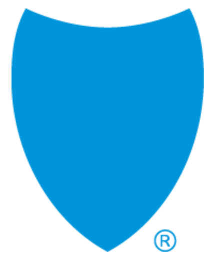
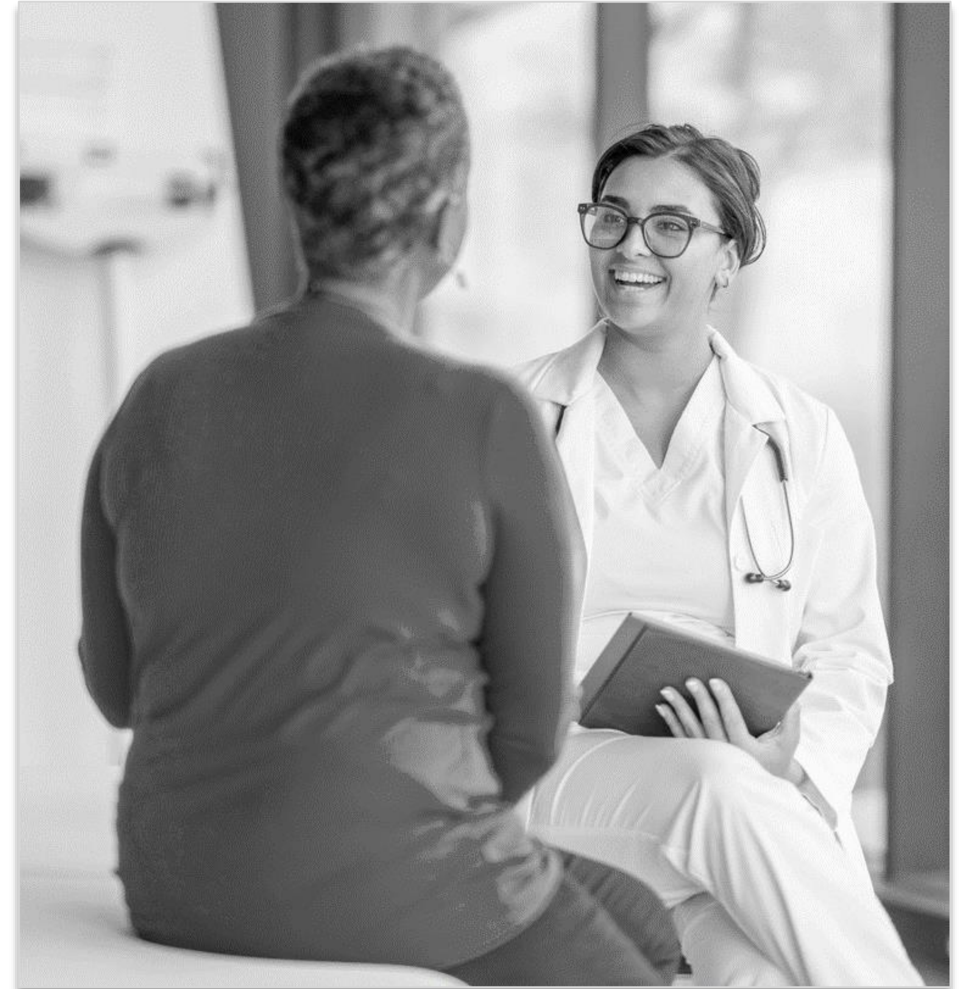


Improving Provider Encounter Data

July 2023

Agenda

1. Encounters website page
2. Top five EDI encounter and claim rejections/solutions
3. Provider Connection update
4. Risk adjustment overview
   - Q&A



New encounters website

Lili Chavez, Systems Analyst, Senior

Encounters page on Provider Connection

Welcome to a one-stop-shop for information related to encounter submissions:

Encounters resources

Provider Connection > Claims > Manage electronic transactions (link under picture) > Encounters Resources

- Encounters overview
- Encounter contacts and frequently asked questions (FAQs)
- Encounter updates and alerts
- Webinar recordings on improving encounter data
- How to enroll in EDI
- EDI Companion Guides
- Provider manuals

How to submit claims | Claims-Routing Tool | Check claim status | Manage electronic transactions | Fee schedule | Claim issues & disputes

e electronic transactions › Encounters resources

Encounters resources

Welcome to the Blue Shield of California and Blue Shield of California Promise Health Plan Encounters Resources page. The information here can help you stay updated on the requirements and guidelines for submitting compliant encounters resulting from services provided to our members.

How encounters work

Blue Shield and Blue Shield Promise receive encounter data submitted by participating independent physician associations (IPAs). The data provides records of payments made to practitioners for services provided to Blue Shield commercial HMO plan members and Medicare Advantage HMO plan members, and to Blue Shield Promise Medi-Cal members, when the IPA is financially responsible for reimbursement in accordance with their provider agreement.

State regulations require the IPAs to submit accurate and timely encounters to the member's health plan. Receiving all encounters correctly and on time also helps IPAs, their affiliated healthcare providers, and the health plan comply with measures included in the Healthcare Effectiveness Data and Information Set (HEDIS).®

Importance of Monthly Performance Summary Reports

Blue Shield and/or Blue Shield Promise send monthly Performance Summary Reports (PSRs) to all participating IPAs and management service organizations (MSOs). The purpose for these reports is to track accuracy and timeliness against the requirements and goals of Blue Shield and/or Blue Shield Promise.

The PSR reflects electronic data interchange (EDI) inbound encounter volumes based on the measurements displayed below, which are based on regulatory expectations. It does not include encounters for members who were not eligible at the time services were provided.

The accuracy and timeliness described below are required to meet the goals.

Accuracy

Acceptance rate is based on the encounters by receipt date, file type and line of business.
Total accepted encounters/total received encounters goal: 95%

Timeliness

- Calculated for 0-30, 0-60, 0-180 days between the service end date and the encounter EDI inbound received date (by Blue Shield or Blue Shield Promise)
- Total acceptance encounters received within N (N=0-30, 0-60, 0-180 days between the service end date and the encounter)

Timeliness goals

- Medi-Cal LA: 65% received by Blue Shield Promise within 30 days from the date of service
- Medi-Cal SD: 65% received by Blue Shield Promise within 60 days from the date of service
- Cal MediConnect 65% received by Blue Shield Promise within 180 days from the date of service
- Medicare, Commercial: 65% received by Blue Shield within 180 days from the date of service

Top five EDI encounter and claim rejections

Kelli Gonczeruk, Systems Analyst/Consultant, Encounters Performance Organization

Top 5 EDI rejections: Blue Shield Encounters (Commercial & Medicare)

Volumes	Rejection reason	Action needed
59,579	Duplicate to a previously processed claim (WBE837P-302 & WBE837I-302)	**For Blue Shield**: Record is a duplicate of a previously accepted within the last 365 days submission.
9,076	We are unable to identify the patient who received services with the information submitted (WBE837P-300 & 0x8110003)	**For Blue Shield**: Please confirm the Subscriber ID correct and resubmit if necessary.
1,967	Unable to identify provider (WBE837I141)	**For Blue Shield**: Please confirm the Provider information correct and resubmit.
1,962	A data element with 'Mandatory' status is missing (8454222)	**For Blue Shield**: Element DTP03 (Date Time Period) is missing. This Element's standard option is 'Mandatory'. Segment DTP is defined in the guideline at position 1350.
1,756	Service Date is required (0x3938b08)	**For Blue Shield**: Segment DTP (Date - Service Date) is missing. It is required on outpatient claims when statement covers period more than one day and drug is not been billed.

Top 5 EDI rejections: Blue Shield Promise Encounters (Medi-Cal*)

Volumes	Rejection reason	Action needed
20,2033	Value of element LIN03 is incorrect. Expected value is from external code list – NDC (0x393933b)	**For Blue Shield Promise:** The submitted NDC is incorrect. It must be the code found on the package, 11 digits and valid according to the Food and Drug Administration (FDA) NDC list.
14,066	Duplicate of a previously accepted record (DUPRej_02)	**For Blue Shield Promise:** Record is a duplicate of a previously accepted within the last 365 days submission.
10,958	NDC code is missing or invalid for the submitted PAD (0xe0277)	**For Blue Shield Promise:** Claims and encounters reporting Physician Administered Drugs (PADs) must include both the Healthcare Common Procedure Coding System (HCPCS) code and a valid National Drug Code (NDC).
2,144	Patient not eligible for submitted date of service (MLRej_02)	**For Blue Shield Promise:** Patient is not eligible for the date of service.
1,126	Invalid Address Information in Billing Provider Address (60003463)	**For Blue Shield Promise:** Value of element N301 is incorrect. Expected value should not be a 'PO BOX' or 'P.O. BOX'.

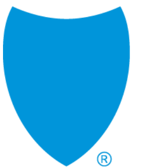
* Medi-Cal Los Angeles and San Diego

Top 5 EDI rejections: Blue Shield Promise claims (Medi-Cal* fee-for-service)

Volumes	Rejection reason	Action needed
25,268	National Drug Code (NDC) is invalid (0x393933b)	**For Blue Shield Promise*:** The submitted NDC is incorrect. It must be the code found on the package, 11 digits and valid according to the Food and Drug Administration (FDA) NDC list.
16,693	Duplicate of a previously accepted record (DUPRej_02)	**For Blue Shield Promise*:** Record is a duplicate of a previously accepted within the last 365 days submission
13,770	Referring, service facility, ordering or supervising provider NPI must be submitted (0xe00009)	**For Blue Shield Promise*:** An NPI must be present if a referring, service facility, ordering or supervising provider is submitted.
1,207	Description should not be used when valid HCPC code is present (60003799)	**For Blue Shield Promise*:** Sub-element SV 101-07 is used. It should not be used when loop 2410 is used and HCPCS code from SV 101-02 is not from external code list.
784	Supervising Provider Name should not be used.(0x3938c72)	**For Blue Shield Promise*:** Loop 2310D (Supervising Provider Name) should not be used when loop 2310B is used with the same information.

* Medi-Cal Los Angeles and San Diego

Provider Connection update



Janet Mills, Principal Learning Consultant, Provider Education

What's new

- Search member eligibility:
  - Member ID
  - Member Last/First and DOB
  - Medicare Beneficiary ID (MBI)
  - Social Security Number (SSN) (NEW!)
  - Client Index Number (CIN) (NEW!)
- Attach documentation to:
  - Finalized claim (NEW!)
  - Pending dispute (NEW!)
- Submit disputes online for Blue Shield Commercial, Shared Advantage®, and BlueCard® claims

Quick-Reference Tutorials (with screenshots)

- Verify eligibility & benefits
- Attach documents to a finalized claim
- Attach documents to a pending dispute
- Submit disputes online for Blue Shield Commercial, Shared Advantage, and BlueCard claims.

Attach documentation to a finalized claim from *Claim status* (log in required)

Quick-Reference Tutorial (with screenshots)

- Attach documents to a finalized claim

Available for all lines of business.

1. Click **Claims** in the top menu, then click **Check claim status**.

2. Using one or more search fields on Claims status, locate the claim for which you are submitting additional documentation.

   Click **Search**.

3. The search result displays in the table below the blue header. Click the claim number.

4. The *Claim details* displays for that claim. Click **Attach supporting documents**.

Search | Other Blue plans | Appeal status
2
All fields are optional
Member information | Claim information | Provider information
Member ID/Subscriber ID/Patient number
Last name
First name
Dates of service
Start date
End date
Check/EFT number
Claim/EOB number
Claim type None
Claim status
Amount paid
$ 0.00 to $ 0.00
Status change
Start date
End date
Provider
Provider tax ID
Provider NPI
Provider number
Hide search
Start over
Search

Showing 1–50 of 31,923 claims: Dates of service: 02/24/2020–02/24/2023 | Provider: 2 selected
Export
Print

Claim status Updated	Claim number	Claim type	Dates of service	EOB	Member name	Member ID/ Subscriber ID	Provider name	Amount billed	Amount paid	Patient responsibility	Check/EFT number
FINALIZED 02/26/2023	000343305500	dical	07/17/2021– 07/17/2021	View EOB	MEMBER, X	12345678901234	Group A	$133.00	$0.00	$0.00	12345678901234

3

Claim 000343305500
Finalized 07/30/2021
Medical | Finalized – denied
4
View EOB
Possible next steps: Attach supporting documents

Attach documentation to a finalized claim
(continued)

5. The *Attach Documents to a Claim* screen displays with prepopulated claims data.

6. Drag and drop or select up to five (5) files at a time for **a total of 20 files**.

	File types	File size (per file)	Max # of files
Blue Shield Blue Shield Promise	PDF, Excel, Word	50 MB	20
BlueCard®	PDF	10 MB	20

5 ATTACH DOCUMENTS TO A CLAIM

Upload supporting documents for your claim. Start by checking that you have the right claim number.

* Required

Enter your claim # *
000343800800
Update

Claim details

Claim #	000343800800
Provider	DISTRICT HOSP
Provider ID	FA0001234567
Tax ID	009009009
Member name	MEMBER, X
Date of birth	01/01/1994
Subscriber name	MEMBER, Y
Subscriber ID	919103940
Patient account	1234
Dates of service	10/19/2021–10/19/2021
Amount billed	$90.00
Amount paid	$0.00

Attach supporting documents *
(PDF, DOC, XLS, 50MB max, up to 20 files total)
All documents will be scanned for viruses.

Drag and drop up to 5 files at a time or
Select files
6

Enter an email where we can reach you if your documents fail a virus scan.

Email *
40 characters max

Briefly describe your documents to make sure they get to the right place.

Notes
0/500

Finish

Attach documentation to a finalized claim *(continued)*

7. An *Attach documents* pop-up displays. Select a "type" for each document. Options are:
   - Medical record
   - Contract/pricing
   - Itemized bill
   - Other, with a description field

   Click **Next document** until all document types are identified. Click **Attach**.

8. Documents display on the *Attach Documents to a Claim* screen.

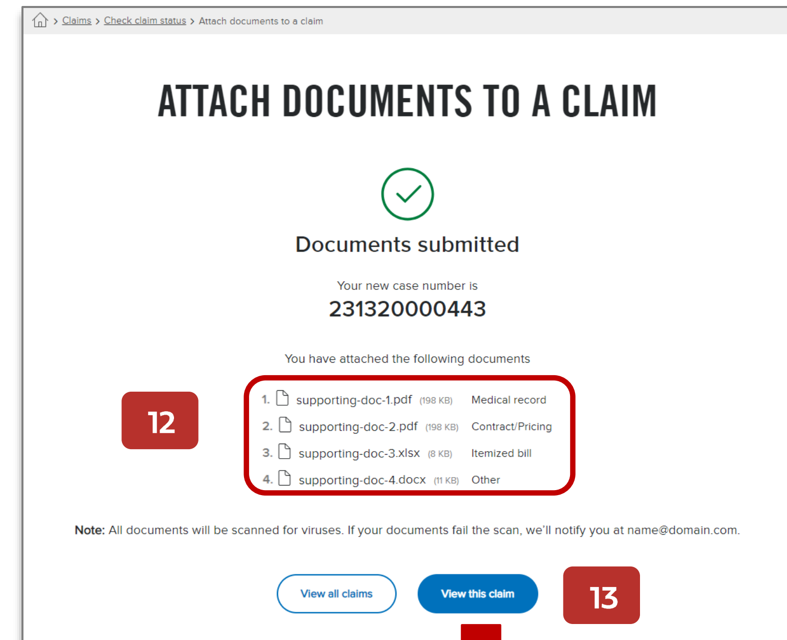
9. Enter an email where you can be notified if there is a problem with accepting your file.

10. Enter a description of the document(s), the reason for submission, and expected outcome.

11. Click **Finish**.

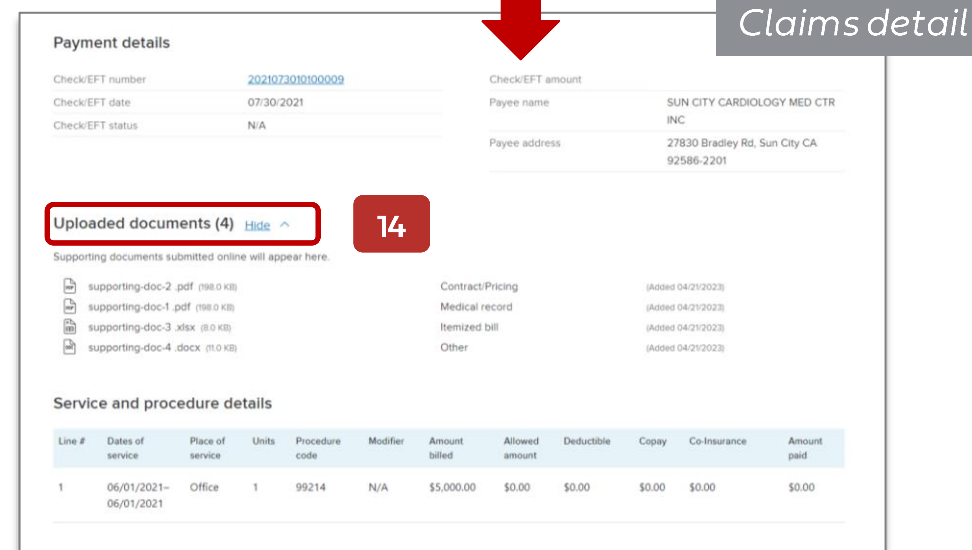
Attach documentation to a finalized claim *(continued)*

12. A confirmation screen displays with a list of the submitted documents.



13. If desired, click **View this claim** to return to the *Claims detail* page.

14. To see a list of documents submitted for this claim, scroll to *Uploaded documents* on the *Claims detail* page and click **Show**. Click **Hide** to collapse the list.
    - Only documents submitted online will display.

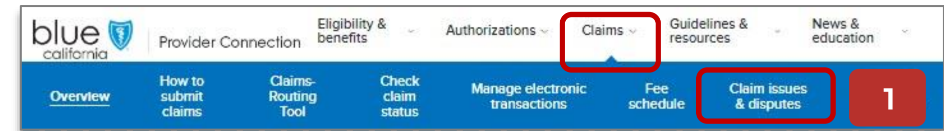


Attach documentation to a pending dispute (log in required)

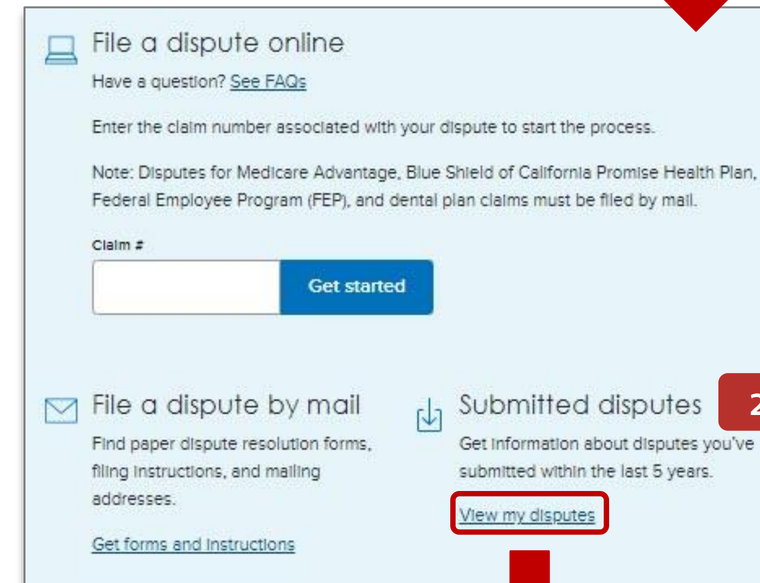
Quick-Reference Tutorial (with screenshots)

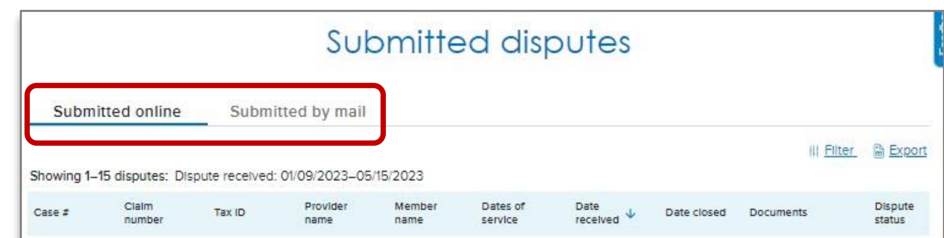
- Attach documents to a pending dispute

1. Click **Claims** in the top menu, then click **Claims issues & disputes.**
   - Scroll to the blue box.



2. Click **View my disputes** under *Submitted disputes.*
   - All claim(s) disputes submitted under the Tax ID(s) connected to your Provider Connection account display on one of two tabs:.
     - The *Submitted online* tab displays disputes filed on Provider Connection.
     - The *Submitted by mail* tab displays all other dispute submissions.





Attach documentation to a pending dispute (continued)

3. Click either the **Submitted online** or the **Submitted by mail** tab.

4. Click **Filter** to open the search functionality.

5. Enter data into one or more search fields to locate the dispute. Click **Show results**.

6. The search result displays in the table below the blue header. Click **Add documents** in the *Dispute status* column.

Attach documentation to a pending dispute (continued)

7. The *Attach Documents to a Dispute* screen displays with prepopulated claims data.
    - Drag and drop or select up to five (5) files at a time for a total of 20 files.
    - An Attach documents pop-up displays. Select a "type" for each document. Click Next document until all document types are identified. Click Attach.
    - Documents display on the *Attach Documents to a Dispute* screen.
8. Enter an email where you can be notified if there is a problem with accepting your file.
9. Enter a description of the document(s), the reason for submission, and expected outcome.
10. Click **Finish**.

7 ATTACH DOCUMENTS TO A DISPUTE

Upload supporting documents for your dispute case. Start by checking that you have the right dispute case number.

* Required

Enter your dispute case # *
231300000045
Update

Dispute details

Claim #	000344476300
Provider	DISTRICT HOSP
Provider ID	FA0001234567
Tax ID	009009009
Member name	MEMBER, X
Date of birth	08/13/1982
Subscriber name	MEMBER, Y
Subscriber ID	XEH909999999
Patient account	12345
Dates of service	04/21/2022–04/21/2022
Amount billed	$400.00
Amount paid	$356.80

Attach supporting documents *
(PDF, DOC, XLS, 50MB max, up to 20 files total)
All documents will be scanned for viruses.

Drag and drop up to 5 files at a time or
Select files

Enter an email where we can reach you if your documents fail a virus scan.

Email * 8

40 characters max

Briefly describe your documents to make sure they get to the right place.

Notes 9

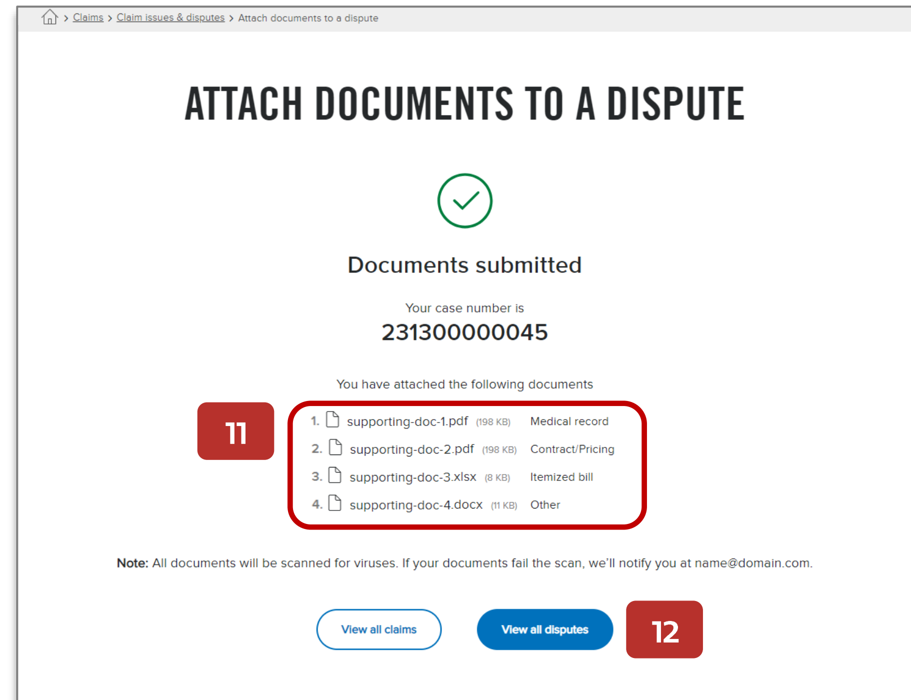
0/500

Finish 10

Attach documentation to a pending dispute (continued)

11. A confirmation screen displays with a listing of the submitted documents.
    - Your case number will not change.

12. If desired, click **View all disputes** to return to the *Submitted disputes* page.



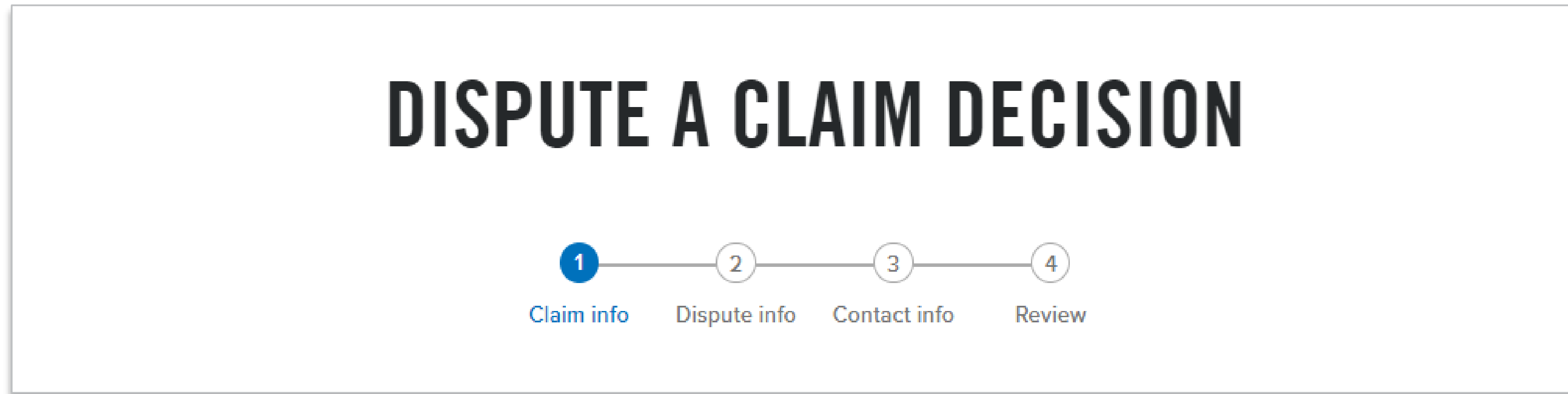
Filing a dispute

- Disputes can be filed online for finalized Commercial, Shared Advantage, and BlueCard.
  - Individual claim or bundled claims for the same type of issue.

- Disputes for Promise Health Plan, Medicare, Medicare Advantage, and FEP claims, must be filed by mail.

- To file a dispute online, go to the *Claim* section on Provider Connection:
  1. Click **Check claim status** in the blue sub-menu bar.
  2. Search for the finalized claim.
  3. Click the claim number to open the *Claims Detail* page.
  4. Click the *Resolve claim issue or dispute* link. This link will be active only if the claim has been finalized

Four steps in the online dispute process



1. Verify claim information.
2. Provide a statement of dispute and supporting documentation.
3. Verify contact information pre-populated from your Provider Connection profile.
4. Review dispute, e-sign, and submit.

- **Quick-Reference Tutorial:** Submit disputes online for Blue Shield Commercial, Shared Advantage, and BlueCard claims.
- Recorded webinar and presentation PDF

Risk adjustment overview

Lorraine Versoza, Risk Adjustment Consultant, Blue Shield Medicare Risk Adjustment

Risk adjustment – Actuarial model implemented by CMS and HHS

Why is risk adjustment important?

Improves patient outcomes

- Encourages regular office visits
- Supports early detection and prevention
- Avoids emergency department and hospitalization

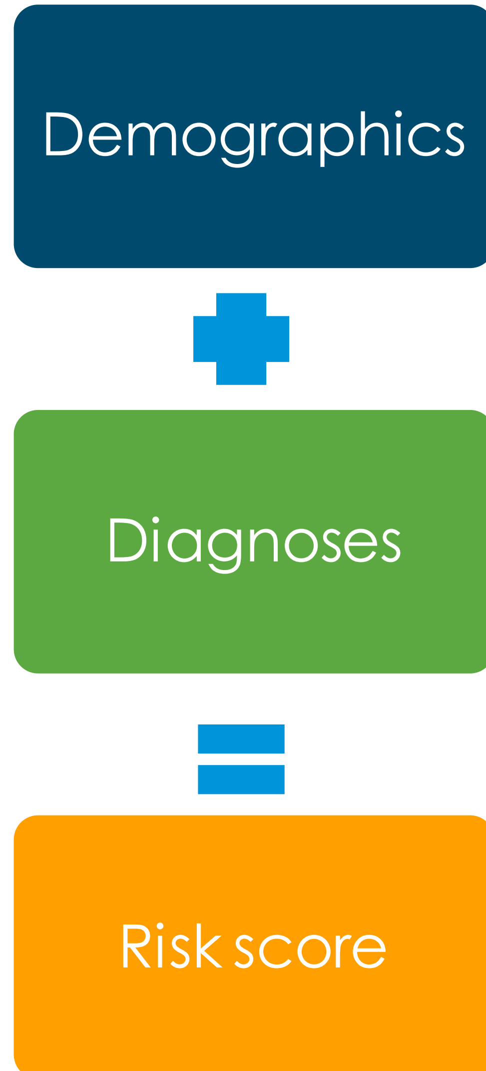
Improves communication between providers

- Enhances continuity of care
- Identifies severity of illness

What are attributes of risk adjustment?

- Supported by evidence-based medicine
- Based on the capture of chronic conditions
- Predicts medical expenses incurred
- Minimizes incentive to enroll based on health
- Encourages competition among health plans

Risk adjustment factor (RAF) overview



1. A higher risk score means the individual will have higher healthcare costs.
   - Essential to ensure there is funding to provide quality patient care.

2. Diagnosis codes establish the complexity of patient health status, medical decision making, and the funding for care.

3. Diagnoses, in conjunction with demographic factors, are used to calculate a risk score.

Complex diagnoses = Higher risk values

Evaluation & Management (E&M) Metrics Report

- E&M metric measures **completeness** of provider groups encounter submissions.
- Benchmarks for Commercial & Medicare are outlined in HMO IPA/Medical Group Procedures Manual.
- Metric is based on number of visits Per Member Per Year (PMPY).

Line of business	Benchmark PMPY	90% threshold PMPY
Commercial	3.0	2.7
Medicare	8.0	7.2

Complete Submission

Blue Shield will measure encounter submissions based on a rolling year of utilization data. The Centers for Medicare & Medicaid Services (CMS) requires EOBs for Medicare Advantage members with Medicare Part C. IPAs are required to submit encounter submissions with Maximum Out-of- Pocket "MOOP" for Medicare Advantage members. If cost share information applies to a record, please submit the information. If cost share information is not available, do not submit the information. Refer to the EDI Companion Guides on Provider Connection at blueshieldca.com/provider for additional details.

For Medicare Advantage encounter data submissions to the CMS, there is also a compliance measurement reflecting the data collection period. Benchmarks using Evaluation and Management (E&M) CPT codes are used. The benchmarks are:

Commercial Membership: 3.0 E&M Visits PMPY

Medicare Advantage Membership: 8.0 E&M Visits PMPY

Certain types of denied services are included in calculating each IPA/medical group's annual E&M visit rates.

A provider network contract may include an incentive program or capitation withhold provision that would apply for performance, relative to the above benchmarks. The current performance target is at least 90% of the benchmark.

HMO/IPA Medical Group Procedures Manual Section 4.4

Action items for you

- Ensure members come in for annual comprehensive visits, and capture their chronic conditions

- Submit all encounter/claim data to Blue Shield

- "If more than 12 diagnosis codes need to be reported, submit a subsequent claim/encounter with Billed Amount as zero charge, and key the additional diagnosis codes at the claim level."
  - EDI Blue Shield Companion Guide

Resources

Action	Contact information
Encounter-related questions Email: EPE@blueshieldca.com	• Provider Connection Encounters resources page • Unsolicited 277C Transaction for Adjudicated Encounters Standard Companion Guide • EDI Blue Shield Promise Companion Guide • EDI Blue Shield Companion Guide
Provider incentives questions	Email: providerincentives@blueshieldca.com
Blue Shield Provider Connection website	blueshieldca.com/provider (Log in required for authenticated tools.)
Provider Connection training (No log in required)	• Reference Guide and Quick-Reference Tutorials (with screenshots)
Provider Customer Service (For general help.)	• Blue Shield Phone: **(800) 541-6652** • Blue Shield Promise Phone: **(800) 468-9935** • Live chat from Provider Connection is available from all pages after login.
Provider Information & Enrollment (For network inquiries, credentialling, etc.)	• Email: bscproviderinfo@blueshieldca.com • Phone: **(800) 258-3091**
AuthAccel Online Authorization System training – no login required.	• Blue Shield prior authorization list • Blue Shield Promise prior authorization list
Blue Shield & Blue Shield Promise	HEDIS® Guides – no log in required.
Medi-Cal billing guidelines Medi-Cal Rx provider portal	• Dialysis: Chronic Dialysis Services (ca.gov) • Dialysis: End Stage Renal Disease Services (ca.gov)
Blue Shield Promise resource for nursing facility providers.	Blue Shield Promise Nursing Facility reference guide

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are independent licensees of the Blue Shield Association