



<b>Policy and Procedure No: MC IT 2.5</b>		<b>Revision No: 5</b>
<b>Division: Care Management</b>		
<b>Department: IT Data Management</b>		
<b>Title: PHC-CA Encounter Data Submissions for Care Management</b>		
<b>Effective Date: 4/1/2015</b>		
<b>Supersedes Policy No: 96002, MC IT 2.0, MC IT 2.1, MC IT 2.2, MC IT 2.3, MC IT 2.4</b>		
<b>Reviewed/Revised by: Xing Liu</b>		<b>Review/Revision Date: 12/1/2025</b>
<b>Approving Committee: Compliance Committee</b>		<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>		

**Purpose:**

To describe the way in which PHC California (the Health Plan) submits encounter data to the Department of Health Care Services (DHCS) or its designee.

**Policy:**

1. The Health Plan shall maintain a Management Information System (MIS) that collects and reports claims and encounter data to DHCS in compliance with 42 CFR 438.242.
2. The Health Plan shall submit encounter data to DHCS in a complete, accurate, reasonable and timely manner for all items and services furnished to enrollees under its contract with DHCS.
3. The Health Plan shall submit encounter data monthly in the form and manner specified in DHCS' All Plan Letter (APL) 14-019, the terms of the Health Plan's Full-Risk contract, as well as guidance provided by existing policy and APLs.
4. The Health Plan shall submit complete, accurate, reasonable, and timely encounter data to DHCS within six (6) business days of the end of each month following the month of payment, or as otherwise agreed upon by DHCS, and in the format specified by DHCS.
5. The Health Plan shall ensure all encounter data is submitted to DHCS within two (2) months of adjudication of fee-for-service (FFS) claims or receipt of capitated encounters. The Health Plan shall require that providers submit claims to the Health Plan no later than twelve (12) months from the date of service.
6. The Health Plan shall ensure the completeness, accuracy, reasonability, and timeliness of all subcontractor encounter data regardless of whether subcontractor is reimbursed on a fee-for-service (FFS) or capitated basis.
7. In the event DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of the Health Plan's encounter data, the Health Plan shall resubmit corrected data within 15 calendar days of the date of DHCS' written request. In the event DHCS issues a Corrective Action Plan (CAP), the Health Plan shall comply with all requirements of the CAP.
8. The Health Plan shall review quarterly encounter data report cards produced by DHCS (Quality Measures for Encounter Data) as described in DHCS APL 14-020 and address any issues accordingly. DHCS metrics include:

- a. DHCS must receive all data regarding an encounter, including replacements and voids, in a timely manner measured from dates of service (DOS).
  - i. 60% must be received by the agency within ninety (90) days of last DOS,
  - ii. 80% within one-hundred and eighty (180) days of last DOS, and
  - iii. 95% within three-hundred and sixty-five (365) days of last DOS.
- b. No more than 5% of encounters submitted may be denied.
  - i. 50% of denials must be resolved within fifteen (15) days of notification by DHCS,
  - ii. 80% within thirty (30) days, and
  - iii. 95% with sixty (60) days.
- c. Grading for institutional, professional, and pharmacy encounters is separate. The Health Plan is required to achieve passing grades for each claim type.

**Procedure:**

1. The Associate Director of Electronic Data Interchange (EDI) and Data Analytics or designee extracts encounter data from the Health Plan's MIS, including FFS and capitated encounters. Files are created in HIPAA 5010 X12 for 837 Professional and 837 Institutional encounter data, based on data requirements defined in DHCS' APL 14-019.
2. The Associate Director of EDI and Data Analytics or designee validates the files' encounter data against agency requirements laid out in the most recent Medi-Cal Managed Care (MMC) Companion Guides published by DHCS. Claims with known issues and denied claims data are flagged for review by the Claims Department. The Associate Director of EDI and Data Analytics or designee also utilizes the DHCS Test Environment to further validate encounter data when possible.
3. The Associate Director of EDI and Data Analytics or designee shall, when information that services are rendered by a physician's assistant or nurse practitioner is received, shall submit rendering provider information in accordance with instructions contained in Medi-Cal Billing Manual for Non-Physician Medical Practitioners and MMC 837P Companion Guide. This includes usage of modifiers U7 for services rendered by Physician's Assistants, SA for Nurse Practitioners, and 99 for multiple modifiers.
4. The Associate Director of EDI and Data Analytics or designee submits the Professional Medical files to the Post-Adjudicated Claims and Encounters System (PACES) biweekly. Institutional Medical Encounters are submitted weekly.
5. The Associate Director of EDI and Data Analytics or Designee generates 837P Professional Encounters for Enhanced Care Management (ECM) and Community Supports providers utilizing notes and invoices if the provider does not submit electronic claims.
6. The Associate Director of EDI and Data Analytics or designee generates 837P Professional Encounters for transportation services utilizing invoices from Call The Car (CTC). The Director of

Member Services notifies the IT Data team when an invoice has been reviewed and a check request is submitted to Accounts Payable for payment, at which point services are considered adjudicated to paid status and submission can be made.

7. The Associate Director of EDI and Data Analytics or designee submits encounters prepared by Magellan Behavioral Health to PACES and forwards all response files from PACES back to Magellan Behavioral Health. Magellan Behavioral Health is responsible for encounter submissions related to services they provide.
8. The Associate Director of EDI and Data Analytics or designee downloads response files and analyzes them to ensure all encounter data has been properly received by DHCS and accepted. The Associate Director of EDI and Data Analytics or Designee reports any denials to the Claims Department, and works with the Claims Department to resubmit claims within fifteen (15) days of notification when denial is correctible.
9. On monthly basis, the Associate Director of EDI and Data Analytics or designee prepares the Encounter Data Submission Reconciliation Form (EDSRF), listing all the filenames submitted, file types, their accepted or rejected status, Submitted Transaction Count, Accepted Transaction Count, Rejected Transaction Count, Submitted Encounter Count, Service Lines Count, Void Encounter Count, Replacement Encounter Count, Accepted Encounter Count, Denied Encounter Count and Report Date. This data is submitted to DHCS as part of the MCPDIP JSON SRF submission.
10. Upon receipt of written notice by DHCS of any problems related to the submittal of data to DHCS, or any changes or clarifications related to the MIS system, the Associate Director of EDI and Data Analytics or Designee and the Health Plan Administrator drafts the Health Plan's response.

**Definitions:**

N/A

**Monitoring:**

The Compliance Officer or designee and the Associate Director of EDI and Data Analytics or designee review Quality Measures for Encounter Data (QMED) reports, Monthly Encounter Data Reports, and Quarterly Stoplight Reports, and other internal reports related to completeness, accuracy, reasonability and timeliness measures. On a regular basis, plan shall review sample claims with procedure code(s) 99211 and identify providers who are not submitting rendering provider information per Medi-Cal billing manual and inform providers of non-compliance.

The Compliance Department is responsible for reviewing and communicating all DHCS All Plan Letters (APLs), regulatory changes, and contractual requirements to internal Business Owners, including updates or changes relating to encounter data.

The Plan Administrator and the National Director of Contracting and Provider Relations work with upstream submitters, including providers and subcontractors, to ensure the Health Plan receives compliant, timely data.

The National Director of Managed Care Operations and Program Development and the Associate Director of EDI and Data Analytics are responsible for implementing claim coding and timeliness edits enforcing compliance.



The Compliance Department monitors timeliness of data submissions on a routine basis.

This policy is updated, as necessary, reviewed and approved annually by the Care Management Compliance Committee.

**References:**

1. DHCS OR Contract #22-20597, Exhibit A, Attachment III, 2.1.2 Encounter Data Reporting
2. DHCS APL 14-009 [Transition of Encounter Data Submission to National Standard Transactions \(ASC X12 837 5010, NCPDP 2.2 or 4.2\)](#), dated July 30, 2014
3. DHCS APL 14-020, Quality Measures for Encounter Data, dated December 24, 2014
4. Medi-Cal billing manual for Non Physician Medical Practitioners (NMP) ([Non-Physician Medical Practitioners \(NMP\) \(non ph\)](#))