Data Layouts and Formats

Dental Claims/encounters Data File
Provider File

SUBMISSION GUIDELINES

Updated 10/29/2015

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1. INTRODUCTION

This document describes the data layouts and formats for receiving the following data file:

- Dental claims data – data related to dental claims

2. GENERAL REQUIREMENTS

2.1 Data Extraction

For this encounter system, ICHP requires the MCOs to submit all paid and denied claims data. Pending claims should not be included in the submission. Our expectation is that we will get quarterly claims file submissions which will cover claims adjudicated in the prior quarter.

2.2 Data Submission

We accept encounter data 24 hours a day, 7 days a week, 365 days a year, except during brief, pre-announced system maintenance periods.

The file naming convention for these files will be "Identifier< Dental, Provider, Pharmacy> " "Plan Name/Code" "YYYYMM" where YYYYMM is the submission year and month.

2.3 Data Element Formatting

1. Date formats are always formatted YYYYMMDD(8).
2. Numeric values are always right-justified, zero filled.
3. Alphanumeric values are always left-justified, blank filled and uppercase.
4. Each file should be delivered in a fixed-length ASCII format with no field labels and no binary data.
5. All null fields must contain blanks/spaces
6. Negative values are not allowed on paid amounts for the dental claims data. Negative amounts are allowed on the pharmacy data.
7. For dollar amounts, we always assume a whole dollar amount unless a decimal is provided. If a portion of your data has decimal values, we will add appropriate fill values (e.g. 00 cents) for each of the values.

   Examples: 125 = $125.00
   125.99 = $125.99

8. All dental and pharmacy files must end with a "Trailer" record containing the "Trailer Identifier< FHK>", "Total # of Records", "Total Paid Dollars on the File", "Paid Month Start Date" and "Paid Month Thru Date"
9. Financial Arrangement Code: The MCO can use the following code set to provide details on how the service was covered as it pertains to payment/reimbursement to the provider of that service:

Value	Financial Arrangement Description
01	Delegated Behavioral Health subcontract
02	Delegated Vision subcontract
03	Delegated Disease Management subcontract
04	Delegated Dental Services subcontract
05	Delegated Long Term Care Service subcontract
06	Other Delegated Services
07	Capitated Providers (non-delegated, in-network providers who are

	paid through a capitation arrangement)
08	Internal Fee For Service General Claims – In-network
09	Internal Behavioral Health Claims
10	Internal Vision Claims
11	Internal Long Term Care Service Claims
12	Value Added Services paid through the claims processing system (services that the health plan provides as additional benefits to their clients that are not required per the Florida Healthy Kids contract)
13	Out-of-network provider – Fee For Service

2.4 Adjustments

The main purpose for collecting encounter data is to have the most accurate information and data representation of all healthcare provided to an individual by an MCO. For the majority of transactions, the original record is the most accurate representation. For a small fraction of the transactions, the original record needs to be updated to improve accuracy - we refer to these updates as "adjustments". The reasons for adjustments vary and include:

- compensation changes,
- audit findings,
- eligibility and enrollment changes, and
- re-adjudication of the claim.

All MCOs perform adjustments to transactions. Frequently, a single adjustment is all that is required to produce the most accurate representation of the healthcare event. For example: if a plan originally paid for four services and rejected two other services, but subsequently agrees to pay for the other two rejected services, the data warehouse must accurately show these changes. If a plan initially submits a transaction for a dental visit, but it later discovers that the child was never enrolled in the program, the MCO needs to void the transaction and the warehouse needs to reflect the change. There may also be instances when multiple adjustments may need to be performed to get to the final judgment on the claim.

ICHP expects MCOs to submit all original transactions, as well as all adjustment transactions. If adjustments are not submitted, the ICHP data warehouse will not have an accurate data representation of an MCO's efforts, which could adversely affect an MCO in the areas of outcomes measures, utilization, and payments.

Traditionally, there are two methods of performing an adjustment:

1. The first method takes the approach of re-submitting the final image of the claim , which would include the updates as well as the data that did not require updating. This is commonly referred to as "claim level adjustments". The header level claim status will denote an "A" for adjusted claims. The detail lines status codes will indicate an "A" for adjusted detail lines only. The detail lines which did not require updating will carry their original status code of a "P". Claim level adjustment is the only method allowed for encounter data submission from the MCO's to ICHP.

2. The second method takes the approach of simply supplying updated information about a particular value and/or line (detail) in a transaction. This is commonly referred to as "line item adjustments". Line item adjustments are not allowed for encounter data submission.

For submissions to ICHP, when an adjustment to a previously submitted transaction is necessary, the entire transaction must be submitted; line item adjustments are prohibited.

In order to maintain an accurate data representation, there must be a process to associate an adjustment transaction to a previously submitted transaction. Accurate analysis and reporting require a dependable association process. Two examples are provided below:

1. The Chaining Process: The chaining process allows for an association of an adjustment transaction to the most recent iteration of an original transaction. A three step chaining process example is provided in Figure 1.

2. The Sequencing Process. The sequence process associates all adjustment transactions to the original transaction by using the original transaction ICN. The order of the adjustment transactions is maintained by using a sequence number. A 3-step sequence process example is provided in Figure 2. Note: Some organizations apply a sequence number of (0000) to the original. In this case, the first adjustment record's sequence number will be (0001). This poses no problem to the encounter adjustment process.

The MCOs can adopt either the chaining process or the sequencing process to submit adjustments.

The Chaining Process

An adjustment transaction is added. The association can be derived by using the Original ICN attribute

A second adjustment transaction is added. The association to original transaction can be derived by using the Original ICN attribute in two steps of indirection.

A third adjustment transaction is added. The association can be derived by using the Original ICN attribute to reach the original transaction in three steps of indirection.

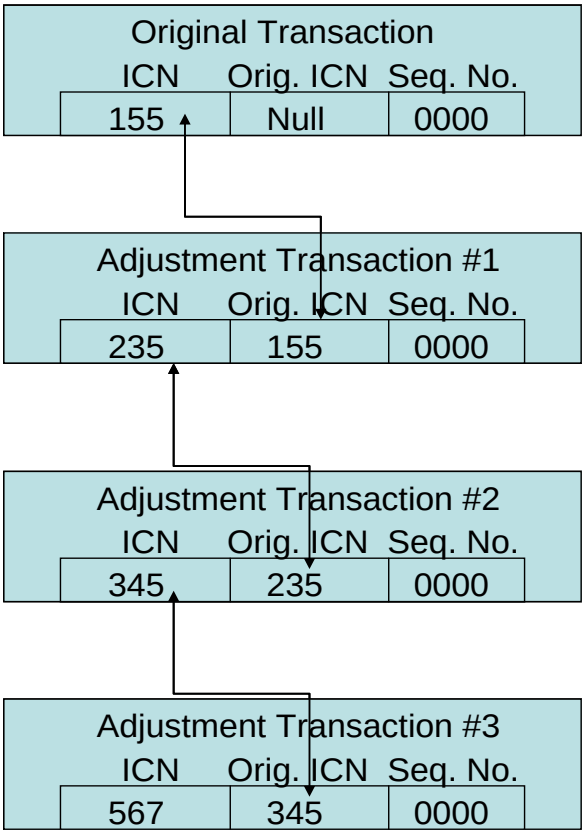

Figure 1: A three step daisy chaining process

The Sequencing Process

An adjustment transaction is added. The association can be derived by using the Original ICN and sequence number (0002)

A second adjustment transaction is added. The association can be derived by using the Original ICN and sequence number (0003)

A third adjustment transaction is added. The association can be derived by using the Original ICN and sequence number (0004)

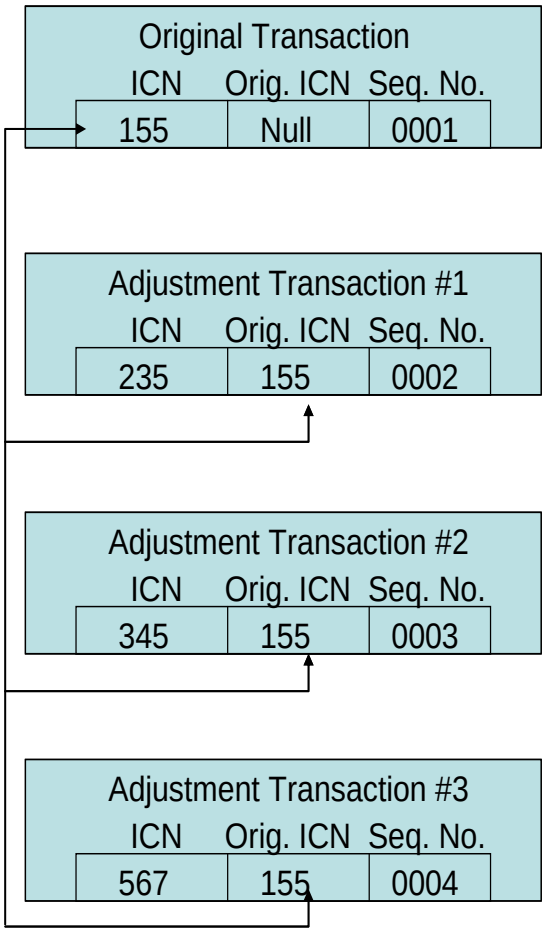

Figure 2: A three step sequencing process

As stated earlier, any adjustment requires the re-submission of all the detail lines. Four sets of values will be used to capture the final image of a service rendered at a given point in time. The values are:

- the MCO's "Plan code",
- the MCO's "Transaction ICN",
- the MCO's "Original Transaction ICN" or a combination of "Original Transaction ICN" and "Sequence Number,"
- the transaction "Header Claim Status Code."

2.5 Definitions

A number of terms have been used throughout the document. In the following, we briefly define these terms for the purposes of the encounter enhancement effort, as they have multiple interpretations within the healthcare community

- Void: A void (Header Claim Status Code "V") is only to be used by the plan if it wants to completely delete a previously submitted transaction. A void transaction must have an ICN (or ICN and sequence number) and the ICN must follow the same approach used by the plan for adjustment (Chaining or Sequencing). *There is no need to negate previously submitted details. To submit a void transaction, send all of the original details, exactly as sent the first time except this time the header status code will be a "V". The detail status codes will not change. There is also no need to change items such as quantity or dollars to negative values.*

- Adjustment: An adjustment (Header Claim Status Code "A") is the change, addition, or deletion of one or more values on a transaction. An adjustment transaction will be sent by the plan if it wishes to add, delete and/or change information contained in a previously submitted transaction. Possible reasons for submitting an adjustment include payment change information or changes necessary to correct a previously rejected transaction. An adjustment transaction must have an original ICN, sequence number (if appropriate), and must use the chaining or sequencing methods that are described above. *When submitting an adjustment transaction, send all of the details necessary to most accurately represent the healthcare event.* The detail level status code will change only for detail lines that required updating.

- ICN (Internal Control Number): It is the unique identifier applied to a transaction by the MCO. This value is used by the plan to distinguish between different transactions and is not the value assigned to the transaction by the healthcare provider. Consider an example in which a physician submits a claim to the plan using an ICN of "333" and the plan applies its own ICN of "440" to the transaction. In this case, ICHP considers "440" as being the transaction's ICN.

- Sequence number: This number is applied to a transaction to identify its order in a set consisting of multiple related transactions. ICHP does not require the use of sequence numbers if a plan is using the daisy chaining process.

- Complete History: All the transactions related to a single event and submitted to ICHP constitute its complete history. A complete history of a transaction that has been adjusted three times will consist of four transactions.

3. DENTAL CLAIMS FILE LAYOUT

FIELD Name	TYPE	Beginning Position	Ending Position	VALUE	DESCRIPTION
Record Type	AN (1)	1	1	D	Record Type
Recipient ID	AN(12)	2	13		Enrollee's SSN
Plan ID	AN(5)	14	18		Program name or ID
Billing Provider -Number	AN(12)	19	30		Unique Provider ID Number (Program ID for the provider)
Billing Provider NPI	AN(10)	31	40		
Billing Provider Taxonomy	AN(10)	41	50		Taxonomy Code
Billing Provider Tax ID	N(9)	51	59		Provider's TAX ID
Treating Provider -Number	AN(12)	60	71		Treating Provider Unique Provider ID
Treating Provider Specialty	AN(2)	72	73	D1 – Endodontia D2 - Oral and maxillofacial surgery D3 - General dentistry D4 – Orthodontia D5 - Pediatric dentistry D6 – Periodontia D7 - Public health dentistry D8 - Other	
Treating Provider NPI	AN(10)	74	83		
Treating Provider Taxonomy	AN(10)	84	93		Taxonomy Code
Treating Provider Tax ID	AN(9)	94	102		Provider's TAX ID
Claim Number (ICN)	AN(25)	103	127		Claim Number submitted on an encounter
Claim Line Number	N(7)	128	134		A sequential number which when associated to a Claim Number uniquely identifies a detail line on an encounter submission.
Claim Sequence Number	AN(4)	135	138		A sequence number which increases incrementally with each iteration of claim adjustment. Only applies for sequencing process.
Mother ICN	AN(25)	139	163		Only applies to adjustments and voids. Points to the ICN of the previous iteration on the claim.
Header Level Status	AN(1)	164	164	P,A,C, D, V	Claim level adjudication status as "paid", "adjusted", "capitated" , "denied" or "voided".
Line Item Level Status	AN(1)	165	165	P,D,A,C	Indicates if the encounter line item is paid, denied, adjusted, or capitated.
Procedure Date	AN(8)	166	173	YYYYMMDD	Date of Service
Tooth ID or Area ID	AN(2)	174	175	1-32 or A-T for tooth ID,	Area ID should be used when the procedure is applied to

FIELD Name	TYPE	Beginning Position	Ending Position	VALUE	DESCRIPTION
				supernumerary tooth ID 51-82 or AS-TS is allowed for limited procedure codes.	quadrants of the arch instead of the individual teeth. Valid area IDs include UL, UR, LL, LR for quadrants, UA and LA for arches.
Tooth Surface	A(5)	176	180	B (buccal), D (distal), F (facial), I (incisal), L (lingual), M (mesial), O (occlusal)	Required where applicable.Tooth surface appropriate for Procedure code billed, could be combination of multiple surfaces.
Procedure Code	AN(6)	181	186		CPT or CDT code
Amount Billed	N(9)	187	195		UCR fee
Amount Paid	N(12)	196	207		Amount paid for the line item on the claim related to the above referenced care
Place of Service Code	AN(2)	208	209	01-99	Code designates a Place of Service where client received services based on an encounter submission.
Date Claim received	AN(8)	210	217	YYYYMMDD	Optional. Date received by processing contractor
Paid Date	AN(8)	218	225	YYYYMMDD	Date Paid or Denied
*Line Item EOB	AN(3)	226	228	Explanation code for each line item processed relating to how the claim was adjudicated	Optional. Explanation of Benefits code
Kidcare ID	AN(10)	229	238	Child's Individual ID	
Dental Insurance ID	AN(10)	239	248	Child's Dental Insurance Number	
Financial Arrangement Code	AN(2)	249	250	Use crosswalk on Page 3	A two digit code that identifies how the service was paid.

*Not required fields

7. PROVIDER FILE LAYOUT

NAME	TYPE	SIZE	Beginning Position	Ending Position	VALUE	Description of Values
Transaction Type	AN	1	1	1	Blank a,c,d	a = Add, c = Change/Edit; d = Delete; Blank = existing member, no change
Period - current month	N	6	2	7	yyyymm	
Plan ID	AN	5	8	12		Program name or ID
Provider ID (Provider Number)	AN	12	13	24		Health plan assigned or program assigned ID for the provider
NPI number	AN	10	25	34		National Provider ID
Taxonomy code	AN	10	35	44		
Provider last name	AN	24	45	68		
Provider's first name	AN	14	69	82		
Address attn	AN	24	83	106		
Address line 1	AN	24	107	130		
Address line 2	AN	24	131	154		
Address line 3	AN	24	155	178		
City	AN	12	179	190		
State	AN	2	191	192		
Zip	N	10	193	202		
Telephone	AN	12	203	214	format: 512-555-1212	
Practice type	AN	2	215	216	01, 02	Optional. Group Practice=01 , Individual Practice=02
Panel size	N	2	217	218		Optional. Number of clients assigned to the provider
County code	N	3	219	221		
Primary Care Provider	AN	1	222	222	Y/N	Yes or No
Provider's License Number	AN	7	223	229		Optional.
Provider's Tax ID	AN	9	230	238		Optional.
Credentialed	AN	1	239	239		Optional. Is Provider Credentialed Y/N?

4. REVISIONS

02/08/2008 : Added NPI and Taxonomy information on the Dental , Pharmacy, and Provider files.

Changed Specialty Code to PCP Y/N on the provider file.

Added Plan ID field to Dental, Pharmacy, and Provider files

03/13/2008 : Changed the Date of Birth field on the pharmacy layout from AN(10) to AN(8).

Changed Amount in dental file from N (9) to N (12)

04/30/2009: Annotated fields that are not mandatory

01/28/2011 : Added additional child identifiers –KidCare ID and Medical Insurance ID/Dental Insurance

Added financial arrangement code to the Dental layout.

10/26/2012: Added adjustment logic description for Dental layout.

Modified Tooth or Area ID definition.

Added Claim sequence number, Mother ICN; Replaced Adjudication Status with Header level status and Line item level status in the Dental file.

10/29/2015: Compiled claims, pharamcy and provider files together. Added “Beginning Position” and “Ending Position” fields.