This tip sheet provides information using X12 encounter data submissions, including resubmissions, adjustments, and voids for health plans. This tip sheet is a training aid. It does not act as a replacement for a health plan’s contractual submission requirements, as found within its contract.

**General Information and Requirements**

Health plans must submit complete, accurate, and timely encounter data to the Agency for Health Care Administration’s (Agency) fiscal agent, DXC Technology (DXC), as defined in the health plan’s contract and in accordance with generally accepted industry best practices. The health plan is held responsible for errors or noncompliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

Medicaid policy requires any third-party entity acting on behalf of a health plan to obtain a Medicaid ID by completing the Medicaid enrollment application. In order for a third-party entity to submit and/or inquire using X12 transactions, it must be linked to the health plan by completing an Electronic Data Interchange Agreement form. It is a violation of Medicaid policy for a health plan to allow a non-Medicaid enrolled third-party entity to act on its behalf.

The health plan must verify that the encounter information it submits to the Agency is accurate, truthful, and complete, in accordance with 42 CFR 438.606. An attestation file is required with every encounter file submission. For more information on attestations, please review the Attestation Tip Sheet located on the Managed Care page of the Florida Medicaid Web Portal.

**Trading Partner ID and Plan Provider ID**

Health plans are assigned a Trading Partner ID (TPID) for each contract type (MMA, LTC, Child Welfare, Specialty and Dental). Health plans must submit encounters using the correct TPID for the services on the encounter. This is important for rate setting.

Health plans are assigned a Plan Provider ID for each contract type and each region. The plan must submit encounters using the correct Plan Provider ID based on the recipient’s assignment. An encounter will deny if the Plan Provider ID does not match to the recipient submitted on the encounter.

Health plans are required to submit encounters, with Dates of Service prior to their respective go-live dates (per region of go-live), with their old TPID.

Encounters with Dates of Service on or after their respective go-live dates (per region of go-live), are required to be submitted with their new TPID.

**Original Submission**

All original encounter submissions, with the exception of hospice original encounters, should contain a claim frequency code of “1” within the X12 837 transaction. A frequency code of “3” must be utilized when submitting hospice original encounters. After the encounter processes, the health plan can easily identify an encounter submission within its 835 transaction by reviewing the encounter’s thirteen-digit Identification Claim Number (ICN). The region code (the first two digits of an ICN) is “70” on all original encounter submissions.

The health plan shall implement and maintain procedures to validate the successful loading of encounter files by the fiscal agent’s electronic data interface (EDI) clearinghouse. The health plan must use the EDI response (X12 999 acknowledgement) files to determine if files were successfully loaded. Within seven (7) days of the original submission attempt, the health plan is required to correct and resubmit any X12 837 files that fail to load.

For more information on successful processing of encounter original submissions, Health Plans can refer to the EDI Companion Guides.

**Resubmissions (Required for Fiscal Agent Denied/Rejected Encounters)**

The health plan must accurately resubmit one-hundred percent (100%) of all encounters for which errors can be remedied within thirty (30) days of an original encounter receiving a denial from the fiscal agent. An encounter may be resubmitted only if the encounter has been denied on the header level and has not previously been resubmitted.
Health plans can identify an encounter resubmission within their 835 transaction by reviewing the region code. All encounter resubmissions will have a region code of “71.” Initial encounter resubmissions require both the ICN of the original denied encounter and the appropriate reference identification qualifier “D9” within the 2300 loop of the X12 837 transaction. The ICN of the most recent resubmission attempt must be included in each subsequent encounter resubmission that is denied/rejected.

The below chart illustrates five common error scenarios and how to correct them:

<table>
<thead>
<tr>
<th>#</th>
<th>Scenario</th>
<th>Method of Correction</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Original encounter submission (region code “70”) adjudicated in a denied status.</td>
<td>The health plan should resubmit the encounter. Encounter resubmissions must include the most recent denied encounter ICN and the appropriate reference identification qualifier of “D9” within the 2300 loop of the X12 837 transaction.</td>
<td>New encounter resubmission (region code “71”) will be reflected on the 835 transaction.</td>
</tr>
<tr>
<td>2</td>
<td>Original encounter submission (region code “70”) adjudicated in a paid status, but reflects denials at the detail level.</td>
<td>The health plan should adjust the encounter. Adjusted encounters must include a frequency code of “7” and the 13-digit ICN of the original paid encounter that is being adjusted in the REF02 segment of the 837 transaction where REF01 equals “F8.”</td>
<td>New encounter adjustment (region code “69”) will be reflected on the 835 transaction.</td>
</tr>
<tr>
<td>3</td>
<td>Encounter adjustment (region code “69”) adjudicated in a denied status.</td>
<td>The health plan should resubmit the adjusted encounter. Resubmissions must include the ICN of the most recent denied encounter adjustment and the appropriate reference identification qualifier of “D9” within the 2300 loop of the X12 837 transaction.</td>
<td>New encounter resubmission (region code “71”) will be reflected on the 835 transaction.</td>
</tr>
<tr>
<td>4</td>
<td>Encounter resubmission (region code “71”) adjudicated in a denied status.</td>
<td>The health plan should resubmit the denied encounter resubmission. Encounter resubmissions must include the ICN of the most recent resubmission attempt and the appropriate reference identification qualifier of “D9” within the 2300 loop of the X12 837 transaction.</td>
<td>New encounter resubmission (region code “71”) will be reflected on the 835 transaction.</td>
</tr>
<tr>
<td>5</td>
<td>Encounter resubmission (region code “71”) adjudicated in a paid status, but reflects denials at the detail level.</td>
<td>The health plan should adjust the paid encounter resubmission. Adjusted encounters must include a frequency code of “7” and the 13-digit ICN corresponding to the most recent paid encounter that is being adjusted in the REF02 segment of the 837 transaction where REF01 equals “F8.”</td>
<td>New encounter adjustment (region code “69”) will be reflected on the 835 transaction.</td>
</tr>
</tbody>
</table>

The health plan is still required to correct and resubmit a previously denied encounter even if outside of the thirty (30) day notice period. The health plan is required to submit encounter data for all services provided. If the health plan does not submit complete encounter data, there will not only be a non-compliance issue, the health plan will also be disadvantaged in the risk adjustment process, and the Agency will not be able to include its true service spend in the rates.

For more information on the successful processing of encounter resubmissions, health plans can refer to the EDI Companion Guides.
Adjustments and/or Voids (Available for Fiscal Agent Paid/Accepted Encounters)

Per its contract, the health plan is required to correct and resubmit one-hundred percent (100%) of previously submitted X12 encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.

A paid encounter can be adjusted (replaces the previously paid encounter with a corrected version) or voided (cancels the previously paid encounter) if incorrect information is present on the paid encounter, or if it contains denials at the detail level.

Adjusted encounters must contain a frequency code of “7” and the 13-digit ICN of the paid encounter being adjusted in the REF02 segment of the 837 transaction.

Note: Each time an encounter is adjusted, a new ICN is generated. The ICN corresponding to the most recent paid encounter should be used when adjusting the encounter.

Voided encounters must contain a frequency code of “8” and the 13-digit ICN of the paid encounter being voided in the REF02 segment of the 837 transaction where REF01 equals “F8.”

Health Plans can identify an encounter adjustment/void within their 835 transaction by reviewing the region code. All encounter adjustments or voids will have a region code of “69.”

Some data elements, such as a recipient ID, provider ID and/or NPI information for both billing and rendering providers, should not be adjusted. For example, a void should occur if the health plan submits an encounter with the wrong billing provider and the encounter pays. Then, a new day encounter containing a frequency code of “1” should be billed with the correct billing provider ID.

Other incorrect data elements, such as procedure codes and/or place of service codes, can be adjusted. For example, if a health plan submits an encounter for the wrong procedure code and the encounter pays, an adjustment can be used to correct the error.

For more information about the successful processing of encounter adjustments and voids, health plans can refer to the EDI Companion Guides.

Note: Florida Medicaid is now accepting encounter data for health plan-denied submissions.

The Agency is not requiring encounters for health plan-denied services. However, if a health plan would like to submit an encounter for a service it has denied, either at the detail or the header level, it can now do so. If, at a later date, the Agency requires health plans to submit health plan-denied encounters, the Agency will only be interested in services denied by the health plan.

Encounters denied by a health plan for missing/incomplete information or transaction standard validity checks are not to be submitted. For more information on successfully submitting plan denied services, health plans can refer to the EDI Companion Guides.

For additional information, health Plans should contact the contract manager at the Agency for Healthcare Administration or review the information at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/report_guide_2015-07-01.shtml.

Helpful Resources

To receive informative, health plan-related alerts, health plans can complete the online subscription form on the Florida Medicaid Health Care Alerts page.

Agency

For more information regarding SMMC and related policies, visit the Agency’s website at http://www.ahca.myflorida.com/smmc.
DXC
For managed care assistance, contact the Medicaid fiscal agent and visit the Florida Medicaid Public Web Portal for important SMMC information.

In addition to alerts, Florida Medicaid offers a variety of encounter data submission assistance to its Managed Care community, including educational materials located on both the Agency’s SMMC website and the public Web Portal.

DXC offers email encounter support for health plans and their registered third-party entities, as well as on-site visits to assist with encounter denials and encounter billing.

For assistance with encounter denials, enrollment issues, billing inquiries, and eligibility inquiries please contact Health Plan Support at healthplan.support@dxc.com.

For assistance with electronic transactions, such as the 837I X12 transaction, please contact Health Plan Support at healthplan.support@dxc.com.

For assistance with encounter denials, enrollment issues, billing inquiries, and eligibility inquiries please contact Health Plan Support at healthplan.support@dxc.com.