Integrated Healthcare ASSOCIATION

HICE health industry collaboration effort

Recommended Actions to Trace Errors to their Sources

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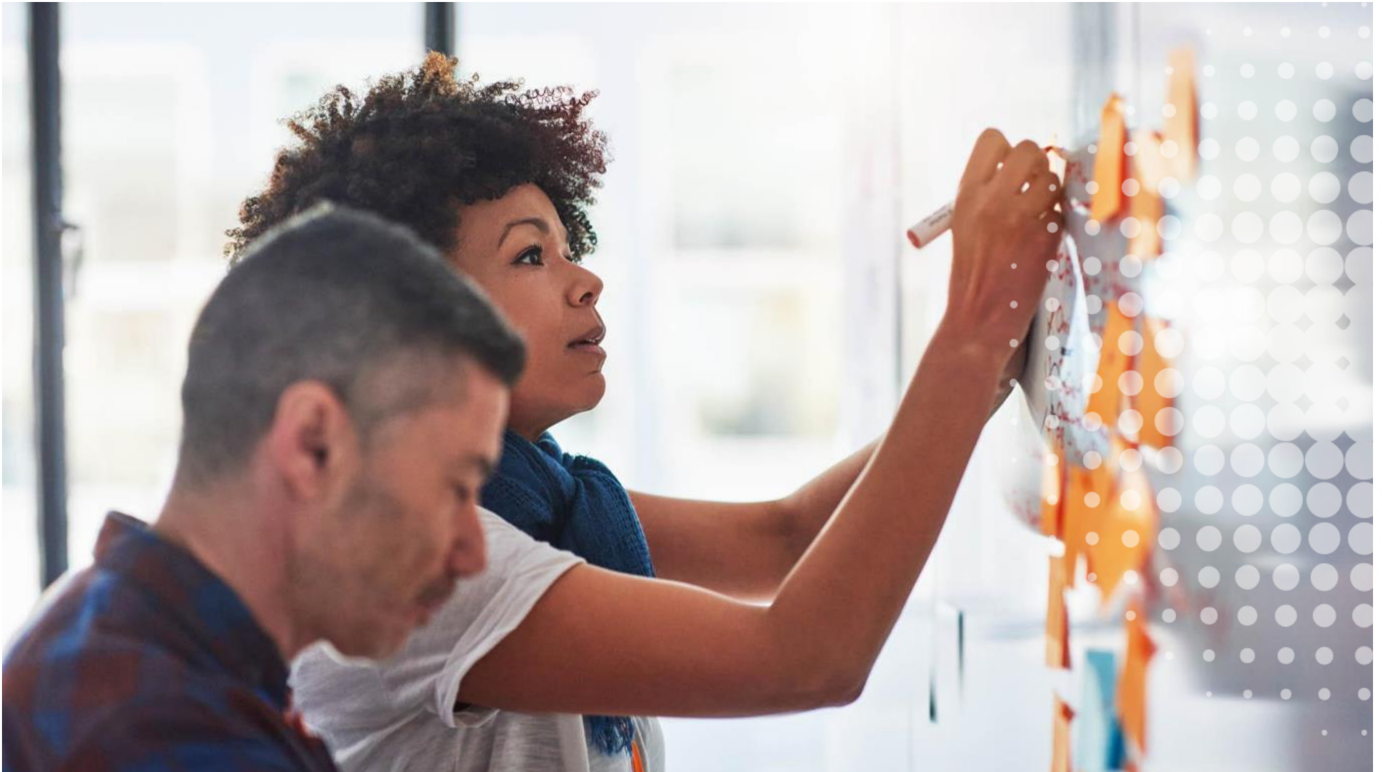


IHA.org/Encounter-Data-Resources

Table of contents

Executive summary 2

Summary of recommendations for health plans 3

Summary of recommendations for encounter data submitters 3

Overview 3

Definitions 4

Issue Background 4

Problem Statement 5

Root Cause Statement 5

Recommended Future State 5

Recommended actions 5

Implement a standard identifier (“trace ID”) 6

Additional considerations 9

Program Background 10

Executive summary

The original encounter ID is a critical component for tracing encounters across the submission pathway. When the receiving party's claims processing system assigns or changes the original encounter ID, that change creates friction for the original submitter as they may no longer be able to identify the encounter using their previously assigned encounter ID.

Recipients' systems may transform the original encounter identifier to align with their internal tracking requirements. The recipients' processing systems may change the format, add a prefix, or remove the original provider-assigned encounter ID altogether. Further, these changes may not be tracked, stored, and communicated back to the submitter in a standard way within the response files. Should an error in the encounter need to be addressed by the original submitter, there is no consistent way to identify the original encounter accurately and easily. Addressing the error, therefore, becomes a manual, time-consuming, and tedious process.

IHA recommends implementing a standard identifier ("trace ID") that contains key identifier information from the submitter and the recipient of the submitted encounter and can then be tracked by the original submitter.

The recommended action outlined below illustrates a process that can be used by California regulators, health plans, and submitters to accurately trace back to the original encounter identifier.

Summary of recommendations for health plans

- To enable original submitters to implement a trace ID, health plans should assign every encounter a unique internal encounter ID that is communicated in the prescribed standard fields within the response file which is sent back to the original submitter.
- For encounters submitted to the Department of Health Care Services (DHCS), health plans should append their plan-assigned ID with the DHCS-assigned ID found in the response file to be able to track down the specific encounter if it needs to be corrected.

Summary of recommendations for encounter data submitters

- To create a trace ID, submitters should create an encounter ID, per usual, and append it with the recipient plan-assigned ID as reported in the response file.

Overview

Definitions

File types: The files listed below are the commonly exchanged encounter and response file types used to transmit key encounter data between trading partners:

- **X222 and X223 Health Care Claim (Professional (837P) and Institutional (837I)), v5010:** The standard format used by professional and institutional providers to transmit healthcare claims and encounters electronically to healthcare payers, either directly or via intermediary billing services and claims clearinghouses.
- **X214 Health Care Claim Acknowledgment (277), v5010**: The ASC X12 277CA acknowledges the validity and acceptability of the claims at the pre-processing stage. This validation process is used by, but not limited to, clearinghouses and payers to determine whether to introduce them to their adjudication system. The pre-adjudication process enables providers to correct and resubmit claims that are incorrectly formatted or missing information.
- **X231 Implementation Acknowledgment for Heath Care Insurance (999), v5010:** The ASC X12 999 is the electronic acknowledgment of a claim or batch of claims. It's intended to report the syntactical errors against a functional group based on an X12 Implementation Guideline, or the acknowledgment of receipt of an error-free transaction set. Syntactical errors refer to WEDI SNIP types one and two.
- **Encounter Validation Response (EVR) Extensible Markup Language (XML) files** (DHCS APL 14-019): The response files will provide details on whether a file was accepted or rejected and whether an encounter data record was accepted or denied. If errors were found in the encounter data files submitted, it will result in a rejected file and/or denied encounter data record.

Plan: Plan refers to the Medi-Cal Managed Care Health Plans (MCPs)s that submit data to DHCS. Plans are both recipients of encounter data (from submitters) and submitters of encounter data to regulators (DHCS), but are not referred to as submitters in this document. (see definition for "submitter"). When referring to plans in this document, it may refer to inbound teams (teams that receive encounter data from MCPs) or outbound teams (teams that send MCP encounter data to the regulator).

Regulator: In this document, regulator refers to DHCS, which receives encounter data from Medi-Cal MCPs.

Submitter: In all cases, submitter refers to the individual(s) generating and submitting an encounter for adjudication, i.e., the submitting provider.

Issue Background

An encounter is generated by a provider and contains key visit details for a beneficiary, including services rendered and provider and patient information, within an 837 Health Care Claim file. The encounter then moves along the submission pathway, transmitting its transaction details to a health plan or regulator for adjudication.

Providers assign a unique identifier – the encounter ID – to each encounter they create, which is used to reference the specific patient transaction. When the encounter is ingested by the recipient, the recipient's claims processing system will assign a new unique identifier used to track encounters within their systems.

Problem Statement

It is difficult for encounter data submitters to track down encounters that need to be corrected if the submitter cannot locate the original encounter using the encounter ID. Being unable to correct and resubmit encounters leads to an inadequate capture of services rendered by the submitting provider and an incomplete picture of the submitter's patient population.

Root Cause Statement

At each point of ingestion, an encounter can be denied or rejected due to errors within the file, such as missing or incorrect information, and sent back to the submitter for correction. A recipient's claims system may change the format of the encounter ID to fit their system requirements. For example, it may add a prefix or suffix, remove the original encounter ID, or potentially replace it with an entirely new ID. When an encounter ID is amended or removed by the recipient's claims processing system, and changes are not appropriately communicated back to the submitter, it is difficult for the original submitter to trace the rejected encounter back to its original unique identifier. Thus, should the submitter need to address an error in the encounter, there is no consistent way for the submitter to identify the original encounter accurately and easily. Tracing the error to the appropriate original encounter becomes a manual, time-consuming, and tedious process.

Recommended Future State

Submitters implement and maintain a standard identifier ("trace ID") that tracks encounters across the submission pathway. Recipients should adhere to standardized processes to keep the trace ID intact.

Recommended actions

Implement a standard identifier ("trace ID")

Submitters should be responsible for creating and maintaining trace IDs once they have the submission confirmation details from their encounter data recipients' response files. Trace IDs should contain key identifier information from both the sender and recipient of the submitted encounter, built out as follows: The submitter creates an encounter ID, uses the health plan or DHCS assigned ID, and then appends the original ID with their recipient's assigned ID. **Figure 1** illustrates the proposed process flow for applying a trace ID between a submitter (provider) and their recipient (MCP).

Figure 1. Process flow for applying a trace ID

Encounter Data: Tracing Errors to their sources

Provider Organization (PO)

837 file: CLM01 = PO1

Create claim or encounter in 837 file. Enter the PO-generated **encounter ID** into the **CLM01** field

Use Clearing House?

Send corrected claim/encounter

Create a Trace ID. Trace IDs are only required for 277 files since 999 files require the entire segment to be resent.

Trace ID:
TRN*2 : REF*1K
PO1 : HP1

*277 file: TRN*2 = PO1*
*277 file: REF*D9 = n/a*
*277 file: REF*1K = HP1*
OR
*999 file: CTX*CLM01 = PO1*

Yes

*277 file: TRN*2 = PO1*
*277 file: REF*D9 = CH1*
*277 file: REF*1K = null*
OR
*999 file: CTX*CLM01=PO1*

Clearing House (CH)

No

Process 837 Batch

Errors?

Yes

Send response files

No

*837 file: REF*D9 = CH1*

*277 file: TRN*2=PO1*
*277 file: REF*D9=CH1*
*277 file: REF*1K=HP1*
OR
*999 file: CTX*CLM01=PO1*

837 file: CLM01 = xx-PO1

Optional: Modifications requested by health plan: prefix added to PO ID in CLM01 field

Update as needed then pass back to provider

Payor/Plan (HP)

*837 file: REF*F8 = HP1 (only for void or replacement claims)*
*837 file: REF*D9 = CH1*

Process 837 Batch

Errors?

Yes

Send response files

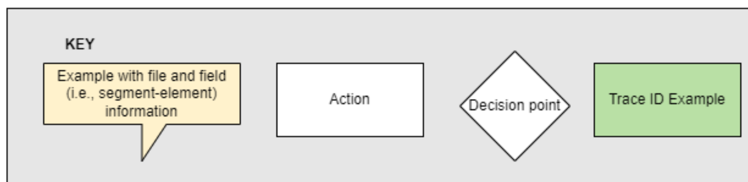
Did PO use clearing house?

Yes

No

No

File moves to next intended recipient



Stakeholder-specific recommendations

Follow the procedures below to enable the use of a trace ID.

Submitters should be responsible for creating and assigning the encounter ID to the CLM01 field of the 837 file. When the encounter is submitted to the next recipient (e.g., a health plan), the submitter should receive a response file from the plan with the plan-specified encounter ID (plan ID). The submitter should then append the encounter ID with the plan ID to create the trace ID (PO1 : HP1). To illustrate, refer to figure 1 (process flow for applying a trace ID).

Clearinghouses are an optional intermediary step between submitters and recipients. Clearinghouses should maintain the original encounter ID generated by the submitter and documented in the CLM01 field (i.e., clearinghouses should not amend the encounter ID in the CLM01 field).

To help with internal tracking, a clearinghouse can assign an internal ID in the REF*D9 field of the 837 file. This clearinghouse internal ID does not need to be tracked by the submitter as it does not interfere with the original submitter-generated encounter ID recorded in the CLM01 field. Once the encounter is considered error-free by the clearinghouse, the clearinghouse should then forward the encounter to the health plan recipient.

- To illustrate, refer to figure 1:
  - **If an error is found**: the clearinghouse will send a response file (e.g., 277 or 999 files) back to the submitter for correction and resubmission. The submitter does not need to create a trace ID at this point since the original encounter ID and clearinghouse ID have not been changed.
  - **If no errors are found**: the clearinghouse will send the 837 file to the health plan recipient.

Plans should refer to the following for their inbound and outbound processes:

- **Inbound to the health plan**: When a plan is the recipient of an encounter, it should assign a unique internal encounter ID ("plan ID") to the encounter. The plan ID should be listed in the prescribed standard field, as outlined in table 1 below, and communicated back to the submitter via the response file.
  - To illustrate, refer to figure 1:
    - **If an error is found**: the health plan sends a response file back directly to the submitter or the clearinghouse used by the submitter for correction and resubmission.
    - **If no errors are found:** the health plan will send the 837 file directly to the regulator or a clearinghouse, if used.
- **Outbound to the regulator:** When a health plan sends an encounter to a regulator, the plan should receive a response file from the regulator with the regulator-specified encounter ID ("DHCS ID"). The plan should then append the encounter's plan ID with the DHCS ID to create the trace ID.

Regulators should assign a unique internal encounter ID ("DHCS ID") once they ingest and process an encounter. The DHCS ID should be recorded and communicated to the health plan via a DHCS response file.

Table 1 identifies the standard fields where encounter IDs should be stored in different file types. Submitters, clearinghouses, plans, and regulators should confirm where the encounter IDs are stored in the files they exchange if they are using fields different than the ones listed below. They should also consider utilizing the designated fields to align with X12 standards.

Table 1. Field information by file type as referenced in figure 1

Field	Loop Information	Definition	File type		
			X222/X223 837	X214 277	X231 999
CLM01	2300 – Claim Information	Claim Information – Claim Submitter's Identifier	X		
REF*F8	2300 – Claim Information	Payer Claim Control Number – Original Reference Number	X		
REF*D9	2300 – Claim Information	Claim Identifier for Transmission Intermediaries – Claim Number	X		
	2200D – Claim Status Tracking Number			X	
TRN*02	2200D – Claim Status Tracking Number	Claim Status Tracking Number – Reference Transaction Trace Number		X	
REF*1K	2200D – Claim Status Tracking Number	Payer Claim Control Number – Payor's Claim Number		X	
CTX*CLM01	2100 – AK2/IK3 – Error Identification	Business Unit Identifier – Context name: 837 Business Unit Identifier			X

Alternative to the recommendation: Creating a crosswalk

If trading partners (PO and health plan or health plan and regulator) don't use a standard identifier convention, they should work together to confirm a crosswalk matching the original submitter ID and the recipient ID. The crosswalk can be created using key fields that both parties agree to.

Additional considerations

Improve standardizations at every exchange point*.

Once an encounter is submitted, health plans should provide response files back to their submitters that indicate encounter submission status. These response files will also include key encounter identifier information that submitters can use to identify and trace the original encounter ID back to any errors.

**Please note this recommendation is also included in the recommended actions for reducing duplicate encounters. Details are available on the IHA Resource Hub.*

Analyze internal processes and set expectations

Organizations should perform internal assessments to understand their claims and encounters processing systems, what their process flows are, what files are expected from which trading partners, and identify where the gaps are. Once organizations understand what the expectations are, they can identify who they need to reach out to and what information is needed from them.

From there, organizations can develop and distribute educational materials for internal use to support ingestion, file review, and outreach opportunities. Some examples of educational materials are:

- Clearly outlined process flow charts that describe the transmission of encounter data within their organizations
- A checklist for reviewing response files and the standard fields needed for encounter identifiers
- Information needed from trading partners

Utilize a tool to help automate the reconciliation process.

Submitters may consider developing or adopting tools that can automate the review of encounter IDs. There are systems available that can automate matching an encounter to its corresponding response file to efficiently address any errors. Recommended functions are the ability to automate ingestion of various response files, review open encounters, or directly rework encounter files.

Program Background

As part of Health Net's Encounter Data Improvement Program, IHA serves as the Encounter Data Governance Entity (EDGE) and coordinates encounter data improvement efforts across California.

Within IHA's multi-pronged approach to move the needle on encounter data, it has established a Data Standards Implementation workstream to work directly with stakeholders to develop recommended actions. These actions are intended to improve encounter data quality across six priority areas identified during the 2020 Health Net Manatt Encounter Data Summit.

Encounter Data Priority Areas:

1. Duplicate encounters
2. Tracing errors to their sources
3. Newborn identification
4. Communicating rejections and remediation
5. Visit-encounter reconciliation
6. Use of local codes

Participants of the Data Standardization Workshop at the 2020 Encounter Data Summit identified tracing errors to their sources as a prevalent encounter challenge. When an encounter moves across the submission pathway, leading to multiple points of ingestion, it can be denied or rejected due to errors within the file and sent back to the submitter for correction. This editing process affects plan and provider organizations across all lines of business and is a time-consuming and tedious process. Timely correction and resubmission directly impact encounter data throughput to DHCS.

To create these recommended actions,, the Data Standards Implementation (DS) Workstream partnered with the Health Industry Collaboration Effort (HICE) and its Encounters Standardization Team (HICE Encounters Team). The HICE Encounters Team is a voluntary group that meets weekly to review, problem-solve, and analyze encounter data issues to improve processes across the industry. To fully understand the scope of the issue, members of the HICE Encounters Team shared their processes for tracing encounters and joined a two-part workgroup session to hone in on the information needed to trace encounters back. The goal was to use a standard identifier to track encounters, which would ultimately help reduce administrative burden, decrease the time between trading partners, and lead to an easier or more automated reconciliation process for all parties. DS and the HICE Encounters Team then finalized the recommended actions and illustrated the submission process between provider organizations and health plans.