length.

- DSS' agent will create and maintain a Master Provider File containing all possible provider ID numbers based upon information obtained from the MCO-supplied provider files and the EDS Provider Master File.
- This provider database will be used to verify the provider information submitted in the encounter data.

Provider Edits:

Provider edits will be done on two levels:

1. Critical Edits:
 - A. Is the provider on the master provider file? Encounter data that fails this edit must be resubmitted to the agent with a provider ID number that is contained on the Master Provider File. Encounters received without a valid provider ID number (i.e., not found in the Master Provider File) will be returned to the submitting MCO as a critical error.
 - B. Address field must be populated.
 - C. Last name must be populated. First and last name fields cannot contain special characters.
2. Informational Edits:
 - A. Is the ID a NPI number? Since the NPI is the preferred provider ID number, an additional informational edit has been added indicating whether the submitted provider ID number is the NPI.
 - B. Provider taxonomy must be populated. DSS requires that the provider taxonomy must be populated with the correct taxonomy 100% of the time. This cannot include "other" or "unknown".

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Updating the Provider Files:

It is the MCO's responsibility to provide updates to the Master Provider File. The MCOs can send the designated agent complete provider files on a regular basis, or new providers can be submitted to the designated agent as needed. Recall that if a valid provider ID number is not in the Master Provider File, the encounter will be rejected.

MCOs should submit the updated provider information to the designated project manager or point of contact as identified in Section 1.2. If provider updates are submitted along with the monthly encounter submission, the provider data should be placed in a file separate from the other encounter data.

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New Subcontractor Process — Section 1.8

New Subcontractor Process

In order to ensure that new subcontractors understand and comply with the encounter data submission process, the following procedures should be followed:

- Upon approval of the subcontractor contract by DSS, the MCO must notify DSS' agent of the new subcontractor name and effective date of the contract.
- The MCO must supply the new subcontractor with a copy of the Encounter Submission and Reporting Guide.
- It is recommended that the MCO schedule a conference call with the new subcontractor and DSS' agent to discuss the various processes (e.g., error resubmission) prior to the submission of a test file.
- Within the first 30 days following the effective date of the contract, the subcontractor must submit a test file to DSS' agent.
- The month following the submission of the test file (within 60 days of the effective date of the contract) the subcontractor will begin submitting monthly encounter submission files.
- The monthly encounter submission file sent to the MCOs by the subcontractor must be reviewed by the MCO prior to submission to DSS' agent. This is to ensure that the submitted file is in the correct format and to avoid processing delays.

This process is intended to ensure that new subcontractors submit encounter data timely and accurately.

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MCO's are required to complete and submit a data certification form with the submission of every encounter file (this includes correction files). DSS has implemented this process in response to a new government mandate regarding certification of data (42 CFR Sections 438.604 and 438.608) when reimbursements to an MCO are based on data submitted for these payments.

Effective August 13, 2003 all encounter data submitted to Mercer must be accompanied by the Data Certification Form. Submissions received by Mercer without this certification will not be processed until certification is received. DSS will only accept certification from the MCO and not from individual subcontractors. The certification should accompany the encounter data submission, or it can be faxed to 602 957 9573 Attn: Cindy Rodgers, or submitted electronically.