KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Encounter Management	**Policy #**	6.35-P
Policy Owner	Claims	**Original Effective Date**	01/2020
Revision Effective Date	06/21/2025	**Approval Date**	09/03/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

To implement an overall Kern Health Systems **(**KHS) Encounter process that will ensure KHS is compliant with Department of Healthcare Services (DHCS) by maintaining and adhering to operational processes through proactive and reactive intervention leveraging data governance.

II. POLICY

Kern Health Systems (KHS) has a contract with the Department of Health Care Services (DHCS) that requires KHS to submit all encounter data for KHS Fee for Service (FFS), Capitated, and delegated to the state in a timely and accurate manner. Kern Health Systems (KHS) will review Encounters for accuracy and acceptance criteria prior to data file submission to the Department of Health Care Services, to ensure a minimum of 97% acceptance rate.

III. DEFINITIONS

TERMS	DEFINITIONS
Encounter	Any claim submission received, either fee for service with one or more paid items, capitated encounters or delegated encounters will be submitted by KHS to the DHCS according to Encounter Submission guidelines outlined in California Department of Health Care Services Encounter Data Transaction Companion Guides. (837 I, 837 P, and NCPDP)

IV. PROCEDURES

A. Responsible Parties

1. Department of Health Care Services (DHCS) – Responsible for providing KHS governing

policies and requirements for encounter submissions and acceptance.

2. Claims – The Claims department is the overall owner of Encounters Management Process. Responsible for ensuring claims are paid accurately and timely. Claims is responsible for ensuring corrections are made timely for encounter denials and rejections.

3. Managed Information Systems- MIS is responsible for providing all reporting to ensure data governance and visibility, the submission and resubmission process including building, and managing the systems leveraged in the Encounters Management Process.

4. Provider Network Management (PNM) is responsible for ensuring provider data leveraged in the Encounter Management Process is accurate.

5. Member Services (MS) is responsible for ensuring member data leveraged in the Encounter Management Process is accurate.

6. Pharmacy (RX) is responsible for ensuring Pharmacy Benefit Manager (PBM) data leveraged in the Encounter Management Process is accurate.

7. Finance- Responsible for working with other departments to ensure encounter data is reconciled to Rate Development Template (RDT) for the Encounter Completeness Monitoring Summary.

8. Delegated Entities – Responsible for submitting all encounters to KHS per DHCS contract and requirements. KHS submits encounters to DHCS on delegated entities behalf and reports all errors and status' to delegated entity.

B. DHCS REQUIREMENTS AND REVIEW

1. DHCS requires KHS to submit all encounter data in an acceptable ANSI X12 5010 Compliant 837 format.

2. DHCS audits KHS encounter data using non-standard and standard SNIP level edits I-VII.

    a. Level I- Electronic Data Interchange (EDI) Standard Integrity
    b. Level II- Implementation Guide Requirements
    c. Level III- Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide Requirements
    d. Level IV- Inter-Segment Situational
    e. Level V- External Code Set Validation
    f. Level VI- Product Type and Type of Service Validation
    g. Level VII- Trading Partner Specific Validation

3. DHCS audits KHS encounter data for validity, accuracy, and timeliness.

4. DHCS publishes an Encounter Data Quality Report Card on a quarterly basis.

5. DHCS monitors KHS encounters for Completeness, Accuracy, Reasonability, and Timeliness in order to assign KHS with an Encounter Data Quality Grade (EDQG).

6. If KHS is identified as low performing on the Encounter Quality Report Card, a Corrective Action Plan (CAP) or Sanctions may be inflicted by DHCS.

7. DHCS publishes an Encounter Completeness Monitoring Summary on a quarterly basis.

8. DHCS monitors KHS encounters and submitted RDT data for reasonability in the following areas: Inpatient, Outpatient and Emergency Room, Pharmacy, and Professional.

9. If KHS receives a red stoplight on a specific category of encounters on the Encounter Completeness Monitoring Summary, a Corrective Action Plan (CAP) or Sanctions may be inflicted by DHCS.

C. SUBMISSION REQUIREMENTS

The lag time in the encounter data is at or higher than the thresholds determined by DHCS based on date of service to State submission date.

Type	Lag of 0-90 Days	Lag of 0-180 Days	Lag of 0-365 Days	Lag > 365 Days
Institutional	60%	80%	95%	5%
Professional	65%	80%	95%	5%
Pharmacy	80%	95%	99%	1%

D. CORRECTION AND RESUBMISSION REQUIREMENTS

1. 50% of denied encounters must be corrected and submitted (and accepted) within 15 calendar days of being denied.

2. 80% of denied encounters must be corrected and submitted (and accepted) within 30 calendar days of being denied.

3. 95% of denied encounters must be corrected and submitted (and accepted) within 60 calendar days of being denied.

E. REPORTING

1. KHS will provide several reports to ensure requirements are met throughout the lifecycle of the DHCS encounter management process.

2. KHS will leverage Pre-Payment Reporting: Report captures claims in a PAY status that have been pre validated against an inventory of errors KHS has historically experienced. Errors are specific to department responsible, type of claim, count of error, and pay amount.

3. KHS will leverage Post Payment Reporting: Report captures claims in a PAID status that have been rejected or denied by DHCS with specific error codes. i.e., invalid bill type, invalid Diagnosis (Dx) code, invalid drop-off location

4. KHS will leverage Encounter Summary Reporting: Report captures all encounters submitted to DHCS by source by counts or dollars. Report includes paid month, count/total dollar amount of encounters submitted, trapped encounters, not submitted, accepted, rejected, and denied.

5. KHS will provide proactive reporting to measure ongoing performance by replicating the Encounter Data Quality Report Card.

6. KHS will provide proactive reporting to measure ongoing performance by replicating the Encounter Completeness Monitoring Summary.

7. KHS will provide proactive reporting to measure ongoing performance by creating standard Key Performance Indicators (KPIs) that are monitored by all responsible parties outlined in the policy.

F. RECONCILIATION

1. KHS is responsible to reconcile the encounters received by providers (FFS/Capitated/Delegated) to ensure all encounters are submitted to DHCS in a timely manner with a 97% accuracy rate.

2. KHS is responsible for reconciling the encounters submitted to DHCS, receiving a status back indicated accepted, rejected, or denied.

3. KHS is responsible for reconciling encounters to utilization by category for RDT reporting.

4. KHS is responsible for reconciling encounters submitted by providers to encounters submitted to DHCS, to ensure all encounters are accounted for in reporting from DHCS in toolkits for Hospital Directed Payments (HDP). See Policy regarding Hospital Directed Payments.

G. SYSTEMS

1. KHS is responsible for identifying potential denials and rejections of encounter data in a proactive and reactive manner.

2. KHS is responsible for reviewing all Pre-Payment potential rejections and address the claim according with the provider by denying the entire claim for a completed corrected claim that meets the Encounter Data criteria.

3. On a weekly basis, KHS will review any Post-Payment potential rejections based on criteria in the California Department of Health Care Services 837 Encounter Data Transaction Companion Guides and address accordingly.

4. KHS will identify solutions to resolve Encounter denials and rejections.

    a. For claims that were billed correctly but will be an Encounter submission rejection, such as Local Code usage, KHS will identify the correct code to map for the Encounter submission through the Encounter Management Process.
    b. Any duplicate encounters identified will be addressed through the Claims Overpayment Process for correction and not sent as encounters to the DHCS.
    c. Void and Replacement scenarios or Corrected claims, will be identified by the appropriate indicators to ensure Encounter acceptance.
    d. Any rejections that occur will be addressed through Provider Education for potential future claim denials, system enhancements as needed or Claim Processor education as needed.
    e. KHS will update systems leveraged by the Encounter Management Process with acceptance/rejection status received from DHCS and reasons if applicable.

5. All KHS personnel involved in the Encounter Management Process will be trained and well versed in the California Department of Health Care Services 837 Encounter Data Transaction Companion Guides as well as any other Guidelines provided by DHCS for Encounter submissions.

6. All KHS personnel will be trained and well versed in the KHS Encounter Management Process and systems leveraged to generate and submit the encounter file to DHCS according to the Encounter Management Policy on a minimum basis of quarterly.

7. KHS personnel will address any rejections and resolve within 10 days so that encounters can be resubmitted within the deadline of 15 days. If a large volume occurs, KHS may request the DHCS grant an extension for submission of the corrected encounter data.

H. RETENTIONS

Every policy and procedure revision/replacement will be maintained for a minimum of six (6) years from the date of its creation or when it was last in effect, whichever is later. Other KHS requirement may stipulate longer retention.

I. COMPLIANCE

Failure to comply with Encounters policy will result in disciplinary actions as per the Sanction Policy. Legal actions also may be taken for violations of applicable regulations and standards such as HIPAA, applicable state laws, and others.

V. ATTACHMENTS

Attachment A:	California Department of Health Care Services Encounter Data Transaction Companion Guides

VI. REFERENCES

Reference Type	Specific Reference
Choose an item.	

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revision	2025-06	Annual Compliance Review with minor updates	Robin Dow-Morales
Revision	2020-01	New policy created to ensure a minimum of 97% acceptance rate for all encounter data submitted to DHCS for KHS FFS, Capitated, and delegated encounters to the state in a timely and accurate manner.	Victoria Hurtado / Robin Dow-Morales

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Human Resources Officer		
Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 6.35-P Encounter Management

Last approved version: 01/2020

Reason for revision: Compliance with annual policy reviews.

Director Approval		
Title	**Signature**	**Date Approved**
Senior Director of Claims Robin Dow-Morales		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____