SFY 2023-24 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) 2023–24, the Agency for Health Care Administration (Agency) continues to contract with Health Services Advisory Group, Inc. (HSAG) to conduct an Encounter Data Validation (EDV) study. The goal of the SFY 2023–24 EDV study is to examine the extent to which the encounters submitted to the Agency by its contracted Managed Medical Assistance (MMA) and Comprehensive 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 2023-2024/EDV***. If you do not have login credentials to access HSAG's SAFE site, please email Celina Mincey (CMincey@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.
- Please include "control total" files for each of the requested data files. Appendix B details the specifications.
- Since the size of the requested files is expected to be large, HSAG recommends the plans to split their data submission by quarter or semi-annual period and compress the files as zip files. If issues persist during the upload, please reach out to Diana Valle at 602-329-7358 or via email at dvalle@hsag.com for alternate options.

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

- Please upload the requested data files by **November 6, 2023,** and notify Diana Valle at 602-329-7358 or via email at dvalle@hsag.com. Also, copy your **Agency Contract Manager**.

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 Diana Valle at 602-329-7358 or via email at dvalle@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.

Encounter Files

The encounter files should be comprised of all final paid and denied encounters associated with the plan specific Trading Partner ID (TPID) listed in Appendix A. The requested encounters should be encounters with dates of service from January 1, 2022, to December 31, 2022, and for all enrollees who are eligible to receive only MMA services that were submitted to the Agency on or before August 31, 2023. 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
- Header Service From/To Date, Admission/Discharge Dates
- Provider Identifier (i.e., Billing Provider National Provider Identifier (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

[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.

- Diagnosis Related Group (DRG)
- National Drug Code and Drug Quantity
- Header and Detail Paid Amount

The encounter files that are being requested include:

- Professional Encounters (i.e., data submitted in the 837P format).
- Institutional Encounters (i.e., data submitted in the 837I format).

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	Encounters for enrollees who are eligible for MMA services only that are associated with the plan specific TPIDs listed in Appendix A from the Professional (837P) and Institutional (837I) transactions
Enrollee	Enrollee eligible to receive only MMA services.
Plan	Applicable plans listed in Appendix A
Dates of Service	January 1, 2022 <= Header First Date of Service <= December 31, 2022 **OR** January 1, 2022 <= Header Last Date of Service <= December 31, 2022
Data Submission Date	Please include all encounters submitted to the Agency on or before August 31, 2023.
Adjudication	Only the final fully adjudicated encounters submitted to the Agency on or before August 31, 2023.
Paid Status	Include paid, denied, and voided encounters submitted to the Agency
File Format	ASCII text file in a pipe (|) delimited format or SAS®[3] format

Minimum Required Data Elements

Table 2 and Table 3 identify the minimum data elements being requested from the 837P and 837I encounter files, respectively. To facilitate the import process of the submitted files, using the **exact** field names and types for these data elements **is required**. 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

[3] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

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.

Encounters from the 837P Transactions

Table 2 presents the minimum data elements being requested for the MMA and Comprehensive Plans' encounters from the 837P transactions.

Table 2—Required Data Elements for the Plans' 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	Please provide value definition for this field.

Field No.	Field Names	Description	Type	Note
14	*ClaimFreqTypeCode*	Claim frequency type code: 1 – Original Claim 7 – Adjustment (Replacement of Paid Claim) 8 – Void	Numeric	
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 ensure to include additional diagnosis code fields available in your plan's claims system up to a maximum of 25 diagnosis code fields. Please label the additional fields as *Dx5*, *Dx6*, …., *Dx25*.				
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	

Field No.	Field Names	Description	Type	Note
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	
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	Character	

Field No.	Field Names	Description	Type	Note
		09 = FFS		
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	
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				

Encounters from the 837I Transactions

Table 3 presents the minimum data elements being requested for the MMA and Comprehensive Plans' encounters from the 837I transactions.

Table 3—Required Data Elements for the Plans' 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	Character	

Field No.	Field Names	Description	Type	Note
		through the system		
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 “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	*DischargeDate*	Date of discharge	Date	Format: MM/DD/YYYY
17	*HFDOS*	The first date on which the service was provided at the header level	Date	Format: MM/DD/YYYY
18	*HLDOS*	The last date of service on which the service was provided at the header level	Date	Format: MM/DD/YYYY
19	*LFDOS*	The first date of service on which the service was provided at the detail line item	Date	Format: MM/DD/YYYY
20	*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				
21	*BillType*	Type of bill	Character	
22	*DischStat*	Discharge status	Character	
23	*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				
24	*Dx1*	The primary diagnosis code (ICD-10-CM code)	Character	
25	*Dx2*	The second diagnosis code (ICD-10-CM code)	Character	
26	*Dx3*	The third diagnosis code (ICD-10-CM	Character	

Field No.	Field Names	Description	Type	Note
		code)		
27	*Dx4*	The fourth diagnosis code (ICD-10-CM code)	Character	
28	…	…	Character	
29	*Dx<N>*	The Nth diagnosis code (ICD-10-CM code)	Character	
Please ensure to include additional diagnosis code fields available in your plan's claims system up to a maximum of 25 diagnosis code fields. Please label the additional fields as *Dx5*, *Dx6*, …., *Dx25*.				
ICD-10-PCS Surgical Codes				
30	*Surg1*	The first surgical code (ICD-10-PCS surgical code)	Character	
31	*Surg2*	The second surgical code (ICD-10-PCS surgical code)	Character	
32	*Surg3*	The third surgical code (ICD-10-PCS surgical code)	Character	
33	*Surg4*	The fourth surgical code (ICD-10-PCS surgical code)	Character	
34	…	…	Character	
35	*Surg<N>*	The Nth surgical code (ICD-10-PCS code)	Character	
Please ensure to include additional surgical code fields available in your plan's claims system up to a maximum of 25 surgical code fields. Please label the additional fields as *Surg5*, *Surg6*, …., *Surg25*.				
Provider Information				
36	*BillProvID*	Medicaid identification number of the billing provider	Character	
37	*BillProvNPI*	National Provider Identifier (NPI) of the billing provider	Character	
38	*AttendProvID*	Medicaid identification number of the attending provider	Character	
39	*AttendProvNPI*	NPI of the attending provider	Character	
40	*ReferProvID*	Medicaid identification number of the referring provider	Character	
41	*ReferProvNPI*	NPI of the referring provider	Character	
Revenue Code and Procedure Code				
42	*RevCode*	Revenue center code	Character	
43	*ProcCode*	Procedure code (CPT-4 or HCPCS)	Character	
44	*Mod1*	The first of up to 4 procedure/service/supplies modifier (if applicable)	Character	

Field No.	Field Names	Description	Type	Note
45	*Mod2*	The second of up to 4 procedure/service/supplies modifier (if applicable)	Character	
46	*Mod3*	The third of up to 4 procedure/service/supplies modifier (if applicable)	Character	
47	*Mod4*	The fourth of up to 4 procedure/service/supplies modifier (if applicable)	Character	
48	*Units*	Units of service	Numeric	
49	*UnitsBilled*	Units billed	Numeric	
Drug Data Elements				
50	*NDC*	NDC code that applies to the service	Character	
51	*DrugQty*	Quantity of the drug indicated by the NDC that is being billed	Character	
52	*DrugUnitMeas*	Unit of measurement of the drug indicated by the NDC	Character	
Payment Information				
53	*PaidDate*	Date of final disposition of the encounter	Date	Format: MM/DD/YYYY
54	*ContractType*	The contract between the plan and the provider paid by the plan: 05 = Capitation 09 = FFS	Character	
55	*AmountPaid_H*	This is the plan paid amount at the header level	Numeric	
56	*AmountPaid_D*	This is the plan paid amount at the detail level	Numeric	
57	*Dtl_Status*	This indicates whether the claim/encounter is paid or denied: P = Paid D = Denied	Character	
58	*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
Comprehensive Plans				
Aetna Better Health of Florida, Inc.	AET-C	Aetna-C	301831	1001203
Humana Medical Plan, Inc.	HUM-C	Humana-C	301834	1000499
Molina Healthcare of Florida, Inc.	MOL-C	Molina-C	301836	1001402
Simply Healthcare Plans, Inc.[4]	SIM-C	Simply-C	301838, 301832, 301835, 301863	1001210, 1000556, 1001225, 1001490
Sunshine State Health Plan, Inc.	SUN-C	Sunshine-C	301866	1000493
UnitedHealthcare of Florida, Inc.	UNI-C	United-C	301840	1001214
MMA Plans				
AmeriHealth Caritas Florida, Inc.	AMH-M	AmeriHealth-M	301833	1001406
South Florida Community Care Network, DBA Community Care Plan	CCP-M	Community Care Plan-M	301837	1001421

[4] Vivida Health was acquired by Simply Healthcare Plans, Inc. as of November 1, 2022. As such, encounters submitted by Vivida Health (TPID=301832) will be reported under Simply Healthcare Plans, Inc. Similarly, Lighthouse Health Plan LLC merged with Simply Healthcare Plans, Inc. on February 2, 2021. Encounters associated with Lighthouse Health Plan (TPID=301835) will also be assessed under Simply Healthcare Plans, Inc. Simply Healthcare Plans, Inc. also purchased Miami Children's Health Plan, LLC and members were moved to Simply Healthcare Plans, Inc. effective May 2021. As such, encounters submitted by Miami Children's Health Plan, LLC (TPID=301863) will be reported under Simply.

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
Plans' 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 *BillProvNPI* • Total number of unique rendering provider NPI by *RendProvNPI* • Sum of "*AmountPaid_H*" • Sum of "*AmountPaid_D*"
Plans' 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 *BillProvNPI* • 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 *ClaimLineNo*. There should **not** be any duplicates based on *ICN* and *ClaimLineNo*.
- 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.