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Description	The ***Process Encounter*** business process receives original or adjusted encounter (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction and determines its submission status, and based on that: • Performs Encounter Edits: o Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction. o Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding. • Performs Encounter Audits: o Verify against historical information. o Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity. • Suspends encounter that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules. o Apply National Correct Coding Initiative (NCCI) Edits. o Apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate. o Prices Encounters: ✓ Calculate state allowed amount. ✓ Calculate paid amount. ✓ Set paid amount to zero dollars. **NOTE:** All encounters will go through most of the business process steps but with different business rules associated with the different encounter claim types. Both Centers for Medicare & Medicaid Services (CMS) and state policy determine business rules for encounter edits, audits, and pricing methodologies. State business rules define whether an encounter goes to a to-be-paid status, suspends, flags for information, or denies. State business rules define whether an edit is fatal or non-fatal as well. *See Constraints*. **NOTE:** An adjustment to an encounter is on an exception use case to this business process that follows the same process path except it requires a link to the previously submitted processed encounter in order to reverse the original encounter and associate the original and replacement encounter in the calculation information. **NOTE:** This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Financial Report*** business processes.
Trigger Event	Interaction-based Trigger Events:

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	• Receive encounter via Accredited Standards Committee (ASC) X12 837 Health Care Claim encounter transactions. • Receive Retail Pharmacy Encounter Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events: • Periodic timetable (e.g., daily, weekly) is due for adjudication and payment cycles.
Result	• The State Medicaid Agency (SMA) adjudicates an encounter. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Prepare Provider Payment*** business process for capitation payment. • If applicable, alert sent to ***Generate Financial Report*** business process with payment and/or error report information. • If applicable, alert sent to send to ***Manage TPL Recovery*** business process for third-party insurance. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	**1. START:** Receive encounter submission or encounter adjustment information. **2.** Perform Fatal Edits: **a.** If electronic encounter submission, perform ASC X12N edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement. **i.** If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. **b.** Validate that encounter submission meets filing deadlines based on service dates.

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	c. If applicable, reject encounter for electronic fatal validation errors and send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops. **3.** Perform Non-Fatal Edits: **a.** Determine encounter status as initial, adjustment to a processed encounter, or a duplicate submission that is already in the adjudication process but not yet completed and loaded into encounter payment history (using a unique Patient Account Number). **i.** If applicable, associate encounter adjustment to original encounter submission. **b.** Validate provider information (e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service). **c.** Validate member information (e.g., demographics, eligibility status on the date of service). **d.** Validate the SMA covers service in member's health benefit and apply appropriate rules. For example: **i.** Adult member benefit package does not cover dental services so deny the encounter. **e.** Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status. **f.** If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. **g.** If state defined business rules identify certain edits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops. **4.** Perform Audits: **a.** Check encounter history for duplicate processed encounter using search key information such as in-house encounter number, date of service, provider and member demographics, service, and diagnosis codes. **b.** If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history. **c.** Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols. **d.** Perform Prospective Payment Integrity Check. **e.** If state defined business rules identify certain audits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to ***Generate Financial Report*** business process with error report information.

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	END: Business process stops. **5.** Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes). **6.** If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules. **7.** Perform Pricing (Shadow-Pricing): **a.** Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC). **b.** Calculates to-be-paid amount by deducting: **i.** Contributions provided by Member. **ii.** Provider advances, liens, and recoupments. **8.** Send alert to ***Prepare Provider Payment*** business process for payment. **9.** **END:** Send alert to ***Generate Financial Report*** business process with payment information. <u>Alternate Path: Suspended Encounter</u> **1.** **START:** Provider submits corrected information in response to an error notification. **2.** Process it as if it is an original encounter. **a.** Go to step 2 of the ***Process Encounter*** business process. **3.** **END:** Business process stops.
Shared Data	EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through 7 encounter data store including payment, in-house encounter number, and Patient Account Number information Provider data store including performing prospective program Integrity (e.g., HIPDB) and Medicare/Medicaid sanctions information, provider network, and contract information Member data store including demographics, eligibility, enrollment, and member-specific pricing Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information Authorization data store including authorization and treatment plan information

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	Rate setting data store including applicable rates Encounter data store including adjudication and encounter payment history information Financial data store including accounts receivable and accounts payable information
Predecessor	**Receive Inbound Transaction** ***Submit Electronic Attachment***
Successor	**Send Outbound Transaction** ***Calculate Spend-down Amount*** ***Generate Financial Report*** ***Submit Electronic Attachment*** ***Manage Data***
Constraints	All encounter claim types will go through most of the steps within the ***Process Encounter*** business process main flow with some variance of business rules and information. Types of counter variances include: Institutional, Professional, Dental, Pharmacy, and Waiver encounters; Medicare Crossover and Medicare Part D pharmacy encounters; and Coordination of Benefits (COB) encounters received from payers secondary to Medicaid (e.g., for IHS eligibles). The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by encounter claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to an encounter follows the same business process path except that it requires a link to the previously submitted and processed encounter in order to reverse the original encounter and associate the original to the adjustment.
Failures	The ***Process Encounter*** business process contains a series of potential points of failure. The encounter could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the encounter. Fatal Edit Failures: Encounter information has fatal edit error. For example: • Encounter submitted without all the required information. • Encounter submitted after encounter filing deadline. Other Edit Failures: Encounter information has other errors. For example: • The SMA does not cover the service because it is not in the health benefit, or is not in an approved facility or performed by an approved provider type. • Service is not appropriate based on member demographics.

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Performance Measures	• Time to complete ***Process Encounter*** business process: e.g., Real Time response = within __ seconds, Batch Response = within __ hour • Accuracy with which edits, audits, and pricing algorithms are applied and to-be-paid and paid amount is calculated = ___% • Consistency of decisions on suspended encounters = ___% • Error rate = __% or less