This Frequently Asked Questions (FAQ) document is designed for use by Managed Care Organizations (health plans) and addresses many of the questions or common concerns related to the submission of Statewide Medicaid Managed Care (SMMC) non-pharmacy encounters. This document is composed of the following sections:

- Registration
- Encounter-Related Questions
- General EDI Transaction Questions
- General Web Portal Questions
- Helpful Resources

Note: New or updated information is indicated by an "UPDATED" or "NEW" designation at the beginning of the paragraph.

Registration

What is the process for registering SMMC treating providers?

Any provider included on an encounter transaction must be recognized as an active provider in the Florida Medicaid Management Information System (FMMIS). Before attempting to register a provider, health plans should refer to the Provider Master List found on the Managed Care Provider Registration page of Florida Medicaid Public Web Portal for verification of existing enrollment. Health plans are also encouraged to review the Pending Provider List (PPL) to verify whether there is an application pending approval with Florida Medicaid. The registration process may be used to add providers that are not known to the FMMIS. For more information on registration, health plans should refer to the Florida Medicaid Provider Registration Guide on the Managed Care Provider Registration page. To view the Managed Care Provider Registration page, navigate to www.mymedicaid-florida.com, and select Provider Registration under the Managed Care menu.

To register an Out of State (OOS) provider and/or to perform other unique registration requests that cannot be performed with provider registration—such as backdating a specific registration—complete the Florida Medicaid Provider Registration Form found on the Managed Care Provider Registration page. When submitting the paper form, the effective date of the registration can be backdated within one year of the registration submission date at the request of the health plan by including the desired effective date within the submission request.
*UPDATED* How is the provider’s NPI effective date determined?

The NPI effective date is equivalent to the effective date of the FMMIS provider file submission. If a provider later updates or changes their NPI registration, the NPI effective date will be based on the date of the updated registration. Please note that the NPI effective date cannot precede the provider’s Medicaid Claims Eligibility Effective date, which is provided in column X of the PML. Health plans can also utilize the NPI to Medicaid ID Search Engine to verify if an NPI is associated with a Medicaid ID. As a reminder, to update an NPI Crosswalk, providers whose Enrollment Type is Limited or Enrolled must submit a completed Florida Medicaid NPI Registration form. Health plans may request updates only when the Enrollment Type is Registered.

*NEW* Is a provider allowed to register an NPI crosswalk without a taxonomy?

The taxonomy is required in the NPI Crosswalk for enrollment and NPI updates received on and after August 25, 2017 and must be valid for the provider’s specialty. Some providers have multiple Medicaid provider IDs sharing an NPI. These providers can combine a different Taxonomy and/or ZIP+4 with the NPI on each provider record in order to distinguish one record from another. For additional guidance, please refer to the Provider Master List Tip Sheet.

*NEW* How is the Date Used for Claims determined?

After August 25, 2017 any NPI Registration form received will process with a Date Used for Claims as Date of Submission. This includes any provider maintenance done to the provider’s file. Any update to the provider file prior to August 25, 2017 will show a Date Used for Claims as Date of Service.

The NPI Registration Date of Submission is based on when the NPI Registration form was received. Please note that the NPI effective date cannot precede the provider’s Medicaid Claims Eligibility Effective date.

*UPDATED* Can a health plan update the NPI crosswalk information of a specific provider file?

A health plan can update the NPI crosswalk information—including the NPI, taxonomy, and zip code—on registered provider files only. To verify if a provider ID is considered Registered, health plans should review the Provider Master Listing. For more information, please review the Provider Master Listing Tip Sheet on the Managed Care Support page.

Are billing agents, clearinghouses, and other third-party entities acting on behalf of an SMMC health plan required to obtain a Medicaid provider ID?

Medicaid policy requires any third-party entity acting on behalf of a health plan to obtain a Medicaid ID by completing a full online Medicaid enrollment application. Additionally, the third-party entity is required to enroll under Provider Type 99-Billing Agent. Both the health plan and the billing agent must complete an Electronic Data Interchange Agreement form. In order for the third-party entity to submit and/or inquire on X12 transactions, it must possess an active Medicaid ID.

Once its Medicaid ID is obtained, the third-party entity can request a Trading Partner ID from Florida Medicaid’s EDI team. The health plan can then assign roles to the third-party entity allowing it to act on behalf of the health plan. It is the responsibility of the health plan to ensure its Medicaid file includes all enrolled third-party entities acting on its behalf.

It is a violation of Medicaid policy for a health plan to allow a non-Medicaid enrolled third-party entity to act on the health plan’s behalf.

Encounter-Related Questions
What logic does FMMIS use when applying the duplicate denial edits to an encounter submission?
An encounter submission may deny as a duplicate if FMMIS identifies an existing accepted encounter or paid fee-for-service claim with a combination of the following conditions:

<table>
<thead>
<tr>
<th>Possible Duplicate</th>
<th>Exact Duplicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>837P Claim contains the same recipient, provider, procedure, procedure code modifier, and overlapping date(s) of service.</td>
<td>Claim contains the same recipient, same provider, procedure code, procedure code modifier, and same date(s) of service.</td>
</tr>
<tr>
<td>837I (Inpatient/LTC) Claim contains the same recipient, provider, and overlapping date(s) of service.</td>
<td>Claim contains the same recipient, provider, and same date(s) of service.</td>
</tr>
<tr>
<td>837I (Outpatient) Claim contains the same recipient, provider, procedure/revenue codes, and overlapping date(s) of service.</td>
<td>Claim contains the same recipient, provider, procedure/revenue codes, and same date(s) of service.</td>
</tr>
<tr>
<td>837D Claim contains the same recipient, provider, tooth number, tooth surface, and date of service.</td>
<td>Claim contains the same recipient, provider, quadrant, tooth number, tooth surface, procedure code, and date of service.</td>
</tr>
</tbody>
</table>

Note: This is a high level view of the duplicate logic in FMMIS. Duplicate editing occurs throughout the system and is different depending on claim type and services being submitted. Procedure code modifiers are only factored into Professional (837P) encounters and will not prevent duplication among other claim types. Procedure code modifiers are used in several ways to determine duplicates, and some may cause the system to bypass duplicate logic. Additionally, it is important to note that duplicate ICN information will only be provided on the 835 when denying at the header level.
How does the health plan verify the origin of an encounter?

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64</td>
<td>DXC internal single reprocessing of encounter</td>
</tr>
<tr>
<td>66</td>
<td>DXC internal mass reprocessing of encounters</td>
</tr>
<tr>
<td>69</td>
<td>Encounter void or adjustment (Initiated by health plan)</td>
</tr>
<tr>
<td>70</td>
<td>Original encounter submission</td>
</tr>
<tr>
<td>71</td>
<td>Encounter resubmission (Initiated by health plan)</td>
</tr>
<tr>
<td>72</td>
<td>Health plan-denied encounter</td>
</tr>
<tr>
<td>73</td>
<td>Pharmacy encounter submission</td>
</tr>
<tr>
<td>74</td>
<td>DXC internal single resubmission of encounter</td>
</tr>
<tr>
<td>75</td>
<td>DXC internal mass resubmission of encounters</td>
</tr>
</tbody>
</table>
How does a health plan submit an encounter for an interim hospital payment?
Health plans may pay hospitals on an interim basis. However, health plans should submit encounters for hospital admissions for the entire admission, even if interim payments were made: The dates of service for the admission should therefore reflect the entire hospital stay, the amount paid should reflect the total amount paid by the health plan for the entire admission, and the type of bill should also reflect an entire stay instead of an interim payment. For more information on the type of bill submission, health plans can refer to the EDI companion guides. The Agency for HealthCare Administration (Agency) will calculate the seven (7) day encounter data submission requirement based on the date of the final payment.

During Agency-recognized holiday closures, do exemptions exist for the encounter data submission timeframe?
Health plans are required to send encounter data submissions within seven (7) days of adjudication. This submission timeframe does not take into account holidays and is based upon calendar days regardless of holidays that may occur during the given timeframe. **There are no exemptions due to closures.** Health plans are encouraged to plan accordingly based on the Agency’s holiday schedule, which can be found on the Florida Web Portal home page.

How is an encounter resubmission identified?
Health plans can easily identify an encounter resubmission within their 835 transaction by reviewing the thirteen-digit Identification Claim Number (ICN). The region code (first two digits of an ICN) is “71” on all encounter resubmissions. If an original encounter denies, health plans have thirty (30) days to send a resubmission encounter to Florida Medicaid.

*UPDATED* When should an encounter resubmission occur?
An Encounter may be resubmitted only if the encounter has adjudicated in a denied status on the header level, has not previously been resubmitted, and contains an error that can be remedied. Initial encounter resubmissions require both the ICN of the most recent 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. For more detailed information on encounter resubmissions, please
refer to the Encounter Data Submission Tip sheet on the Managed Care Support section of the Florida Medicaid Web Portal.

*UPDATED* If an encounter resubmission has been denied/rejected multiple times, which ICN should be indicated on the subsequent resubmission attempt?
Subsequent encounter resubmissions must contain the appropriate reference identification qualifier of “D9” within the 2300 loop of the X12 837 transaction and the 13-digit ICN of the most recent resubmission attempt.

Note: Each time an encounter is resubmitted, a new ICN is generated; the ICN corresponding to the most recent resubmission attempt should be used when resubmitting.

Can paid encounters that contain incorrect information be voided or adjusted?
A paid encounter can be adjusted or voided if incorrect information is present on the paid encounter.

- Adjusted encounters must contain a frequency code of “7” and the 13-digit ICN of the paid encounter that is being adjusted in the REF02 segment of the 837 transaction.
- Voided encounters must contain a frequency code of “8” and the 13-digit ICN of the paid encounter that is being voided in the REF02 segment of the 837 transaction.

For more information on successful processing of encounter adjustments and voids, health plans can refer to the EDI companion guides.

If a paid encounter has been adjusted multiple times, which ICN should be indicated on each adjustment attempt?
Adjusted encounters must contain a frequency code of “7” and the 13-digit ICN of the paid encounter that is 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 submitting an adjustment.

*UPDATED* How are encounter adjustments and voids identified?
Health plans can easily identify encounter adjustments and voids within their 835 transaction by reviewing the thirteen-digit Identification Claim Number (ICN). The region code (first two digits of an ICN) is “69” on all successful encounter adjustments and voids.

*UPDATED* What is the difference between a void and an adjustment?
A void cancels the previously accepted encounter, while an adjustment replaces the previously accepted encounter with a corrected version.
Can the same 837 batch contain a combination of original, resubmission, voided, and adjusted encounters?
Multiple encounters—regardless of whether any encounter is an original or a replacement—can be submitted within a single 837 batch.

How should a health plan remedy an adjustment attempt that adjudicated in a denied status?
The health plan should resubmit the denied encounter adjustment. The encounter resubmission must include the ICN of the denied encounter adjustment and the appropriate reference identification qualifier of “D9” within the 2300 loop of the X12 837 transaction.

When should a health plan choose to adjust an encounter versus voiding an encounter?
Some incorrect data elements—such as a recipient ID and/or provider ID—should not be adjusted. For example, a void should occur if a health plan submits an encounter for 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 with the wrong procedure code and the encounter pays, an adjustment can be used to correct the error.

*UPDATED* Can encounters contain details with zero health plan-paid amounts?
If a health plan has a capitated relationship with the servicing/treating provider, FMMIS will accept encounters containing zero-paid amounts. Note: The CN101 segment within loop 2300 of the 837 X12 transaction must be “05” if the CN102 segment (monetary amount) equals zero (0). For more information on successful processing of encounters containing zero-health plan-paid amounts, health plans can refer to the EDI Companion Guides.

Note: When submitting encounters with “09” in the CN101 segment, the CN102 segment (monetary amount) must have at least one service line payment greater than zero.

Can health plans submit encounters containing CPT Category II Codes?
Yes, FMMIS will accept encounters containing CPT Category II Codes. It is important to note that, if utilizing a modifier with the CPT Category II Code, only 1P, 2P, 3P, and 8P are permissible. Encounter submissions that include inappropriate modifiers will be denied. CAT II Codes are only billed to offer additional insight into the rendered services and should be billed with payable procedure codes that require the use of CAT II codes. Additionally, health plans should report a zero billed amount for detail line items that include CPT Category II Codes.

Are encounters required for health plan-denied services?
At this time, 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 to the Agency. For more information on successfully submitting plan denied services, health plans can refer to the EDI companion guides.

**Is testing available for encounter submissions?**
A dynamic encounter testing environment tool for use by the SMMC community is available as of March 2, 2015. This new tool will test a health plan’s readiness for various upcoming changes to Florida Medicaid encounter data. To participate in testing, health plans should refer to the SMMC Encounter Testing Tip Sheet and the SMMC Encounter Test Scenarios located on the Managed Care section of the Florida Web Portal.

**NEW** Is the health plan allowed to alter the NPI crosswalk on an 837 transaction if the crosswalk received from the provider differs from the crosswalk that is registered with FL Medicaid?
Health plans should submit the NPI Crosswalk information as submitted by providers in their encounter transaction and should not modify the data. For additional guidance, please refer to the Provider Master List Tip Sheet.

**Is a health plan required to correct and resubmit a previously denied encounter, even if it is outside of the thirty (30) day timeframe for resubmission?**
Yes. The contract requires health plans to submit encounter data for all services provided. In part, this will be measured by comparing the health plans’ financial reports to their encounter data submissions. If the financial reports do not match the encounter data, there will be a potential non-compliance issue. Also, the Agency uses encounter data for rate setting and calculating risk adjustment scores. If a health plan does not submit complete encounter data, there will not only be a non-compliance issue, the health plan will be disadvantaged in the risk adjustment process, and the Agency will not be able to include its true service spend in the rates.

**UPDATED** Is assistance with understanding adjustment reason codes currently available to health plans?
X12 5010 835 transactions contain Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to provide information in understanding an encounter’s status. Both accepted and denied encounters may contain multiple remark and reason codes. FMMIS is used for both Fee-for-Service and Encounters. Therefore, some codes may be considered informational-only for encounters and may not be the direct reason for the encounter status. When reconciling a header denied encounter or an encounter denied detail, health plans should review the provided CARC and RARC combination. To better understand the codes and their meanings, health plans are encouraged to review the EOB clarification document posted to the Managed Care area of the portal. Error codes were added to the EOB clarification document to assist with health plan remediation, however these codes cannot be returned on the 835 file as they are not HIPAA X12 Compliant. For additional assistance concerning CARC/RARC clarification after reviewing the EOB clarification document, the plan can email the Health Plan Support team at healthplan.support@dxc.com.

**UPDATED** Is Rendering Provider information required on encounters?
If the billing provider is registered as an individual, the rendering provider information submitted in loop 2310B of the 837 X12 transaction should be left blank. When the billing provider is registered as a group, the 2310B loop is required. Health plans may review Column U of the Provider Master Listing to determine whether the provider is an Individual or Organizational Provider.
When are NDC codes required?
The National Drug Code (NDC) is required on all encounters that contain HCPCS drug codes. HCPCS drug codes include J-codes, certain A-codes, C-codes, Q-codes, and S-codes. Additionally, a valid HCPCS code and NDC combination are required on institutional encounters when pharmacy revenue codes are present. This requirement applies to revenue codes 631, 632, 633, 634, 635, 636, and 637.

The HCPCS to NDC crosswalk is published and updated quarterly by the Centers for Medicare and Medicaid Services (CMS). Not all drugs listed on the CMS crosswalk are eligible for reimbursement by Florida Medicaid.

What is the appropriate format of an NDC?
Florida Medicaid requires that the NDC be 11 digits, entered in a 5-4-2 digit format. The NDC is obtained from the package of the dispensed drug.

How is NDC information reported in the 837 File?
NDC numbers are to be reported as an eleven character data stream with no separators in the LIN03 segment of the file. In addition to the NDC, the 837 transaction must also include the identifier “N4” in the LIN02 segment, the National Drug Unit Count in the CTP04 segment, and the value “UN” in the CTP05-1 segment.

For more information on reporting National Drug Codes within in the 837 file, health plans can refer to appropriate reimbursement handbooks or the EDI Companion Guide.

General EDI Transaction Questions

How can health plans identify encounters that have been suspended?
Suspended claims will appear on the 277U financial file for encounters. These files will be available for download in the Florida Web Portal. Specific information about the 277U is available in the FMMIS 277U Health Care Payer Unsolicited Claim Status Companion Guide which can be found on the EDI Companion Guides page.

Are 835 transactions only generated on a weekly basis?
At this time, X12 5010 835 transactions are processed on a daily and weekly basis. Health plans are encouraged to review the Daily 835 File Tip Sheet for additional information.

Are there plans to change the existing layout of an 835 transaction to sort by tracking number or treating provider number?
There are no plans to change the current transaction at this time. For more information on the 835 transaction, health plans can refer to the 835 companion guide which can be found on the EDI Companion Guides page.

Can an accent mark be used in an X12 transaction?
Accents and other special characters can cause an X12 files to fail processing.

*UPDATED* Can a health plan send inbound files via File Transfer Protocol?
Transfer Protocol (FTP) if the health plan is actively enrolled with Florida Medicaid and the following information can be provided to the DXC Health Plan Support team:

- The nine-digit FL Medicaid provider ID
- The Florida Medicaid Trading Partner ID
- The Web Portal username for the provider account (MEUPS Username)

**Note:** If the above needed information is unknown, SFTP/FTP access will not be granted to the requesting health plan. Additionally, files sent via SFTP/FTP cannot be accepted for Web Portal agent accounts.

**General Web Portal Questions**

**What is the current inactivity timeout setting on the Web Portal?**

Sessions on the Web Portal expire after nineteen (19) minutes of inactivity. For users’ convenience, a timer appears at the top right of the Web Portal page.

**“UPDATED” Can health plans utilize online claims entry?**

Encounters must be submitted via 5010 X12 batch. However, "kick payment" claims can be entered via Direct Data Entry within the secure Web Portal. **Note:** A “kick payment” is a method of reimbursing capitated health plans in the form of a separate, one-time, fixed payment for a specific service, such as transplants or obstetrical delivery services.

**Does eligibility data on the Web Portal reflect real time updates?**

Yes. Eligibility data reports current information as maintained in FMMIS.

**When a manager with high level access leaves the health plan, how is the manager’s secure Web Portal access removed?**

Secure Web Portal accounts can be closed as needed. If the administrator account (the highest level of authorization) needs to be closed, call the DXC Provider Services Contact Center (PSCC) (1-800-289-7799, option 5). The PSCC representatives can assist with changing passwords or closing/re-issuing an administrator account.

**Helpful Resources**

The Agency’s Statewide Medicaid Managed Care Program Website

Managed Medical Assistance (MMA) health plans and Long-term Care (LTC) health plans can find helpful policy information by visiting the Agency’s SMMC Program website and navigating to the Managed Medical Assistance area.

DXC Technology—Florida Medicaid’s fiscal agent—is here to help!

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

For assistance with EDI transactions and other EDI-related inquiries, please contact healthplan.support@dxc.com.
Encounter Support Contacts
For further information on health plan contact resources, please review the Encounter Support Contact sheet.

For more information
Agency for Health Care Administration (Agency)
For more information regarding SMMC and related policies, visit the Agency's website at http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml.

DXC Technology
For assistance with encounter claims, contact Encounter Support or for all other questions, contact the Medicaid fiscal agent at 800-289-7799 and select Option 7.