Kansas Foundation for Medical Care, Inc.

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URAC ACCREDITED Independent Review Organization: External Expires 06/01/2021

September 25, 2020

Shirley Norris
Director of Managed Care
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St., Room 900
Topeka, KS 66612

RE: **Percent of Encounter Submissions within 30 Days Performance Measure of UnitedHealthcare Community Plan of Kansas for 2019**

Dear Ms. Norris:

Enclosed is KFMC's report for the 2019 Percent of Encounter Submissions within 30 Days, a performance measure of UnitedHealthcare Community Plan of Kansas (UnitedHealthcare). The report includes the calculation and validation methodology and stratified tables of counts and percentages.

Please contact me, jmcnamee@kfmc.org, if you have any questions or concerns.

Sincerely,

John R. McNamee, Ph.D., MA
Senior Health Data Analyst

Electronic Version:
Sheri Jurad, EQR Audit Manager/Supervisor, KDHE
Christiane Swartz, Deputy Medicaid Director/Director of Medicaid Operations, KDHE
Dr. Janice Panichello, Senior Health Data Analyst, KDHE
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Bobbie Graff-Hendrixson, Senior Manager Contracts & Fiscal Agents Operations, KDHE

Enclosure(s)

Percent of Encounter Submissions within 30 Days – 2019
UnitedHealthcare Community Plan of Kansas
September 25, 2020

Background/Objectives

As the external quality review organization (EQRO) for the State of Kansas, the Kansas Foundation for Medical Care (KFMC) calculated quarterly rates for a set of performance measures for the managed care organizations (MCOs): UnitedHealthcare Community Plan of Kansas (UnitedHealthcare), Aetna Better Health of Kansas, and Sunflower Health Plan. The measures are used for the pay-for-performance (P4P) incentive program. The P4P requirements were defined by the State with input from the MCOs.

Reports of preliminary rates (exemptions approved by the State had not been applied, and validation activities were not fully complete) were previously submitted to the State and MCOs. On request, the MCOs also received files of encounters not meeting numerator criteria. The purpose of the preliminary reports and data files was to:

- Aid the MCOs in identification of encounters that may be eligible for exemption from the measure;
- Provide an opportunity for the State and MCOs to offer comments and documentation to support correction of any factual errors; and
- Provide an opportunity for the MCOs to clarify any issues or findings identified by KFMC.

KFMC received the MCOs' comments, and the State completed the process of approving exemptions; rates and findings were revised, where appropriate.

Performance Measure Calculated

The P4P incentive program provides incentives to the MCOs for timely and complete submission of encounter data to the State's fiscal agent. This report details data sources, calculation methods, validation activities, and final rates for the performance measure "Percent of covered service accurately submitted via encounter within 30 days of claim paid date" for 2019.

The quarterly percentages of covered service accurately submitted via encounter within 30 days of claim paid date for CY2019, by quarter, are displayed in Table 1. The percentages reflect exemptions to the denominator approved by the State.

Incentive payments are made based on quarterly measurements. The P4P performance target for each measurement is to achieve or maintain 98.00%. UnitedHealthcare met this target for each quarter. The respective percentages for quarters Q1 through Q4 were 99.71%, 99.96%, 99.76%, and 99.16%.

Table 1. Percent of Encounter Submissions within 30 Days, CY2019 – UnitedHealthcare					
2019	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Number of claims paid or denied by the MCO	1,425,299	1,513,105	1,523,073	1,535,648	5,997,125
Number submitted as encounters within 30 days	1,421,172	1,512,462	1,519,436	1,522,758	5,975,828
Percentage	99.71%	99.96%	99.76%	99.16%	99.64%
Target (98.00%)	**Met**	**Met**	**Met**	**Met**	

The data source is the Medicaid Management Information System (MMIS). The denominator is the number of claims initially submitted to the fiscal agent by the MCO within the measurement quarter. The denominator includes new-day and adjusted encounters from all claim types (professional, institutional, dental, and pharmacy) and has been deduplicated to include only the first submitted encounter record per claim. Submission dates are identified by the MMIS field DTE_BILLED.

The technical specifications are provided in Table 2.

Table 2: Technical Specifications for Encounter Data Submission within 30 Days, CY2019	
Measure Name	Percent of covered service accurately submitted via encounter within 30 days of claim paid date
Population	Covered services for all KanCare members
Specifications	**Denominator**: Encounters for covered services initially submitted to the fiscal agent during the measurement period, excluding encounters that cannot be submitted due to MMIS backlog or State issue to not submit encounters due to backlog in the queue **Numerator:** Encounters meeting denominator criteria where the submission date is within 30 calendar days of the paid date
Timeframe	Calendar year 2019 with calendar quarter measurement periods
Component	**Additional Detail**
Source Data	Data sources used to calculate the numerator and denominator are Medicaid Management Information System (MMIS) encounter tables.
Population	The populations from which the denominators are drawn include: • All claim types (professional, institutional, dental, and pharmacy), • Paid and denied claims, and • New-day and adjusted claims.
Denominator	Submission date (identified by MMIS DTE_BILLED field) is within the calendar quarter. Deduplication is to the first submitted encounter per claim. Deduplication routine queries back to 1/1/2013 for initial submissions Deduplication is stratified by the four claim types. Encounters approved by the State as exemptions due to backlog issues are excluded from the denominator.
Numerator	Calculations use the formula (Submission Date – Paid Date) ≤ 30.
Target	The performance target for each quarter is 98.00 %.

Validation Activities and Technical Methods

Appendix A, Tables Stratified by Type of Claim, contains additional analytic results, including counts of:

- Encounters submitted in 2019,
- Encounters removed during deduplication,
- Claim meeting denominator criteria (before exempt encounters are excluded),
- Claims not meeting numerator criteria, and
- Non-numerator claims, by submission date, with the 10 highest counts displayed per quarter.

Appendix B, Activities and Technical Methods, describes:

- Teams and primary contacts,
- Data sources,
- Cleaning and validation of source data,
- Technical methods of measure calculations, and
- Technical methods of post-calculation analysis and reporting.

No areas of concern were identified by KFMC during validation activities.

The State approved an exemption request by UnitedHealthcare for 20,508 encounters whose submission was delayed due to upgrades to MMIS. Analysis showed that some of the encounters were resubmission of encounters which had been uploaded to MMIS within 30 days of the paid date. Others were initially submitted within 30 days. Only 31 of the exempted records were matched to claims submitted in 2019 more than 30 days after the paid date. These 31 were removed from the measure's denominators.

Conclusions

UnitedHealthcare met the quarterly target or incentive payment (98.00%) for each quarter of measurement year 2019. The respective rates for quarters Q1 through Q4 were 99.71%, 99.96%, 99.76%, and 99.16%.

Recommendations

KFMC has no recommendations.

End of written report

Appendix A

Percent of Encounter Submissions within 30 Days – 2019

UnitedHealthcare

Community Plan of Kansas

Tables Stratified by Type of Claim

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Table A1. Encounter Submissions within 30 Days, CY2019 – UnitedHealthcare					
All Claim Types*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	1,572,069	1,644,366	1,766,077	2,130,029	7,112,541
Minus duplicates identified by MCO ICN^	-118,250	-98,822	-212,971	-564,111	-994,154
Minus duplicates identified by selected fields†	-28,520	-32,447	-30,036	-30,290	-121,293
Number of claims represented by an encounter	1,425,299	1,513,097	1,523,070	1,535,628	5,997,094
Minus claims with a State-approved exemption	-0	-8	-3	-20	-31
Number submitted over 30 days after paid date	4,127	643	3,637	12,890	21,297
Denominator (claims represented minus exemption)	1,425,299	1,513,105	1,523,073	1,535,648	5,997,125
Numerator (submitted within 30 days)	1,421,172	1,512,462	1,519,436	1,522,758	5,975,828
Percentage	99.71%	99.96%	99.76%	99.16%	99.64%
Physician*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	347,594	354,772	347,951	411,994	1,462,311
Minus duplicates identified by MCO ICN^	-37,266	-16,116	-31,557	-89,905	-174,844
Minus duplicates identified by selected fields†	-925	-1,185	-1,092	-902	-4,104
Number of claims represented by an encounter	309,403	337,471	315,302	321,187	1,283,363
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	834	251	1,850	1,669	4,604
Denominator (claims represented minus exemption)	309,403	337,471	315,302	321,187	1,283,363
Numerator (submitted within 30 days)	308,569	337,220	313,452	319,518	1,278,759
Percentage	99.73%	99.93%	99.41%	99.48%	99.64%
HCBS and Mental Health*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	299,483	343,242	428,528	608,384	1,679,637
Minus duplicates identified by MCO ICN^	-32,837	-34,110	-118,824	-288,098	-473,869
Minus duplicates identified by selected fields†	-1,470	-1,873	-506	-522	-4,371
Number of claims represented by an encounter	265,176	307,259	309,198	319,764	1,201,397
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	478	118	290	4,376	5,262
Denominator (claims represented minus exemption)	265,176	307,259	309,198	319,764	1,201,397
Numerator (submitted within 30 days)	264,698	307,141	308,908	315,388	1,196,135
Percentage	99.82%	99.96%	99.91%	98.63%	99.56%
Other Professional*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of professional encounters submitted	210,223	256,842	276,631	373,268	1,116,964
Minus duplicates identified by MCO ICN^	-25,531	-33,177	-44,445	-138,744	-241,897
Minus duplicates identified by selected fields†	-16,591	-20,632	-20,266	-21,496	-78,985
Number of claims represented by an encounter	168,101	203,033	211,920	213,028	796,082
Minus claims with a State-approved exemption	-0	-8	-3	-20	-31
Number submitted over 30 days after paid date	1,439	198	1,026	5,471	8,134
Denominator (claims represented minus exemption)	168,101	203,025	211,917	213,008	796,051
Numerator (submitted within 30 days)	166,662	202,827	210,891	207,537	787,917
Percentage	99.14%	99.90%	99.52%	97.43%	98.98%

* Encounters submitted to the State's fiscal agent in 2019. Professional encounters were defined as encounters for professional-billed claims (i.e., billed on a CMS-1500 or equivalent claim form). The physician, HCBS, and mental health strata of professional encounters were identified by provider type codes 31, 55, and 11, respectively.

^ Deduplicated to one encounter per combination of member's Medicaid ID, first day of service, and MCO internal control number.

† Fields selected for deduplication were member's Medicaid ID, first day of service, billing provider's national provider identification (NPI), billed amount, date paid (or denied), and amount paid.

Table A1. Encounter Submissions within 30 Days, CY2019 – UnitedHealthcare (Continued)					
Facility*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of facility encounters submitted	131,324	140,489	143,315	147,946	563,074
Minus duplicates identified by MCO ICN^	-8,445	-2,784	-4,469	-9,695	-25,393
Minus duplicates identified by selected fields†	-145	-198	-232	-190	-765
Number of claims represented by an encounter	122,734	137,507	138,614	138,061	536,916
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	326	27	442	1,205	2,000
Denominator (claims represented minus exemption)	122,734	137,507	138,614	138,061	536,916
Numerator (submitted within 30 days)	122,408	137,480	138,172	136,856	534,916
Percentage	99.73%	99.98%	99.68%	99.13%	99.63%
Dental*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of dental encounters submitted	46,732	59,164	49,679	63,768	219,343
Minus duplicates identified by MCO ICN^	-5,812	-10,888	-4,354	-17,881	-38,935
Minus duplicates identified by selected fields†	-219	-337	-243	-192	-991
Number of claims represented by an encounter	40,701	47,939	45,082	45,695	179,417
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	350	3	0	98	451
Denominator (claims represented minus exemption)	40,701	47,939	45,082	45,695	179,417
Numerator (submitted within 30 days)	40,351	47,936	45,082	45,597	178,966
Percentage	99.14%	99.99%	100.00%	99.79%	99.75%
Pharmacy*	**Q1**	**Q2**	**Q3**	**Q4**	**CY2019**
Number of pharmacy encounters submitted	536,713	489,857	519,973	524,669	2,071,212
Minus duplicates identified by MCO ICN^	-8,359	-1,747	-9,322	-19,788	-39,216
Minus duplicates identified by selected fields‡	-9,170	-8,222	-7,697	-6,988	-32,077
Number of claims represented by an encounter	519,184	479,888	502,954	497,893	1,999,919
Minus claims with a State-approved exemption	-0	-0	-0	-0	-0
Number submitted over 30 days after paid date	700	30	23	31	784
Denominator (claims represented minus exemption)	519,184	479,888	502,954	497,893	1,999,919
Numerator (submitted within 30 days)	518,484	479,858	502,931	497,862	1,999,135
Percentage	99.87%	99.99%	100.00%	99.99%	99.96%

* Encounters submitted to the State's fiscal agent in 2019, by claim type; facility encounters were defined as encounters for institutionally-billed claims (i.e., billed on a UB-04 or equivalent claim form), dental encounters were defined as encounters for claims billed on an American Dental Association (ADA) dental claim form, and pharmacy encounters were defined as encounters for claims billed through the MCO's pharmacy benefits manager.

^ Deduplicated to one encounter per combination of member's Medicaid ID, first day of service, and MCO internal control number.

† Fields selected for deduplication were member's Medicaid ID, first day of service, billing provider's NPI, billed amount, date paid (or denied), and amount paid.

‡ Fields selected for deduplication of pharmacy encounters were member's Medicaid ID, dispense date, billing provider's NPI, billed amount, date paid (or denied), amount paid, dispensed quantity, and days' supply.

Table A2 was reported to UnitedHealthcare on March 30, 2020, to assist with identification of encounters that met exclusion criteria. It does not reflect the 31 exclusions approved after that date.

Table A2. Dates with Highest Incidence of Late Submissions, CY2019 – UnitedHealthcare

Quarter and Denominators*	Claim Type^	Date of Submission	Submitted Over 30 Days	Percent of All Over 30 Days	Percent of Denominator
2019 Q1	Pharmacy	1/24/2019	617	14.95%	0.04%
Denominator: 1,425,299	Other Professional	3/5/2019	448	10.86%	0.03%
Numerator: 1,421,172	Physician	1/25/2019	280	6.78%	0.02%
Percent: 99.71%	Physician	1/16/2019	256	6.20%	0.02%
	Other Professional	1/23/2019	244	5.91%	0.02%
All Over 30 Days: 4,127	Physician	1/10/2019	223	5.40%	0.02%
Percent: 0.29%	Other Professional	1/25/2019	195	4.72%	0.01%
	Dental	1/4/2019	182	4.41%	0.01%
	HCBS/MH	1/25/2019	178	4.31%	0.01%
	Facility	1/25/2019	159	3.85%	0.01%
	Total of Top 10		**2,782**	**67.41%**	**0.20%**
2019 Q2	Physician	4/10/2019	90	14.17%	0.01%
Denominator: 1,513,097	Physician	6/4/2019	81	12.76%	0.01%
Numerator: 1,512,462	HCBS/MH	5/22/2019	77	12.13%	0.01%
Percentage: 99.96%	Other Professional	4/10/2019	76	11.97%	0.01%
	Other Professional	6/4/2019	50	7.87%	0.00%
All Over 30 Days: 635	Other Professional	5/17/2019	28	4.41%	0.00%
Percentage: 0.04%	Physician	5/22/2019	27	4.25%	0.00%
	Physician	6/26/2019	21	3.31%	0.00%
	Pharmacy	5/16/2019	18	2.83%	0.00%
	Other Professional	5/22/2019	18	2.83%	0.00%
	Total of Top 10		**486**	**76.54%**	**0.03%**
2019 Q3	Physician	7/25/2019	1,716	47.22%	0.11%
Denominator: 1,523,070	Other Professional	7/25/2019	974	26.80%	0.06%
Numerator: 1,519,436	Facility	7/23/2019	224	6.16%	0.01%
Percentage: 99.76%	HCBS/MH	7/25/2019	208	5.72%	0.01%
	Facility	7/31/2019	172	4.73%	0.01%
All Over 30 Days: 3,634	Physician	7/22/2019	58	1.60%	0.00%
Percentage: 0.24%	Physician	7/31/2019	58	1.60%	0.00%
	HCBS/MH	8/1/2019	54	1.49%	0.00%
	Facility	8/14/2019	23	0.63%	0.00%
	Pharmacy	9/18/2019	22	0.61%	0.00%
	Total of Top 10		**3,509**	**96.56%**	**0.23%**
2019 Q4	HCBS/MH	10/8/2019	3,776	29.34%	0.25%
Denominator: 1,535,628	Other Professional	10/11/2019	3,657	28.41%	0.24%
Numerator: 1,522,758	Other Professional	10/8/2019	1,065	8.28%	0.07%
Percentage: 99.16%	Facility	11/8/2019	785	6.10%	0.05%
	Physician	10/8/2019	719	5.59%	0.05%
All Over 30 Days: 12,870	Physician	11/8/2019	588	4.57%	0.04%
Percentage: 0.84%	HCBS/MH	11/8/2019	585	4.55%	0.04%
	Other Professional	11/11/2019	427	3.32%	0.03%
	Facility	10/10/2019	387	3.01%	0.03%
	Physician	11/11/2019	275	2.14%	0.02%
	Pharmacy	1/24/2019	617	14.95%	0.04%

* The denominator is the number of claims initially submitted as an encounter record to the State fiscal agent by the MCO in 2019. The count "All Over 30 Days" is the number of encounters in the denominator that were submitted over 30 days after the MCO paid or denied the claim, that is, the number of claims not meeting numerator criteria.

^ Claim types for encounters included: facility (billed on a UB-04 or equivalent claim form), professional (billed on a CMS-1500 or equivalent claim form), dental (billed on an American Dental Association dental claim form, and pharmacy (billed through the MCO's pharmacy benefits manager). Professional encounters were subset into physician, HCBS, and mental health (MH) claims identified by provider type codes 31, 55, and 11, respectively.

Appendix B

Percent of Encounter Submissions within 30 Days – 2019

UnitedHealthcare

Community Plan of Kansas

Activities and Technical Methods

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Description of Activities

Teams and Primary Contacts

Table B1 lists members of the KFMC measure calculation and validation team, and Table B2 lists State and MCO staff members serving as primary contacts for validation of this measure.

Table B1. KFMC Measure Calculation and Validation Team

Name	Title
John McNamee, PhD, MA	Senior Health Data Analyst

Table B2. State and MCO Primary Contacts

Name	Title
State	
Shirley Norris	Director of Managed Care, KDHE
Sheri Jurad	External Quality Review Audit Manager/Supervisor, KDHE
Janice Panichello	Senior Health Data Analyst, KDHE
UnitedHealthcare	
Kasey Mullins	Senior Director of Clinical Quality
Todd Carlon	Kansas Compliance Officer

Data Sources

The primary source of encounter data was the reporting warehouse of the Medicaid Management Information System (MMIS). For external quality review and other State-contracted activities, KFMC routinely downloads and archives MMIS encounter data. For CY2019 percentages, all were queried from KFMC's archived tables.

MMIS stores encounter records in four sets, depending on type of claim. The calculation and reporting of the performance measure were stratified to match MMIS's sets of encounters. The claim types used for stratification were:

- **Facility** – encounters for institutionally-billed claims (i.e., billed on a UB-04 or equivalent form);
- **Dental** – encounters for claims billed on an American Dental Association (ADA) dental claim form;
- **Pharmacy** – encounters for claims billed through the MCO's pharmacy benefits manager; and
- **Professional** – encounters for professional-billed claims (i.e., billed on a CMS-1500 or equivalent claim form). For reporting, the professional encounters were subdivided based on provider type:
  - **Physician** – encounters having provider type code 31;
  - **Home and Community Based Services (HCBS) and Mental Health** – encounters having provider type codes 55 or 11; and
  - **Other Professional** – encounters not having provider type codes 11, 31, or 55.

Data Cleaning and Validation

Encounter records queried for the measure underwent data cleaning and validation steps prior to rate calculation, including:

- Records were counted stratified by MCO, claim type, and MCO paid date. Records with missing or invalid MCO paid date values were removed from analysis;
- Records with missing billing provider NPI were counted stratified by MCO, claim type, and provider type;

- Records without an MCO ICN number were counted by MCO and claim type and then assigned a unique, dummy MCO ICN number for deduplication purposes; and
- MCO ICN numbers associated with multiple members, dates of service, billing providers, and payment amounts were analyzed for potential integrity issues.

Integrate Data into Repository

The source data were queried using SAS software and subsequently stored as SAS datasets. Data cleaning, validation analysis, and rate calculations were also performed using SAS code and datasets.

Technical Methods of Measure Calculation

The following paragraphs contain the technical details related to final calculations for the percent of covered service accurately submitted via encounter within 30 days of claim paid date measure. Because all three MCOs' data underwent the same processes, the paragraphs are not MCO-specific.

Initial Data

Two sets of encounters were initially queried from the source data tables. First, all encounters submitted by the MCOs to MMIS during 2019 were drawn. These records were flagged as potential denominator records. Many of these records were resubmissions of claims, which were considered duplicates and not included in the denominator. Because the earliest encounter submitted for a claim may have occurred before 2019, all potential earlier submissions were identified by matching the records submitted in 2019 to MMIS encounter records submitted prior to 2019 on member's Medicaid ID, date of service, and MCO paid date. At this stage, the encounters underwent the previously described data cleaning and validation steps.

Deduplicating

In certain circumstances, MCOs will need to modify an encounter record for a claim using a void-and-replace process. Both the original encounters and the replacement encounters were intentionally included in the output of the initial queries. The technical specifications state that the first submitted encounter for a claim is to be used for calculating the number of days from paid date to submission date. The encounters submitted secondarily were considered duplicates and removed from analysis. Deduplication was done in two stages.

The first stage of deduplication was based on the MCO ICN field. Encounters with the same claim type, member Medicaid ID, first date of service (or dispense date), paid date, and MCO ICN were assumed to represent the same claim. If the MCO ICN field was not populated (the field was not required before early 2015), a unique dummy value was assigned to bypass the deduplication. Duplicate encounters were moved from the dataset of potential denominator records to a new dataset.

The second stage deduplicated using a combination of fields. For professional, facility, and dental encounters, two encounters were considered to represent the same claim if they had the same claim type, member Medicaid ID, first date of service, billing provider NPI, amount billed, paid date, and amount paid. The records were sorted by these fields plus submission date and MMIS ICN. The first record representing the claim was retained and the duplicates were moved to a different dataset. The list of fields differed slightly for pharmacy encounters. Two pharmacy encounters were considered to

represent the same claim if they had the same member Medicaid ID, dispense date, billing provider NPI, amount billed, paid date, and amount paid, quantity supplied, and days supplied.

The two stages of deduplication were designed to complement each other. Using the MCO ICN, duplicates caused by replacing an encounter with one having a different billing provider NPI could be eliminated (the encounters were not always populated with the NPI submitted on the claim form). The second stage could remove duplicates submitted during the transition period for the MCO ICN field (e.g., the MCO ICN may have been populated on the replacement encounter but not on the original).

Calculating Preliminary Percentages

After deduplication, exemptions approved by the state were removed. The number of records that remained is the stratum's preliminary denominator.

For each remaining record, the difference between the submission date and the paid date was calculated. If submission date minus paid date was less than or equal to 30, the record was counted for the stratum's preliminary numerator.

After percentages were calculated for each stratum, the stratified preliminary numerators and denominators were summed to obtain the preliminary numerator and denominator for all claim types.

Files for MCO Validation

Records meeting denominator criteria in which the submission date minus paid date was greater than 30 were subsequently exported into text files and made available to MCOs, on request, for identifying encounters potentially meeting exclusion criteria or processes that could be improved.

Technical Methods of Post-Calculation Analysis and Reporting

This section describes validation and root-cause analysis performed by KFMC after calculation of the preliminary percentages for the performance measure.

Counts During Measure Calculation

Stratified counts of records at major stages of measure calculation are reported in Appendix A, Table A1.

Submission Dates

Stratified counts of encounters submitted over 30 days after the paid date were calculated to assist MCOs in identifying dates on which submission issues occurred. Counts were stratified by MCO, quarter, claim type, and submission date. For each quarter, the 10 submission dates with the highest counts are displayed in Appendix A, Table A2. For each submission date in Table A2, the percentage of all claims submitted over 30 days and their percentage of the denominator that were submitted on that date are also displayed. Table A2 was reported to the MCO on March 30, 2020. It does not reflect exclusions approved by the State after that date.