HSAG HEALTH SERVICES ADVISORY GROUP

SFY 2022-23 Encounter Data Validation Study Plan Data Submission Requirements

Background

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship.

During State Fiscal Year (SFY) 2022–23, the Agency for Health Care Administration (Agency) has contracted with Health Services Advisory Group, Inc. (HSAG) to conduct an encounter data validation (EDV) study. The goal of the SFY 2022–23 EDV study is to examine the extent to which the long-term care (LTC) encounters submitted to the Agency by its contracted Managed Medical Assistance (MMA) and LTC plans (collectively referred to as plans) are complete and accurate.[1] This document defines specific data submission requirements for the data from the plans' data systems.

Submission Guidelines

- HSAG requests that all data files be submitted to HSAG's secure SAFE site at https://safe.hsag.com. Files should be submitted in the following path: ***/Plan Name/Contract Year 2022-2023/EDV***. If you do not have login credentials to access HSAG's SAFE site, please email Kari Vanderslice (KVanderslice@hsag.com) with your name, email address, and plan affiliation to complete the registration to access the SAFE site and appropriate folder.
- Using the exact field names and types for the requested data elements is **required** to facilitate the import process of the submitted files. Please also include a file layout document to ensure the appropriate fields are submitted and extracted. If your plan identifies additional data fields that may be beneficial for the EDV study, please include these fields at the end of the file and note them in the file layout document.
- For ease of data extraction and file transition, you may split your data submission by quarter or semi-annual period.
- Please include "control total" files for each of the requested data files. Appendix B details the specifications.
- Please upload the requested data files by **January 13, 2023** and notify Melissa Branigan at 540-422-9100 or via email at mbranigan@hsag.com. Also, copy your **Agency Contract Manager**.

[1] A list of contracted plans to be evaluated in this study is included in Appendix A.

HSAG will conduct a preliminary file review to confirm the accuracy of the data submitted by each plan for the study. [2] If data issues are identified from the initial submission that warrant resubmission, a second review of the resubmitted data will be performed. No more than two data submissions will be allowed without further discussion.

Questions

- Please contact Melissa Branigan at 540-422-9100 or via email at mbranigan@hsag.com if you have questions or require any assistance with the file uploading process.
- Please direct other questions to Eliza Buyong at 602-801-6862 or via email at ebuyong@hsag.com.

LTC Encounter Files

The encounter files should be comprised of all LTC encounters associated with the plan specific Trading Partner ID (TPID) listed in Appendix A, with dates of service from January 1, 2021, to December 31, 2021, and for all members enrolled in a plan listed in Appendix A. The encounter files should contain only encounters that have reached their final status and should not include the interim adjustment history.

HSAG will evaluate the extent to which values populated for the key data elements in the Agency's data warehouse match those in the plans' submitted files. The key data elements to be evaluated for the EDV study include, but are not limited to the following:

- Enrollee ID
- Dates of Service, Admission/Discharge Dates
- Provider Identifier (i.e., Billing Provider NPI, Rendering Provider NPI, Attending Provider NPI, and Referring Provider NPI)
- Diagnosis Code (Primary and Secondary Diagnosis Codes)
- Procedure Code (CPT/HCPCS Codes and Surgical Procedure Codes) and Modifier
- Revenue Code
- Diagnosis Related Group (DRG)
- National Drug Code and Drug Quantity
- Header and Detail Paid Amount

[2] To ensure the project is completed on time, HSAG will be limited in the number of times it can process and review a plan's submitted data. Each plan will be allowed to submit its data two times. Each time, HSAG will conduct a cursory review to (1) ensure it conforms to the data file specifications and requirements and (2) meets a minimum level of quality (e.g., reasonably populated fields). Following initial feedback from HSAG, each plan will be allowed to resubmit its data one time. If issues continue to exist in the resubmitted data, information will either be excluded from the study or used "as is" based on a final decision by the Agency.

The encounter files that are being requested include:

- LTC encounters from the 837 Profession (837P) transactions
- LTC encounters from the 837 Institutional (837I) transactions

File Extract Specifications

Table 1 identifies the specific field qualifications required for extracting the encounter files.

Table 1—Encounter File Specifications

Requirement	Specification
Claim Type	LTC encounters associated with the plan specific TPIDs listed in Appendix A from the 837P and 837I transactions
Plan	Applicable plans listed in Appendix A
Dates of Service	January 1, 2021 <= Header First Date of Service <= December 31, 2021 **OR** January 1, 2021 <= Header Last Date of Service <= December 31, 2021
Data Submission Date	Please include all LTC encounters submitted to the Agency on or before October 31, 2022.
Adjudication	Only the final fully adjudicated encounters submitted to the Agency on or before October 31, 2022.
Paid Status	Include paid, denied, and voided encounters
File Format	ASCII text file in a pipe (|) delimited format

Minimum Required Data Elements

Table 2 and Table 3 identify the minimum data elements being requested from the 837P and 837I LTC encounter files, respectively. In order to facilitate the import process of the submitted files, using the exact field names and types for these data elements **<u>is required</u>**. While the list below outlines the minimum data elements that will be used in the EDV study, there is no limitation on the number of data elements that can be extracted. Additional data elements may be provided at the end of the list of required data elements if they facilitate the extraction process or are beneficial for the EDV study.

LTC Encounters from the 837P Transactions

Table 2 presents the minimum data elements being requested for the LTC encounters from the 837P transactions.

Table 2—Required Data Elements for the LTC Encounters from the 837P Transactions

Field No.	Field Names	Description	Type	Note
1	*PlanID* [A]	Plan identifier for each plan	Character	
2	*PlanAbbrev*	Plan abbreviation with values listed in Appendix A	Character	
3	*TPID*	Trading partner ID for each plan	Character	
4	*SbmDt*	Date when a record was submitted to the Agency	Date	Format: MM/DD/YYYY
Enrollee Information				
5	*RecipID*	Unique identification number assigned to an enrollee	Character	
6	*PatAccNo*	Patient account number	Character	
Encounter Information				
7	*TCN*	Transaction control number - Unique identification number assigned to each encounter by the plan	Character	
8	*ClaimLineNo*	Claim line number of the detail line item	Numeric	
9	*ICN*	Florida Medicaid unique control number assigned to the invoice to allow tracking through the system	Character	
10	*AdjICN*	Adjusted ICN	Character	
11	*LastClaimInd*	Last claim indicator	Character	
12	*AdjDate*	Adjudication date	Date	Format: MM/DD/YYYY
13	*ClaimType*	Type of encounters for example “M” for medical or "B" for professional crossover.	Character	
14	*ClaimFreqTypeCode*	Claim frequency type code: 1 – Original Claim 7 – Adjustment (Replacement of Paid Claim) 8 – Void	Numeric	

Field No.	Field Names	Description	Type	Note
Dates of Service				
15	*HFDOS*	The first date on which service was provided at the header level	Date	Format: MM/DD/YYYY
16	*HLDOS*	The last date on which service was provided at the header level	Date	Format: MM/DD/YYYY
17	*LFDOS*	The first date on which service was provided at the detail line item	Date	Format: MM/DD/YYYY
18	*LLDOS*	The last date on which service was provided at the detail line item	Date	Format: MM/DD/YYYY
ICD-10-CM Diagnosis				
19	*Dx1*	The primary diagnosis code (ICD-10-CM code)	Character	
20	*Dx2*	The second diagnosis code (ICD-10-CM code)	Character	
21	*Dx3*	The third diagnosis code (ICD-10-CM code)	Character	
22	*Dx4*	The fourth diagnosis code (ICD-10-CM code)	Character	
23	…	…	Character	
24	*Dx<N>*	The Nth diagnosis code (ICD-10-CM code)	Character	**Please add all diagnosis code fields.**
Provider Information				
25	*BillProvID*	Medicaid identification number of the billing provider	Character	
26	*BillProvNPI*	National Provider Identifier (NPI) of the billing provider	Character	
27	*RendProvID*	Medicaid identification number of the provider rendering the service	Character	
28	*RendProvNPI*	NPI of the rendering provider	Character	
29	*RendProvSpec*	The reported area of specialization for the provider rendering the service	Character	
30	*ReferProvID*	Medicaid identification number of the referring provider	Character	

Field No.	Field Names	Description	Type	Note
31	*ReferProvNPI*	NPI of the referring provider	Character	
Place of Service and Procedure Code				
32	*POS*	Place of service code – The location at which service was rendered such as office, home, emergency room, etc.	Character	
33	*ProcCode*	Procedure code (CPT-4 or HCPCS)	Character	
34	*Mod1*	Modifier code – The first of up to 4 procedure/service/supplies modifier (if applicable)	Character	
35	*Mod2*	Modifier code – The second of up to 4 procedure/service/supplies modifier (if applicable)	Character	
36	*Mod3*	Modifier code – The third of up to 4 procedure/service/supplies modifier (if applicable)	Character	
37	*Mod4*	Modifier code – The fourth of up to 4 procedure/service/supplies modifier (if applicable)	Character	
38	*Units*	Units of service	Numeric	
39	*UnitsBilled*	Units billed	Numeric	
Drug Data Elements				
40	*NDC*	NDC code that applies to the service	Character	
41	*DrugQty*	Quantity of the drug indicated by the NDC that is being billed	Character	
42	*DrugUnitofMeas*	Unit of measurement of the drug indicated by the NDC		
Payment Information				
43	*PaidDate*	Date of final disposition of the encounter	Date	Format: MM/DD/YYYY
44	*ContractType*	The contract between the plan and the provider paid by the plan: 05 = Capitation 09 = FFS	Character	
45	*AmountPaid_H*	This is the plan paid amount at the header level	Numeric	
46	*AmountPaid_D*	This is the plan paid amount at the detail level	Numeric	

Field No.	Field Names	Description	Type	Note
47	*Dtl_Status*	This indicates whether the claim/encounter is paid or denied: P = Paid D = Denied	Character	
48	*Usermem01 – UserMem99*	User defined. Plan may use up to 99 fields for any additional fields	User Defined	
[A] Lookup file containing "value" definitions should be included for these fields				

LTC Encounters from the 837I Transactions

Table 3 presents the minimum data elements being requested for the LTC encounters from the 837I transactions.

Table 3—Required Data Elements for the LTC Encounters from the 837I Transactions

Field No.	Field Names	Description	Type	Note
1	*PlanID* [A]	Plan identifier for each plan	Character	
2	*PlanAbbrev*	Plan abbreviation with values listed in Appendix A	Character	
3	*TPID*	Trading partner ID for each plan	Character	
4	*SbmDt*	Date when a record was submitted to the Agency	Date	Format: MM/DD/YYYY
Enrollee Information				
5	*RecipID*	Unique identification number assigned to an enrollee	Character	
6	*PatAccNo*	Patient account number	Character	
Encounter Information				
7	*TCN*	Transaction control number – unique identification number assigned to each encounter by the plan	Character	
8	*ClaimLineNo*	Claim line number of the detail line item	Numeric	
9	*ICN*	Florida Medicaid unique control number assigned to the invoice to allow tracking through the system	Character	
10	*AdjICN*	Adjusted ICN	Character	
11	*LastClaimInd*	Last claim indicator	Character	
12	*AdjDate*	Adjudication date	Date	Format: MM/DD/YYYY

Field No.	Field Names	Description	Type	Note
13	*ClaimType*	Type of encounters for example "I" for inpatient or "A" for inpatient crossover.	Character	
14	*ClaimFreqTypeCode*	Claim frequency type code: 1 – Original Claim 7 – Adjustment (Replacement of Paid Claim) 8 – Void	Numeric	
Dates of Service				
15	*AdmitDate*	Date of admission	Date	Format: MM/DD/YYYY
16	*HFDOS*	The first date on which the service was provided at the header level	Date	Format: MM/DD/YYYY
17	*HLDOS*	The last date of service on which the service was provided at the header level	Date	Format: MM/DD/YYYY
18	*LFDOS*	The first date of service on which the service was provided at the detail line item	Date	Format: MM/DD/YYYY
19	*LLDOS*	The last date of service on which the service was provided at the detail line item	Date	Format: MM/DD/YYYY
Bill Type, Discharge Status, and DRG				
20	*BillType*	Type of bill	Character	
21	*DischStat*	Discharge status	Character	
22	*DRG*	DRG code (three-digit field; please submit if it is an inpatient encounter paid on DRG rate as reported on the encounter)	Character	
ICD-10-CM Diagnosis Codes				
23	*Dx1*	The primary diagnosis code (ICD-10-CM code)	Character	
24	*Dx2*	The second diagnosis code (ICD-10-CM code)	Character	
25	*Dx3*	The third diagnosis code (ICD-10-CM code)	Character	
26	*Dx4*	The fourth diagnosis code (ICD-10-CM code)	Character	
27	…	…	Character	
28	*Dx<N>*	The Nth diagnosis code (ICD-10-CM code)	Character	**Please add all diagnosis code fields.**

Field No.	Field Names	Description	Type	Note
ICD-10-PCS Procedure Codes				
29	*Surg1*	The first surgical code (ICD-10-PCS surgical code)	Character	
30	*Surg2*	The second surgical code (ICD-10-PCS surgical code)	Character	
31	*Surg3*	The third surgical code (ICD-10-PCS surgical code)	Character	
32	*Surg4*	The fourth surgical code (ICD-10-PCS surgical code)	Character	
33	…	…	Character	
34	*Surg<N>*	The Nth surgical code (ICD-10-PCS code)	Character	**Please add all surgical code fields.**
Provider Information				
35	*BillingProvID*	Medicaid identification number of the billing provider	Character	
36	*BillingProvNPI*	National Provider Identifier (NPI) of the billing provider	Character	
37	*AttendingProvID*	Medicaid identification number of the attending provider	Character	
38	*AttendingProvNPI*	NPI of the attending provider	Character	
39	*ReferProvID*	Medicaid identification number of the referring provider	Character	
40	*ReferProvNPI*	NPI of the referring provider	Character	
Revenue Code and Procedure Code				
41	*RevCode*	Revenue center code	Character	
42	*ProcCode*	Procedure code (CPT-4 or HCPCS)	Character	
43	*Mod1*	The first of up to 4 procedure/service/supplies modifier (if applicable)	Character	
44	*Mod2*	The second of up to 4 procedure/service/supplies modifier (if applicable)	Character	
45	*Mod3*	The third of up to 4 procedure/service/supplies modifier (if applicable)	Character	
46	*Mod4*	The fourth of up to 4 procedure/service/supplies modifier (if	Character	

Field No.	Field Names	Description	Type	Note
		applicable)		
47	*Units*	Units of service	Numeric	
48	*UnitsBilled*	Units billed	Numeric	
Drug Data Elements				
49	*NDC*	NDC code that applies to the service	Character	
50	*DrugQty*	Quantity of the drug indicated by the NDC that is being billed	Character	
51	*DrugUnitMeas*	Unit of measurement of the drug indicated by the NDC	Character	
Payment Information				
52	*PaidDate*	Date of final disposition of the encounter	Date	Format: MM/DD/YYYY
53	*ContractType*	The contract between the plan and the provider paid by the plan: 05 = Capitation 09 = FFS	Character	
54	*AmountPaid_H*	This is the plan paid amount at the header level	Numeric	
55	*AmountPaid_D*	This is the plan paid amount at the detail level	Numeric	
56	*Dtl_Status*	This indicates whether the claim/encounter is paid or denied: P = Paid D = Denied	Character	
57	*UserMem01 – UserMem99*	User defined. Plan may use up to 99 fields for any additional fields	User Defined	
[A] Lookup file containing "value" definitions should be included for these fields				

Appendix A: List of Plans

Table A.1 specifies a list of plans included in the study.

Table A.1—List of Participating Plans

Plan Name	Plan Abbreviation	Shortened Name	Trading Partner Identifier (TPID)	Plan Base Medicaid ID
MMA Comprehensive Plans				
Aetna Better Health of Florida, Inc.	AET-C	Aetna-C	301823	1001200
Humana Medical Plan, Inc.	HUM-C	Humana-C	301826	1000513
Molina Healthcare of Florida, Inc.	MOL-C	Molina-C	301827	1001399
Simply Healthcare Plans, Inc.	SIM-C	Simply-C	301828	1001206
Sunshine State Health Plan, Inc.	SUN-C	Sunshine-C	301865	1000516
UnitedHealthcare of Florida, Inc.	UNI-C	United-C	301829	1001219
LTC Plan				
Florida Community Care	FCC-L	Florida Community Care-C	301860	1000536

Appendix B: Control Total Specifications

Table B.1 lists the control total specifications for each type of requested data. The inclusion of control totals will allow HSAG to determine if the correct number of records are received. The control totals document should be submitted as a separate Microsoft Excel or Word document.

Table B.1—Control Total Specifications

Data	Specifications
LTC Encounters from 837P Transactions	• Total number of records • Total number of unique *PlanID* • Total number of unique *TCN* • Total number of unique *ICN* • Total number of unique enrollees by *RecipID* • Total number of unique billing provider NPI by *BillingProvNPI* • Total number of unique rendering provider NPI by *RendProvNPI* • Sum of "*AmountPaid_H*" • Sum of "*AmountPaid_D*"
LTC Encounters from 837I Transactions	• Total number of records • Total number of unique *PlanID* • Total number of unique *TCN* • Total number of unique *ICN* • Total number of unique enrollees by *RecipID* • Total number of unique billing provider NPI by *BillingProvNPI* • Total number of unique attending provider NPI by *AttendProvNPI* • Sum of "*AmountPaid_H*" • Sum of "*AmountPaid_D*"

Appendix C: Tips for Data Extraction

To avoid multiple resubmissions, the list below provides tips for proper data extraction based on historical studies:

- Include encounters that have reached their final status. One useful way of evaluating whether the adjustment history has been excluded is to check whether there are any duplicates based on *ICN* and *LineNo*. There should be no duplicates based on *ICN* and *LineNo*.
- Verify the total number of records in the extracted files are reasonable or aligned with other reports generated by your plan.
- Ensure all requested data fields have been included and populated with appropriate information. Below are a few examples:
  - No values should be missing in the dates of service fields.
  - Replace the system default missing value with a blank. For example, if “00000” in the plan’s system means missing values for the *ProcCode* field, please replace it with a blank.
  - Verify whether the sum of the paid amount at the detail level match the paid amount at the header level.
  - Verify fields (e.g., diagnosis code fields) are populated with the expected values.
- Verify that the control totals submitted to HSAG match the extracted data.