UPDATE (04/24/20): Due to health plan focus on COVID-19 activities, Florida Medicaid has moved the implementation date of Special Feed Elimination to July 1st, 2020. Starting May 8th, 2020, Florida Medicaid will be monitoring submissions of the new requirements and will be providing feedback, and outreach to health plans needing corrections related to the new requirements. This provides an opportunity to verify compliance with the new requirements prior to the new July 1st, 2020 implementation date. On July 1st, 2020 health plans will be held accountable for compliance with the new requirements and may be required to resubmit any, or all encounters found to be absent or in error of those requirements.

Note: Health plans will still be required to continue submission of special feed data on their regular schedule until notified to discontinue that process.

What is Special Feed Elimination?
The Agency for Health Care Administration is continuing its efforts to transition from the special feed to FMMIS encounter data for capitation rate setting and to reconcile between the encounter, the health plan’s database, the ASR reporting and the data submitted by the providers within the health plan’s network.

When will Special Feed Elimination be implemented?
FMMIS modifications scheduled to be completed before July 1st, 2020. Encounters with a date of service of July 1st, 2020 or later must include payments to capitated network providers. Beginning July 1st, 2020 encounters must include a 20 character prepend to the Line Item Control Number, which will be used for reconciliation between the health plans and Florida Medicaid.

Why don’t I see all Line Item Control Numbers returned on the 835s?
Current 835 transactions report back only unique Line Item Control Numbers within an encounter. Replicated Line Item Control Numbers within an encounter are consolidated into a single Line Item Control Number on the 835. New Line Item Control Number requirements for a unique value will assure that all Line Item Control Numbers are returned on the 835s.

How are health plans impacted?
Health plans must start reporting on their encounter data the allowable amount for services when the health plan has a capitated relationship with the network providers. Health plans will be required to prepend 20 characters to the ‘line item control number’ (REF section of Loop 2400 with a ‘6R’ identifier) within their encounter X12 transaction submissions. The Florida Medicaid Management Information System (FMMIS) will begin documenting health plan compliance.

How is the allowable amount reported?
The allowable amount is reported two different ways, depending if there is a downstream paid claim or not:

1. A capitated relationship with a subcontracted service provider (example a Managed Care Plan) where there is a downstream paid claim.
   - In this scenario, the health plan should submit:
     i. ‘05’ in CN101 within the 2300 loop of their X12 transaction.
     ii. The downstream (service provider submitted) paid amount for the services, in SVD02 within the 2430 loop of their X12 transactions.
2. A capitated relationship with a subcontracted service provider (example a Physician Network) where there is not a downstream paid claim.
   - In this scenario, the health plan should submit:
     - ‘06’ in CN101 within the 2300 loop of their X12 transactions.
     - The health plan’s internally determined amount, calculated price, or allowed amount for the service in the SVD02 within the 2430 loop of their X12 transactions.

What is the CN101 segment used for?
The X12 2300 loop CN101 is used to identify (to FLMMIS) the relationship of the health plan to their network providers. Prior to the special feed transition to FLLMMIS, the CN101 values were ‘09’ = FFS relationship, and ‘05’ = Capitated relationship. With the special feed to FLMMIS transition, a new value of ‘06’ has been added. The value of ‘06’ is needed to identify (to FLMMIS) the different types of capitated relationships the health plan may have with their network providers.

When should I use a CN101 value of ‘05’?
If a claim submitted to the health plan by a capitated network provider contains a dollar amount paid by the network provider, then the CN101 value of ‘05’ is appropriate. The dollar amount paid by the network provider and submitted to the health plan should be used to populate the SVD02 within the 2430 loop of the X12 transaction submitted to FLMMIS.

When should I use the CN101 value of ‘06’?
If a claim submitted to the health plan by a capitated network provider does not contain a dollar amount paid by the network provider, this would indicate that the health plan has a capitated relationship with their network provider that has a further capitated relationship with other entities. In this scenario, the CN101 value of ‘06’ is appropriate to identify (to FLMMIS) that extended capitated relationship. In the absence of a dollar amount paid by the network provider and submitted to the health plan, the health plans internally determined amount, calculated price, or allowed amount should be used to populate the SVD02 within the 2430 loop of the X12 transaction submitted to FLMMIS.

What if some services within an encounter would qualify for a CN101 value of ‘05’ and some services within an encounter would qualify for a CN101 value of ‘06’?
Since the CN101 is a header level value that would apply to all of the line items within the encounter, in this scenario: Submit the CN101 value of ‘06’, and for the services that had a paid amount submitted to the health plan (05), submit that paid amount in the SVD02. For the services that did not have a paid amount submitted to the health plan (06), submit the determined amount, calculated price, or allowed amount in the SVD02.

Is the CN102 segment affected by this change?
No. The CN102 segment is only used for FQHC and RHC submissions and is not related to this change.
Special Feed Elimination
Frequently Asked Questions (FAQ)

See examples below:

**Example 1:**

CLAIM SUBMITTED TO THE HEALTH PLAN BY THEIR NETWORK PROVIDER THAT CONTAIN NO PAID AMOUNTS (NO DOWNSTREAM PAYMENT)

CN101 = 06

<table>
<thead>
<tr>
<th>STATE</th>
<th>TYPE OF CLAIM</th>
<th>LINE NUMBER</th>
<th>CAP_IND</th>
<th>DETAIL SBMT CHRG AMT</th>
<th>PAID_AMT</th>
<th>SHDWM_PAID_AMT</th>
<th>ALLOWED_AMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>1</td>
<td>Y</td>
<td>135.00</td>
<td>0.00</td>
<td>78.76</td>
<td>78.76</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>2</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>3</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

See examples below:

**Example 1:**

CLAIM SUBMITTED TO THE HEALTH PLAN BY THEIR NETWORK PROVIDER THAT CONTAIN NO PAID AMOUNTS (NO DOWNSTREAM PAYMENT)

CN101 = 06

<table>
<thead>
<tr>
<th>STATE</th>
<th>TYPE OF CLAIM</th>
<th>LINE NUMBER</th>
<th>CAP_IND</th>
<th>DETAIL SBMT CHRG AMT</th>
<th>PAID_AMT</th>
<th>SHDWM_PAID_AMT</th>
<th>ALLOWED_AMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>1</td>
<td>Y</td>
<td>135.00</td>
<td>0.00</td>
<td>78.76</td>
<td>78.76</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>2</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>3</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

(No Paid Amount Submitted by network provider)

- **Line #1**: Billed Amount
- **Line #2**: Adjust amounts for line level balancing to consider shadow paid amount in SVD02
- **Line #3**: health plan determined, allowed, or calculated amount in SVD02

(Health plan determined, allowed, or calculated amount)

Page 3 of 6

May 11, 2020
Example 2:

CLAIM SUBMITTED BY THE NETWORK PROVIDER TO THE HEALTH PLAN THAT HAS A COMBINATION OF LINE ITEMS THAT CONTAIN A PAID AMOUNT (A DOWNSTREAM PAYMENT) AND DO NOT CONTAIN A PAID AMOUNT (NO DOWNSTREAM PAYMENT)

<table>
<thead>
<tr>
<th>STATE</th>
<th>TYPE_OF_CLAIM</th>
<th>LINE_NUMBER</th>
<th>CAP_IND</th>
<th>DETAIL_SBITM_CHRG_AMT</th>
<th>PAID_AMT</th>
<th>SHOW_PAID_AMT</th>
<th>ALLOWED_AMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>1</td>
<td>Y</td>
<td>165.00</td>
<td>0.00</td>
<td>78.76</td>
<td>78.76</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>2</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>3</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>4</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>5</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>6</td>
<td>Y</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>7</td>
<td>Y</td>
<td>20.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>8</td>
<td>Y</td>
<td>10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>9</td>
<td>Y</td>
<td>10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>10</td>
<td>Y</td>
<td>10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>11</td>
<td>N</td>
<td>120.00</td>
<td>12.00</td>
<td>12.00</td>
<td>12.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>12</td>
<td>Y</td>
<td>40.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FLF</td>
<td>FLPROFFCT</td>
<td>13</td>
<td>Y</td>
<td>45.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

REF*6R*XXXXX~
SVD*301840*78.76*HC:XXXX**3~
CAS*CO*45*86.24*3~

→ health plan determined, allowed, or calculated amount in SVD02
→ Adjust amounts for line level balancing

DTP*573*D8*XXXXX~

REF*6R*XXXXX~
SVD*301840*0*HC:XXXX**3~
CAS*CO*45*108*3~

→ health plan determined, allowed, or calculated amount in SVD02

DTP*573*D8*XXXXX~

.
.
.

REF*6R*XXXXX~
SVD*301840*12*HC:XXXX**3~
CAS*CO*45*108*3~
DTP*573*D8*XXXXX~

→ Paid amount (SVD02)

Note: In this scenario, the CN101 value should be ‘06’.
How will providers know how to create a 20 character prepend to the Line Item Control number?

Example:

<table>
<thead>
<tr>
<th>TPID (the last three characters)</th>
<th>Region (2 characters)</th>
<th>Adjudication Date (YYMMDD)</th>
<th>Sequence Number (9 characters with leading zeros)</th>
<th>Network Provider Submitted control number (up to 30 characters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>999</td>
<td>99</td>
<td>999999</td>
<td>9999999999</td>
<td>9999…</td>
</tr>
</tbody>
</table>

Example:

TPID: 1001201
Region: 02
Date: September 2, 2019
Sequence of line process for the day: 351,892
Submitted from Network Provider: 5897458732

Result: 2010219090200035118925897458732

What is the purpose of the Line Item Control Number?
The Line Item Control Number is the means to uniquely identify any line item on any encounter.

What will the Line Item Control Number be used for?
The Line Item Control Number will be used for potential reconciliation between the Health Plan and the FLMMIS.

How will that reconciliation work?
As we transition from the health plan special feed to a FLMMIS based rate assessment model, questions may arise regarding specific encounter inclusion/exclusion in that model. The Line Item Control Number, with its unique identification, will facilitate comparative analysis of encounters in question.

What is the adjudication date?
The adjudication date is the date that the claim was adjudicated by the health plan. This date would typically be the same date that is used in timeliness monitoring. This date would be used as a reconciliation starting point in targeting a group of, or individual encounters. This date would typically be the adjudication cycle date, as it would remain the same throughout the cycle, even if the cycle transcends midnight.
What is the sequence number?
The sequence number is the number that uniquely identifies any line item, across all encounters, for any given adjudication date and region.

How should I populate the sequence number?
A typical method of populating the sequence number would be to start at 000000001 for the first line item being adjudicated in your adjudication cycle where the adjudication cycle date has been incremented to recognize the new cycle date and increment the sequence number for every line item adjudicated thereafter. In this way, all line items within an encounter would have contiguous sequencing and therefore be more readily reconcilable.

Can the Network Provider Control Number be used as all of the sequence number?
No. The Network Provider Control Number is a claim level number that would not uniquely identify each line item.

Can the Network Provider Control Number be used as part of the sequence number?
Potentially yes, this would require strict control and coordination of all provider control numbers submitted within your network to assure non-duplication. It would also require appending a line item sequence number to the network provider control number for each line item.

Can I test these X12 modifications with Florida Medicaid?
Health plans can begin testing Special Feed Elimination for X12 5010 EDI batch files. All health plans have access to the X12 testing environment (Florida Medicaid Web Portal BETA). If you wish to test Special Feed Elimination for X12 5010 EDI batch files or need assistance with testing, please contact healthplan.support@dxc.com. For more information about X12 encounter transactions testing, refer to the X12 Testing page.

What resources are available for more information on Special Feed Elimination?
Agency eAlerts have previously been sent to the health plan and provider community informing of key implementation dates and are available on the Managed Care Alerts page of the public Web Portal. Future eAlerts regarding Special Feed Elimination will also be posted on the public Web Portal. The following resources will also be made available on the public Web Portal:

- Companion Guide updates, including 837I, 837P, and 837D
- Special Feed Elimination Tip Sheet

To learn more about the Special Feed Elimination process, visit: AHCA’s Program website and navigate to the Statewide Medicaid Managed Care page.

For more information on successfully processing encountered containing plan paid amounts, Health plans can refer to the EDI companion guides.