Data Layouts and Formats

Claims/Encounters Data Files
Pharmacy and Provider Files

SUBMISSION GUIDELINES

Updated 01/30/2015

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1. INTRODUCTION

This document provides guidelines for the submission of encounter/claims, pharmacy and provider data from Managed Care Organizations (MCOs) in the State of Florida to the Institute for Child Health Policy (ICHP). The method of electronic file transfer and the required fields and their formats are discussed. Also, the acceptable strategies for providing adjustments to previous encounters are explained in detail.

2. GENERAL REQUIREMENTS

2.1 Data Extraction

For this encounter system, ICHP requires the MCOs to submit all paid and denied claims data. No claims/encounters should be excluded from submission due to amount paid, claim status, diagnosis, procedure, or any other factor. The files should include claims for all services and benefits rendered by the health plan and should include behavioral health claims.The only exceptions are claims that are still pending. 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 Connectivity

All file exchanges, including reports, will occur through ICHP servers set up for each MCO. A separate guide detailing logon and file transfer procedures is available through the ICHP MCO Support Team.

2.3 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 encounter files will be structured as ENC*IDCCYYMM*:

> **"ENC"** is constant.
> **ID** = Plan code. MCOs that have multiple plan codes may use any one of their plan codes in the file name since each unique encounter transaction will identify the plan code in which the client is assigned.
> **CCYYMM** = Year and month when the submission was made.

The pharmacy file naming convention will be PHMIDCCYYMM and provider file will be PROVIDCCYYMM.

2.4 Data Element Formatting

1. Date formats are always formatted as YYYYMMDD(8).
2. Numeric values are always right-justified, zero filled.
3. Alphanumeric values are always left-justified, blank filled and uppercase.
4. Signed values (ending alpha characters to denote positive or negative values) are never allowed on dollar amounts.

5. Negative values are not allowed on paid amounts for the medical claims data. Negative amounts are allowed on the pharmacy data.
6. *If the claim is paid "per-diem" or on DRG basis then the total payment can be provided on the first detail.*
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
   125.9 = $125.90
8. Each file 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 codeset 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

3. 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 well child 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.

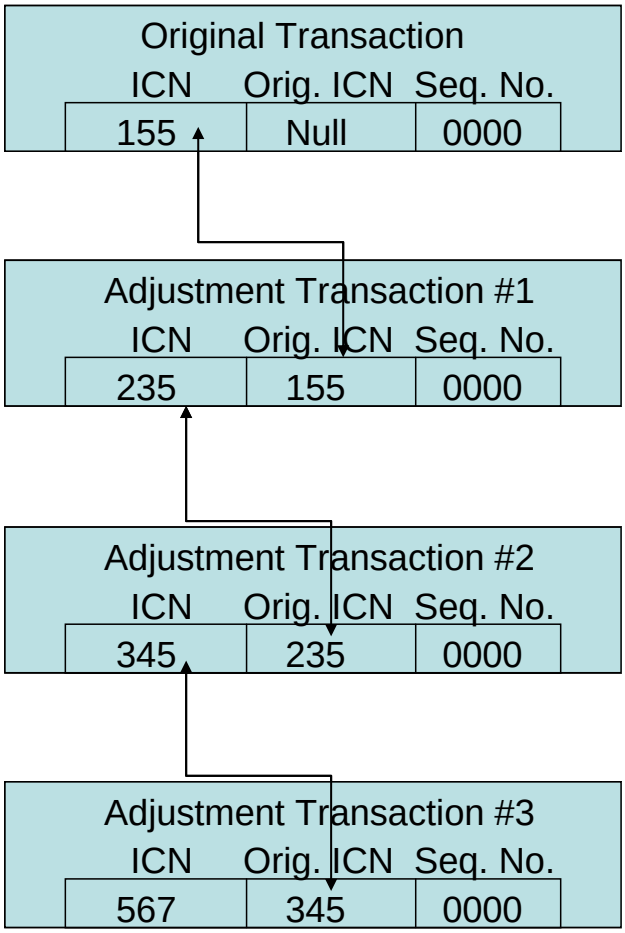

Figure 1: A three step daisy chaining process

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)

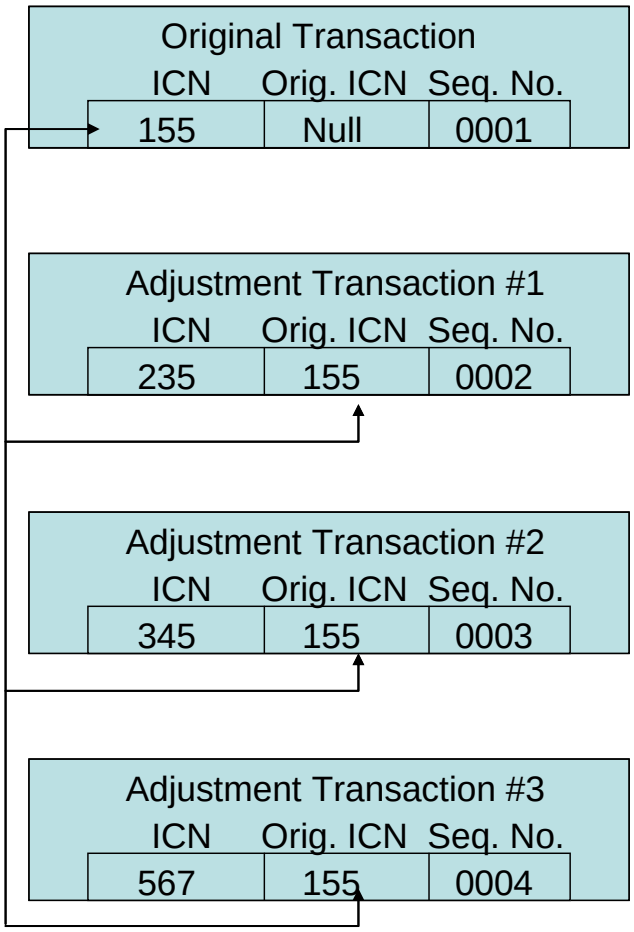

Figure 2: A three step sequencing process

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."

4. 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.

5. CLAIMS LAYOUT

Variable Names	FORMAT	Description
RECIPIENT ID	AN (12)	Program identification number for the Client (SSN)
BIRTH DATE	YYYYMMDD(8)	
GENDER	AN(1)	M=male , F=Female, U=Unknown
*FIRST NAME	AN(15)	NOT REQUIRED.
*LAST NAME	AN(15)	NOT REQUIRED.
*ZIP CODE	AN(10)	NOT REQUIRED .Format XXXXX-XXXX
PLAN_ID	AN(5)	Program name or ID
CLAIM_NO (ICN)	AN (27)	Claim number submitted on an encounter submission.
CLAIM_LINE_NO	AN (3)	A sequential number which when associated to a Claim Number uniquely identifies a detail line on an encounter submission.
CLAIM_SEQUENCE_NUMBER	AN(4)	A sequence number which increases incrementally with each iteration of claim adjustment.
MOTHER_ICN	AN(27)	Only applies to adjustments and voids. Points to the ICN of the previous iteration on the claim.
FORM CODE	AN(1)	Origin of the claim U=UB or facilty , H=professional or HCFA
PLACE_OF_SERVICE_CD	AN (2)	Code designates a Place of Service where client received services based on an encounter submission.
PROCEDURE_CD	AN (6)	Submitted procedure code--code representing the medical services, supplies, or procedures performed.
MOD1_CD	AN(2)	First Modifier
MOD2_CD	AN(2)	Second Modifier
MOD3_CD	AN(2)	Third Modifier
MOD4_CD	AN(2)	Fourth Modifier
*EPSDT INDICATOR	AN(1)	NOT REQUIRED. Y=Yes,N=No
REVENUE_CD	AN(4)	Revenue code (facility claims only)
DRG _CD	AN(4)	Diagnosis Related Grouping Code. A prospective payment methodology for inpatient hospital services based on the Medicare taxonomy of diagnosis
DIAG1_CD	AN (6)	Principal **DISCHARGE** Diagnosis**.** Code designates a diagnosis on an encounter submission.
DIAG2_CD	AN (6)	Secondary **DISCHARGE** Diagnosis Code. Code designates a diagnosis on an encounter submission.
DIAG3_CD	AN (6)	Secondary **DISCHARGE** Diagnosis. Code designates a diagnosis on an encounter submission.
DIAG4_CD	AN (6)	Secondary **DISCHARGE** Diagnosis. Code designates a diagnosis on an encounter submission.
DIAG5_CD	AN (6)	Secondary **DISCHARGE** Diagnosis. Code designates a diagnosis on an encounter

Variable Names	FORMAT	Description
		submission.
DIAG6_CD	AN (6)	Secondary **DISCHARGE** Diagnosis. Code designates a diagnosis on an encounter submission.
DIAG7_CD	AN (6)	Secondary **DISCHARGE** Diagnosis. Code designates a diagnosis on an encounter submission.
DIAG8_CD	AN (6)	Secondary **DISCHARGE** Diagnosis. Code designates a diagnosis on an encounter submission.
DIAG9_CD	AN (6)	Secondary **DISCHARGE** Diagnosis. Code designates a diagnosis on an encounter submission.
SURGICAL _PROC_CD_1	AN(6)	First Surgical code for facility claims
SURGICAL _PROC_CD_2	AN(6)	Second surgical code for facility claims
SURGICAL_PROC_CD_3	AN(6)	Third surgical code for facility claims
SURGICAL _PROC_CD_4	AN(6)	
SURGICAL _PROC_CD_5	AN(6)	
SURGICAL _PROC_CD_6	AN(6)	
SVC_START_DT	YYYYMMDD(8)	Date that services began for a specific encounter submission.
SVC_END_DT	YYYYMMDD(8)	Date that services ended for a specific encounter submission.
BILLING_PROVIDER_ID	AN (12)	Program ID of the Billing Provider
BILLING_PROVIDER_NPI	AN(10)	NPI number of the provider
BILLING_PROVIDER_TAXONOMY	AN(10)	Taxonomy Code.
PERFORMING_PROVIDER_ID	AN(12)	Program ID for provider that performed the service rendered on the detail
PERFORMING_PROVIDER_NPI	AN(10)	NPI number
PERFORMING_ PROVIDER_TAXONOMY	AN(10)	Taxonomy Code
*DISCHARGE_REASON_CD	AN (2)	NOT REQUIRED. Identifies the patient's status as of the through date of service on an inpatient claim
BILLED_UNITS	AN (8)	Quantity of units billed for a specified line item on an encounter submission.
HEADER_LEVEL_STATUS_CODE	AN(1)	Indicates if the claim was Paid, Denied, Adjusted, Voided, or Capitated (P, D, A, V, C)
DETAIL_LEVEL_STATUS_CODE	AN (1)	Indicates if the encounter line item was Paid, Denied, Adjusted, or Capitated (P, D, A, C)
ADMIT_TYPE_CD	AN (1)	Code Identifying the reason for admission to an inpatient hospital facility. Valid values are 1=Emergency 2=Urgent 3=Elective 4=Newborn 5=Trauma 9=Not Available.
ADMIT_DIAG_CD	AN (6)	Client diagnosis at time of admission.
ADMISSION_DATE	YYYYMMDD(8)	Client date of admission to a facility.
DISCHARGE_DATE	YYYYMMDD(8)	Discharge date designated on an encounter submission.
ADMISSION SOURCE	AN(2)	Code identifying the source of a client's admission to an inpatient facility

Variable Names	FORMAT	Description
DISCHARGE STATUS CODE	AN(2)	Inpatient claims only
OCCURRENCE SPAN CODE_1	AN(2)	Inpatient claims only
OCCURRENCE SPAN CODE_2	AN(2)	Inpatient claims only
OCCURRENCE SPAN CODE_3	AN(2)	Inpatient claims only
PLAN_ADJUDICATE_DT	YYYYMMDD(8)	Date that the program Adjudicated the encounter submission item.
PAID_DT	YYYYMMDD(8)	Date that encounter submission item was paid.
*CATEGORY_OF_SERVICE	AN (3)	NOT REQUIRED. This field indicates the state-level category of service
*EOB_CD	AN (3)	NOT REQUIRED.Code designates an Explanation of Benefits pertaining to an encounter submission.
TYPE_BILL_CD	AN (3)	Type of Bill. Facility Claims only.Code that designates information about an encounter, including the Class, Frequency, and Facilty cited.
DETAIL BILLED_AMT	AN (12)	Amount billed for a specified line item on an encounter submission.
DETAIL ALLOWED_AMT	AN (12)	Allowed Amount of a specific encounter record.
DETAIL PAYMENT_AMT	AN (12)	Dollar amount paid for a submitted encounter.
KIDCARE ID	AN (10)	Child's Individual ID
MEDICAL INSURANCE ID	AN (10)	Child's Medical Insurance Number
FINANCIAL ARRANGEMENT CODE	AN (2)	A two digit code that identifies how the service was paid. Use crosswalk on Page 4
DIAGNOSIS_CODE1_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y = Present at the time of admission N =Not present at the time of admission U = Unknown. Documentation is insufficient to determine if the condition was present at the time of inpatient admission W = Clinically Undetermined. Provider is unable to clinically determine whether the condition was present at the time of inpatient admission The POA indicator should be left blank if the diagnosis code is exempt from POA reporting.
DIAGNOSIS_CODE2_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.
DIAGNOSIS_CODE3_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.
DIAGNOSIS_CODE4_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.
DIAGNOSIS_CODE5_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.
DIAGNOSIS_CODE6_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.

Variable Names	FORMAT	Description
DIAGNOSIS_CODE7_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.
DIAGNOSIS_CODE8_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.
DIAGNOSIS_CODE9_POA	AN(1)	A code indicating whether the associated diagnosis was present at the time of the inpatient admission. Valid values could be: Y, N, U, W.

***=Not required fields**

6. PHARMACY CLAIMS FILE LAYOUT

Field Name	Type	Size	Definition
Claim Number	N	40	The claim number
Claim Status	AN	1	Indicates the status of a CLAIM submitted by a pharmacy: P - Payable or Paid R - Original claim reversed D- Denied A-Adjusted
Recipient ID	AN	12	Unique identifier assigned to the member (SSN)
*Patient Last Name	AN	30	Not Required. Last Name of the client
*Patient First Name	AN	30	Not Required. First name
Date of Birth	AN	8	Patient DOB (yyyymmdd)
*Sex Code	AN	1	Not Required. U=Not specified M=Male F=Female
*Client_ Category (Eligibility Category)	AN	2	Not Required. The eligibility category of the member. This field will be blank if information not available
Plan ID	AN	5	Program name or ID
Pharmacy Number	AN	8	The ID number for the Pharmacy
*Pharmacy Name	AN	30	Not Required. Name of pharmacy
*Pharmacy Street Address	AN	30	Not Required. Address of pharmacy
*Pharmacy City	AN	20	Not Required. City of pharmacy
*Pharmacy State	AN	2	Not Required. State of pharmacy
*Pharmacy Zip	AN	10	Not Required. Zip code of pharmacy
Prescriber Number	AN	12	Health plan assigned or program assigned ID of the prescriber.
Prescriber NPI	AN	10	NPI of the provider
*Prescriber Last Name	AN	30	Not Required. Last name of prescribing physician
*Prescriber First Name	AN	30	Not Required. First name of prescribing physician
RX Fill Date	AN	8	Dispensing date of RX (YYYYMMDD)
Authorize Refill	AN	2	Number of refills authorized by prescriber
NDC Number	AN	11	National Drug Code
*Label Name	AN	50	Not Required. NDC description and the drug strength
*Source Type	AN	1	Not Required. S - Single Source, G - Generic, B - Branded Generic, I - Innovator
*DEA Code	AN	1	Not Required. 0 - Non-Controlled, 1 - Research Only, 2 - Most Abused, 3 - Less Abused, 4 - Potential Abuse, 5 - Controlled Sale
*Legend Indicator	AN	1	Not Required. L - Legend, N - OTC
RX Days Supply	AN	3	Estimated number of days prescription will last
RX Quantity	N	6	Number of metric units of medication dispensed
Unit Type	AN	3	Units dispensed; Primary Values EA=each, ML=milliliter; GM=gram Additional Allowed Values AM=Ampule, APO=Apothecary, CP=Capsule, INT=International Unit, KT=Kit, MG=Milligram, OZ=Ounces, SP=SP, TB=Tablet, TP=TP, UN=Unit, VL=Vial
RX Submit Amount	N	12	Amount billed from pharmacy
Amount Paid	N	12	Amount Paid
Patient Amount Due	N	12	Correct co-pay for member

Drug Cost	N	12	Calculated cost of drug
*Recipient Location	AN	2	Not Required. 00=Not Specified 01=Home 02=Inter Care 03=Nursing Home 04=Long Term/Extended Care 05=Rest Home 06=Boarding Home 07=Skilled Care Facility 08=Sub-acute Care Facility 09=Acute Care Facility 10=Outpatient 11=Hospice Not a required field for Vendor Drug
*Therapeutic Class	AN	3	Not Required.
Paid date	AN	8	YYYYMMDD(8)
Kidcare ID	AN	10	Child's Individual ID
Medical Insurance ID	AN	10	Child's Medical Insurance Number
Dental Insurance ID	AN	10	Child's Dental Insurance Number

* Not Required fields

7. PROVIDER FILE LAYOUT

NAME	TYPE	SIZE	VALUE	Description of Values
Transaction Type	AN	1	Blank a,c,d	a = Add, c = Change/Edit; d = Delete; Blank = existing member, no change
Period - current month	N	6	yyyymm	
Plan ID	AN	5		Program name or ID
Provider ID (Provider Number)	AN	12		Health plan assigned or program assigned ID for the provider
NPI number	AN	10		National Provider ID
Taxonomy code	AN	10		
Provider last name	AN	24		
Provider's first name	AN	14		
Address attn	AN	24		
Address line 1	AN	24		
Address line 2	AN	24		
Address line 3	AN	24		
City	AN	12		
State	AN	2		
Zip	N	10		
Telephone	AN	12	format: 512-555-1212	
Practice type	AN	2	01, 02	Optional. Group Practice=01 , Individual Practice=02
Panel size	N	2		Optional. Number of clients assigned to the provider
County code	N	3		
Primary Care Provider	AN	1	Y/N	Yes or No
Provider's License Number	AN	7		Optional.
Provider's Tax ID	AN	9		Optional.
Credentialed	AN	1		Optional. Is Provider Credentialed Y/N?

8. REVISIONS

February 2008:	Added trailer record. Changed the label Original ICN to Mother ICN. Added the language Principal Diagnosis to Diagn1.
February 20, 2008:	Changed the length of provider ID from 9 to 12 characters. Changed Provider Type to Provider Taxonomy to capture national codes. Added a new field to capture NPI information
March 13, 2008:	Changed peforming provider ID to length 12 to make it consistent with other IDs Added clarification on per diem payments/
April 30, 2009:	Annotated fields that are not mandatory
January 30, 2011:	Added two additional client identifiers and the financial arrangement code
November 1, 2011:	Added POA codes 1-9.
OCT 29, 2012:	Clarified the defination of principal and secondary diagnoses. These should always be discharge diagnosis.
JAN. 30, 2015	Compile claims, pharamcy and provider files together.