HSAG HEALTH SERVICES ADVISORY GROUP

# SFY 2024–25 Encounter Data Validation Study
# Specialty 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) 2024–25, the Florida 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 2024–25 EDV study is to examine the extent to which the encounters submitted to the Agency by its contracted Specialty Plans are complete and accurate.[1] This document defines specific data submission requirements for the data from the plans' data systems. In general, one type of data file is being requested:

1. Encounter data, including encounters from the 837P and 837I transaction files

## 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 2024-2025/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

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

persist during the upload, please reach out to Diana Valle at 602-329-7358 or via email at dvalle@hsag.com for alternate options.

- Please upload the requested data files by **October 18, 2024,** 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 Rachel Perry at 602-575-7200 or via email at rperry@hsag.com.

## Encounter Files

The encounter files should be comprised of all final paid and denied encounters associated with the plan specific Trading Partner IDs (TPIDs) listed in Appendix A. The requested encounters should be encounters with dates of service from **January 1, 2023, through December 31, 2023**, and for all enrollees who are eligible to receive services that were submitted to the Agency on or before August 31, 2024. 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 and Discharge Dates
- Provider Identifier (i.e., Billing Provider National Provider Identifier [NPI], Rendering Provider NPI, Attending Provider NPI, and Referring Provider NPI)

[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 Codes (Primary and Secondary Diagnosis Codes)
- Procedure Codes (Current Procedural Terminology [CPT]/Healthcare Common Procedure Coding System [HCPCS]) and Procedure Code Modifiers
- Surgical Procedure Codes
- Revenue Code
- Diagnosis Related Group (DRG)
- National Drug Code (NDC)
- Header and Detail Paid Amounts

## 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 services that are associated with the plan specific TPIDs listed in Appendix A from the Professional (837P) and Institutional (837I) transactions. As noted by the Agency, these encounters can be identified by using the following ClaimType[1] codes:<br>**Professional encounters**: "B" or "M"<br>**Institutional encounters**: "A", "C", "I", "L", or "O" |
| Plan | All plans listed in Appendix A |
| Dates of Service | January 1, 2023 ≤ Line First Date of Service ≤ December 31, 2023<br>**OR**<br>January 1, 2023 ≤ Line Last Date of Service ≤ December 31, 2023 |
| Data Submission Date | Please include all encounters submitted to the Agency on or before August 31, 2024 |
| Adjudication | Only the final fully adjudicated encounters submitted to the Agency on or before July 31, 2024 |
| Paid Status | Include both paid and denied encounters submitted to the Agency |
| File Format | ASCII text file in a pipe (\|) delimited format or SAS format |

[1] ClaimType codes represent the encounter type. (B: professional crossover, M: professional, A: inpatient crossover, C: outpatient crossover, I: inpatient, L: long-term care, and O: outpatient).

## 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

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 encounters from the 837P transactions. As noted by the Agency, please include encounters with a ClaimType (i.e., encounter type) of "B" (professional crossover) or "M" (professional).

**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 | PrcsDt | Date when a record was processed by FMMIS | 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 [A] | Type of encounter. For example, "M" for professional or "B" for professional crossover | Character | Please provide value definition for this field. |
| 14 | ClaimFreqTypeCode | Claim frequency type code:<br>1 – Original Claim<br>7 – Adjustment (Replacement of Paid Claim) | Numeric | |

| Field No. | Field Names | Description | Type | Note |
| --- | --- | --- | --- | --- |
| | | 8 – Void | | |
| **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 $N^{th}$ diagnosis code (ICD-10-CM code) | Character | |
| Please ensure to include additional diagnosis code fields available in the Agency's data warehouse 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 | 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/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 | Format: Number (9,2) |
| 39 | UnitsBilled | Units billed | Numeric | |
| **Drug Data Elements** | | | | |
| 40 | NDC | National Drug Code (NDC) that applies to the service | Character | |
| 41 | DrugQty | Quantity of the drug indicated by the NDC that is being billed | Character | |
| 42 | DrugUnitMeas | Unit of measurement of the drug indicated by the NDC | Character | |
| **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:<br>05 – Capitation<br>09 – FFS | Character | |
| 45 | AmountPaid_H | Plan paid amount at the header level | Numeric | Format: Number (11,2) |

| Field No. | Field Names | Description | Type | Note |
|---|---|---|---|---|
| 46 | AmountPaid_D | Plan paid amount at the detail level | Numeric | Format: Number (11,2) |
| 47 | Dtl_Status | Indicates whether the claim/encounter is paid or denied:<br>P – Paid<br>D – Denied | Character | |
| 48 | Usermem01 – UserMem99 | User defined. The Agency 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 encounters from the 837I transactions. As noted by the Agency, please include encounters with a ClaimType (i.e., encounter type) of "A" (inpatient crossover), "C" (outpatient crossover), "I" (inpatient), "L" (long-term care), or "O" (outpatient).

**Table 3—Required Data Elements for the 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 | PrcsDt | Date when a record was processed by FMMIS | 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 | |

| Field No. | Field Names | Description | Type | Note |
|---|---|---|---|---|
| 11 | LastClaimInd | Last claim indicator | Character | |
| 12 | AdjDate | Adjudication date | Date | Format: MM/DD/YYYY |
| 13 | ClaimType [A] | Type of encounters. "A" for inpatient crossover, "C" for outpatient crossover, "I" for inpatient, "L" for long-term care, or "O" for outpatient | Character | Please provide value definition for this field. |
| 14 | ClaimFreqTypeCode | Claim frequency type code:<br>1 – Original Claim<br>7 – Adjustment (Replacement of Paid Claim)<br>8 – Void | Numeric | |
| **Dates of Service** | | | | |
| 15 | AdmitDate | Date of admission | Date | Format: MM/DD/YYYY |
| 16 | Discharge Date | 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 | Diagnosis Related Group (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 code) | Character | |

| Field No. | Field Names | Description | Type | Note |
|---|---|---|---|---|
| 27 | Dx4 | The fourth diagnosis code (ICD-10-CM code) | Character | |
| 28 | ... | … | Character | |
| 29 | Dx<N> | The $N^{th}$ diagnosis code (ICD-10-CM code) | Character | |
| Please ensure to include additional diagnosis code fields available in the Agency's data warehouse up to a maximum of 25 diagnosis code fields. Please label the additional fields as *Dx5*, *Dx6*, …., *Dx25*. | | | | |
| **ICD-10-PCS Procedure 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 the Agency's data warehouse 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 | 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 | |
| 45 | Mod2 | The second of up to 4 procedure/service/supplies modifier (if | Character | |

| Field No. | Field Names | Description | Type | Note |
|---|---|---|---|---|
| | | applicable) | | |
| 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 | Format: Number (9,2) |
| 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:<br>05 – Capitation<br>09 – FFS | Character | |
| 55 | AmountPaid_H | Plan paid amount at the header level | Numeric | Format: Number (11,2) |
| 56 | AmountPaid_D | Plan paid amount at the detail level | Numeric | Format: Number (11,2) |
| 57 | Dtl_Status | This indicates whether the claim/encounter is paid or denied:<br>P – Paid<br>D – Denied | Character | |
| 58 | UserMem01 – UserMem99 | User defined. The Agency 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 Specialty Plans Included in the EDV Study**

| Plan Name | Plan Abbreviation | Shortened Name | Trading Partner Identifier (TPID) | Plan Base Medicaid ID |
|---|---|---|---|---|
| **Specialty Plans** | | | | |
| Children's Medical Services Network | CMS-S | Children's Medical Services-S | 301993 | 1009927 |
| Clear Health Alliance (HIV/AIDS Specialty Plan) | CHA-S | Clear Health-S | 301839 | 1001196 |
| Molina Specialty Plan SMI | MOL-S | Molina-S | 303224 | 1095646 |
| Sunshine Child Welfare Specialty Plan | SUN-S-CW | Sunshine-S-CW | 301868 | 1000486 |
| Sunshine SMI Specialty Plan | SUN-S-SMI | Sunshine-S-SMI | 303263 | 1087735 |

# 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. Please use the template inserted below to submit the control totals, ensuring each sheet is filled out for the requested data types.

FL_SFY2024-2025_EDV_ControlTotal_Sp

**Table B-1—Control Total Specifications**

| Data | Specifications |
|---|---|
| Encounters from 837P Transactions | • Total number of records<br>• Total number of unique *PlanID*<br>• Total number of unique *ICN*<br>• Total number of unique *TCN*<br>• Total number of unique enrollees by *RecipID*<br>• Total number of unique by *BillProvNPI*<br>• Total number of unique by *RendProvNPI*<br>• Total sum of *Units*<br>• Sum of *AmountPaid_H*<br>• Sum of *AmountPaid_D* |
| Encounters from 837I Transactions | • Total number of records<br>• Total number of unique *PlanID*<br>• Total number of unique *ICN*<br>• Total number of unique *TCN*<br>• Total number of unique enrollees by *RecipID*<br>• Total number of unique *BillProvNPI*<br>• Total number of unique *AttendProvNPI*<br>• Total sum of *Units*<br>• Sum of *AmountPaid_H*<br>• 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.