HSAG HEALTH SERVICES ADVISORY GROUP

SFY 2021-22 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) 2021–22, 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 2021–22 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

- Due to the expected size of the requested data files, HSAG requests that all data files be submitted to HSAG's secure file transfer protocol (SFTP) site. Please request access before **October 15, 2021** via email by sending the user's name, email address, and plan affiliation to Lacey Hinton at lhinton@hsag.com.
- In order to facilitate the import process of the submitted files, using the exact field names and types for the requested data elements is required. 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 **October 29, 2021** and notify Lacey Hinton at 602-801-6804 or via email at lhinton@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 Lacey Hinton at 602-801-6804 or via email at lhinton@hsag.com if you have questions or require any assistance with access to HSAG's SFTP site or 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 with dates of service from January 1, 2020 to December 31, 2020, 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 837P transactions
- LTC encounters from 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 from 837P and 837I transactions
Plan	All plans listed in Appendix A
Dates of Service	January 1, 2020 <= Header First Date of Service <= December 31, 2020 **OR** January 1, 2020 <= Header Last Date of Service <= December 31, 2020
Data Submission Date	Please include all LTC encounters submitted to the Agency on or before July 31, 2021.
Adjudication	Only the final fully adjudicated encounters submitted to the Agency on or before July 31, 2021.
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 **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.

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	Numeric	

Field No.	Field Names	Description	Type	Note
		7 – Adjustment (Replacement of Paid Claim) 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	**Please include as many rows as needed, up to 25 diagnosis code fields.**			
Provider Information				
24	*BillProvID*	Medicaid identification number of the billing provider	Character	
25	*BillProvNPI*	National Provider Identifier (NPI) of the billing provider	Character	

Field No.	Field Names	Description	Type	Note
26	*RendProvID*	Medicaid identification number of the provider rendering the service	Character	
27	*RendProvNPI*	NPI of the rendering provider	Character	
28	*RendProvSpec*	The reported area of specialization for the provider rendering the service	Character	
29	*ReferProvID*	Medicaid identification number of the referring provider	Character	
30	*ReferProvNPI*	NPI of the referring provider	Character	
Place of Service and Procedure Code				
31	*POS*	Place of service code – The location at which service was rendered such as office, home, emergency room, etc.	Character	
32	*ProcCode*	Procedure code (CPT-4 or HCPCS)	Character	
33	*Mod1*	Modifier code – The first of up to 4 procedure/service/supplies modifier (if applicable)	Character	
34	*Mod2*	Modifier code – The second of up to 4 procedure/service/supplies modifier (if applicable)	Character	
35	*Mod3*	Modifier code – The third of up to 4 procedure/service/supplies modifier (if applicable)	Character	
36	*Mod4*	Modifier code – The fourth of up to 4 procedure/service/supplies modifier (if applicable)	Character	

Field No.	Field Names	Description	Type	Note
37	*Units*	Units of service	Numeric	
38	*UnitsBilled*	Units billed	Numeric	
Drug Data Elements				
39	*NDC*	NDC code that applies to the service	Character	
40	*DrugQty*	Quantity of the drug indicated by the NDC that is being billed	Character	
41	*DrugUnitofMeas*	Unit of measurement of the drug indicated by the NDC		
Payment Information				
42	*PaidDate*	Date of final disposition of the encounter	Date	Format: MM/DD/YYYY
43	*ContractType*	The contract between the plan and the provider paid by the plan: 05 = Capitation 09 = FFS	Character	
44	*AmountPaid_H*	This is the plan paid amount at the header level	Numeric	
45	*AmountPaid_D*	This is the plan paid amount at the detail level	Numeric	
46	*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
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

Field No.	Field Names	Description	Type	Note
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	**Please include as many rows as needed, up to 25 diagnosis code fields.**			
ICD-10-PCS Procedure Codes				
28	*Surg1*	The first surgical code (ICD-10-PCS surgical code)	Character	
29	*Surg2*	The second surgical code (ICD-10-PCS surgical code)	Character	
30	*Surg3*	The third surgical code (ICD-10-PCS surgical code)	Character	
31	*Surg4*	The fourth surgical code (ICD-10-PCS surgical code)	Character	
32	**Please include as many rows as needed, up to 25 surgical procedure code fields.**			
Provider Information				

Field No.	Field Names	Description	Type	Note
33	*BillingProvID*	Medicaid identification number of the billing provider	Character	
34	*BillingProvNPI*	National Provider Identifier (NPI) of the billing provider	Character	
35	*AttendingProvID*	Medicaid identification number of the attending provider	Character	
36	*AttendingProvNPI*	NPI of the attending provider	Character	
37	*ReferProvID*	Medicaid identification number of the referring provider	Character	
38	*ReferProvNPI*	NPI of the referring provider	Character	
Revenue Code and Procedure Code				
39	*RevCode*	Revenue center code	Character	
40	*ProcCode*	Procedure code (CPT-4 or HCPCS)	Character	
41	*Mod1*	The first of up to 4 procedure/service/supplies modifier (if applicable)	Character	
42	*Mod2*	The second of up to 4 procedure/service/supplies modifier (if applicable)	Character	
43	*Mod3*	The third of up to 4 procedure/service/supplies modifier (if applicable)	Character	
44	*Mod4*	The fourth of up to 4 procedure/service/supplies modifier (if applicable)	Character	
45	*Units*	Units of service	Numeric	
46	*UnitsBilled*	Units billed	Numeric	
Drug Data Elements				
47	*NDC*	NDC code that applies to the service	Character	
48	*DrugQty*	Quantity of the drug indicated by the NDC that is being billed	Character	
49	*DrugUnitMeas*	Unit of measurement of the drug indicated by the NDC	Character	
Payment Information				
50	*PaidDate*	Date of final disposition of the encounter	Date	Format: MM/DD/YYYY
51	*ContractType*	The contract between the plan and the	Character	

Field No.	Field Names	Description	Type	Note
		provider paid by the plan: 05 = Capitation 09 = FFS		
52	*AmountPaid_H*	This is the plan paid amount at the header level	Numeric	
53	*AmountPaid_D*	This is the plan paid amount at the detail level	Numeric	
54	*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				
Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	COV-C	Aetna	301823	1001200
Humana Medical Plan, Inc.	HUM-C	Humana	301826	1000513
Molina Healthcare of Florida, Inc.	MOL-C	Molina	301827	1001399
Simply Healthcare Plan, Inc.	SHP-C	Simply	301828	1001206
Sunshine State Health Plan, Inc.	SUN-C	Sunshine	301865	1000516
United Healthcare of Florida, Inc.	URA-C	United	301829	1001219
Wellcare of Florida d/b/a Staywell Health Plan of Florida, Inc.	STW-C	Staywell	301830	1000545
LTC Plan				
Florida Community Care	FCC-L	Florida Community Care	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*"