Rhode Island Executive Office of Health and Human Service

2023 Encounter Data Validation Study

UnitedHealthcare Community Plan of Rhode Island Dental

September 2023

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Table Of Contents

List of Tables

Introduction

Encounter data reporting improvements are an ongoing project across federal and state healthcare agencies. Reliable and accurate encounter data can lead agencies to drive healthcare improvements that can positively affect the overall population and those who have high-risk health issues. Yearly encounter data validation (EDV) activities conducted by state agencies or external quality review organizations (EQROs) can help identify incomplete data, perform missing data quality checks, and assess the frequency and impact of late encounter data submissions.

The Rhode Island Executive Office of Health and Human Services (EOHHS) collects encounter data from managed care organizations (MCOs). The encounter submissions consist of all paid encounters, including:

- original,
- corrected,
- adjusted/voided,
- paid at zero dollar (alternative payment arrangements), and
- partial payments denied at the line level and paid at the header level.

All claims/encounters submitted to EOHHS are stored and maintained in the Rhode Island Medicaid Management Information System (MMIS) and maintained by fiscal intermediary, Gainwell Technologies LLC.

During calendar year (CY) 2022, IPRO conducted an EDV study that compared the MCOs' claims data versus the claims data of Rhode Island's EQRO. To ensure complete and accurate data are received and available for reporting, IPRO will be comparing the two sources of claims data.

The objective of this study is to verify the accuracy of encounter data submitted to EOHHS by the MCOs. The encounter data submitted to EOHHS were reconciled to the corresponding source claims data from the originally adjudicated claims. All data element discrepancies were reported and investigated.

The review period included service dates ranging from January 1 to December 31, 2021, for encounters submitted to the state between January 1, 2021, and March 31, 2022. For inpatient stays, the statement from-date was requested to be utilized.

Methodology

IPRO requested MCO claims data residing in the claims system for the periods of service noted above for the eligible encounter types and fields. The study was conducted for the following participating Medicaid MCOs:

- Neighborhood Health Plan of Rhode Island (NHPRI)
- Neighborhood Health Plan of Rhode Island, Integrity Medicare-Medicaid Plan (NHPRI MMP)
- Point32Health
- UnitedHealthcare Community Plan of Rhode Island (UHC)
- UHC Dental

IPRO requested the MCOs provide all paid claims/encounters with dates of service from January 1 to December 31, 2021, and submitted to EOHHS between January 1, 2021, and March 31, 2022. The claims/encounters provided to IPRO included:

- original,
- corrected,
- adjusted/voided,
- paid at zero dollar (alternative payment arrangements), and
- partial payments denied at the line level and paid at the header level.

IPRO provided MCOs detailed documentation specifying the data elements used to compare to the claims/encounters IPRO received from EOHHS. The MCOs submitted applicable claims by claim type to IPRO.

The EDV study was conducted utilizing the following methodology:

1. MCOs submitted specified data elements obtained from their adjudicated source claims that correspond to the selected audit period. To verify the source claims data, IPRO requested that the MCOs include the internal control number (ICN) if available; the ICN is obtained when the encounter is adjudicated in the state MMIS.
2. IPRO imported the MCO files and generated separate data tables per encounter type per MCO. Analyses were conducted using SAS®.
3. To identify discrepancies, IPRO compared the values of each data element from the MCO source data to values of the corresponding data element from the EOHHS source data.
4. The percentage of records with discrepant values were calculated for each data element, and those with less than a 90% match rate were identified.
5. IPRO reviewed discrepancies and categorized the data element discrepancies for each encounter type, where applicable.
6. Among data elements with less than a 90% match rate, IPRO selected a random sample of 1,000 discrepant records for each encounter type and discrepancy category for each MCO. IPRO provided counts of all discrepant records by discrepancy category to EOHHS. The sample size was determined based on the number of discrepancies.
7. IPRO identified omitted and surplus ICNs. The omitted ICNs were identified as the encounters in the MCO's claims files that were not present in IPRO's data warehouse (DW). The surplus ICNs were identified in IPRO's DW that were included in the MCO's claims files.

Interviews with MCOs

IPRO conducted teleconferences with the MCOs to discuss the following:

- Review claim discrepancies identified by IPRO.
- Walkthrough MCO's processes for receipt, reconciliation, translation, and submission of claims to EOHHS.
- If applicable, assess any changes to standard processes and/or claims systems used for EDV submission,
- Review of discrepant claims on the MCOs claim adjudication system and the 837-encounter submission string, if applicable (institutional, professional, and dental claims).
- Review of discrepant claims on the National Council for Prescription Drug Program (NCPDP), if applicable (pharmacy claims).
- Demonstration by MCOs to IPRO and EOHHS in which discrepant values from several claims included in the sample file were adjudicated and displayed on their claims adjudication system.

- Following the review of discrepant claims, MCOs displayed how each ICN's data elements appeared on the 837 submission string (institutional, professional, and dental claims) or the NCPDP (pharmacy claims) encounter extracts submitted to EOHHS.

Following the interviews with the MCOs, IPRO worked with Gainwell, EOHHS's MMIS, to identify any inconsistencies between the values and/or information provided by the MCOs and confirmed the information EOHHS received for each data element by encounter type.

Data File Layout Request

The MCOs were provided file layouts (presented in **Tables 1–5**) for each of the following encounter types, as applicable:

- professional claims,
- institutional inpatient claims,
- institutional outpatient claims,
- dental claims, and
- pharmacy claims.

Professional Encounters and Claims

Table 1: Professional Claims File Fields

Data Element/Field Name	Type	Description
MCO_NAME	Char	MCO name
PLAN_CODE	Char	
MEDICAID_MEMBER_ID	Char	Unique number assigned to the recipient received on daily 834 eligibility files
ICN	Char	Internal control number (ICN), if available, if encounter was submitted and accepted by state's MMIS
MCO_ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)), including any leading zeros
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
PLACESVC	Char	A code to indicate where the service was provided (place of service)
ICD-10-CM diagnosis codes (based on the header-level diagnosis)		
DIAGCD1	Char	Primary diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis

Data Element/Field Name	Type	Description
Payment information		
PTMT_ADJ_DATE	Date	MCO adjudication date (mm/dd/yyyy)
AMT_MCO_PAID_HDR	Num	The MCO paid amount from the header for header paid claims; total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
AMT_MCO_PAID_DTL	Num	The MCO paid amount from the detail for detail paid claims; total paid amount of the line item (Number (12,2))
AMT_OTH_INS_PD_DTL	Num	The TPL paid amount from the detail (Number (12,2))
Procedure code information		
PROCCODE	Char	Procedure/supplies/service code (i.e., CPT®-4, CDT®, and/or HCPCS), if present
QTY_UNITS_BILLED	Num	The units of service billed at the detail (Number (9,2))
MODIFIER1	Char	The first of up to four procedure/service/supplies modifier (if applicable)
MODIFIER2	Char	The second of up to four procedure/service/supplies modifier (if applicable)
MODIFIER3	Char	The third of up to four procedure/service/supplies modifier (if applicable)
MODIFIER4	Char	The fourth of up to four procedure/service/supplies modifier (if applicable)
National drug code information		
NDC_CODE	Char	The national drug code for the drug dispensed on the claim (if present)
Provider information		
BILLING_PROV_ID	Char	The Billing Provider Medicaid ID
BILLING_PROV_NPI	Char	The Billing Provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider Medicaid ID
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider Medicaid ID
REFERRING _PROV_NPI	Char	The Referring Provider NPI

MCO: managed care organization; MMIS: Medicaid Management Information System; ID: identifier; Char: characters; Num: numerals; ICD-10-CM: International Classification of Diseases, 10th Edition, Clinical Modification; TPL: Third Party Liability; CPT: Current Procedural Terminology; CDT Current Dental Terminology; HCPCS: Healthcare Common Procedure Coding System; NPI: National Provider Identifier.

Institutional Inpatient Encounters and Claims

Table 2: Institutional Inpatient Claims File Fields

Data Element/Field Name	Type	Description
MCO_NAME	Char	MCO name
PLAN_CODE	Char	
MEDICAID_MEMBER_ID	Char	Unique number assigned to the recipient received on daily 834 eligibility files
ICN	Char	Internal control number (ICN), if available, if encounter was submitted and accepted by state's MMIS
MCO_ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)), including any leading zeros
DTE_ADMISSION	Date	Date that the recipient was admitted by the provider for inpatient care (mm/dd/yyyy)

Data Element/Field Name	Type	Description
DTE_DISCHARGE	Date	Date that the recipient was discharged by the provider for inpatient care (mm/dd/yyyy)
DTE_FIRST_SVC_HDR	Date	Date on which the statement period on the claim began from the header paid claims (mm/dd/yyyy)
DTE_LAST_SVC_HDR	Date	Date on which the statement period on the claim ended from the header paid claims (mm/dd/yyyy)
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
ADMITTYP	Char	Admission type
DIS_STAT	Char	Patient discharge status code
TYPEBILL	Char	Type of bill (three-digit code)
DRG	Char	DRG code (three-digit field; please submit value in this field only if it is an inpatient claim paid on a DRG rate as reported on the encounter)
ICD-10-CM diagnosis codes (based on the header-level diagnosis)		
DIAGCD1	Char	Primary diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
DIAGCD13	Char	Thirteenth diagnosis
DIAGCD14	Char	Fourteenth diagnosis
DIAGCD15	Char	Fifteenth diagnosis
DIAGCD16	Char	Sixteenth diagnosis
DIAGCD17	Char	Seventieth diagnosis
DIAGCD18	Char	Eighteenth diagnosis
DIAGCD19	Char	Nineteenth diagnosis
DIAGCD20	Char	Twentieth diagnosis
DIAGCD21	Char	Twenty-first diagnosis
DIAGCD22	Char	Twenty-second diagnosis
DIAGCD23	Char	Twenty-third diagnosis
DIAGCD24	Char	Twenty-fourth diagnosis
DIAGCD25	Char	Twenty-fifth diagnosis
ICD-10-PCS codes		
SURG1	Char	Surgical code 1
SURG2	Char	Surgical code 2
SURG3	Char	Surgical code 3
SURG4	Char	Surgical code 4
SURG5	Char	Surgical code 5
SURG6	Char	Surgical code 6
SURGDTE1	Date	Surgical date 1 (mm/dd/yyyy)
SURGDTE2	Date	Surgical date 2 (mm/dd/yyyy)

Data Element/Field Name	Type	Description
SURGDTE3	Date	Surgical date 3 (mm/dd/yyyy)
SURGDTE4	Date	Surgical date 4 (mm/dd/yyyy)
SURGDTE5	Date	Surgical date 5 (mm/dd/yyyy)
SURGDTE6	Date	Surgical date 6 (mm/dd/yyyy)
Payment information (inpatient claims are paid at the header-level)		
PTMT_ADJ_DATE	Date	MCO adjudication date (mm/dd/yyyy)
PAIDDATE_HDR	Date	Paid date (mm/dd/yyyy) from the header for header paid claims
AMT_MCO_PAID_HDR	Num	The MCO paid amount from the header for header paid claims; total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
PAIDDATE_DTL	Date	Paid date (mm/dd/yyyy) from the detail for detail paid claims
AMT_MCO_PAID_DTL	Num	The MCO paid amount from the detail for detail paid claims; total paid amount of the line item (Number (12,2))
AMT_OTH_INS_PD_DTL	Num	The TPL paid amount from the detail (Number (12,2))
Procedure code, revenue code, and national drug code		
PROCCODE	Char	Procedure/supplies/service code (i.e., CPT-4, CDT, and/or HCPCS), if present
UNITS_BILLED	Num	Units of service billed for payment (Number (9,2))
MODIFIER1	Char	The first of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER2	Char	The second of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER3	Char	The third of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER4	Char	The fourth of up to four procedures/services/supplies modifiers (if applicable)
REVENUE_CODE	Char	Revenue center code (including any leading zeros)
NDC_CODE	Char	The national drug code for the drug dispensed on the institutional claim (if present)
Provider information		
BILLING_PROV_ID	Char	The Billing Provider Medicaid ID
BILLING_PROV_NPI	Char	The Billing Provider NPI
ATTENDING_PROV_ID	Char	The Attending Provider Medicaid ID
ATTENDING_PROV_NPI	Char	The Attending Provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider Medicaid ID
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider Medicaid ID
REFERRING _PROV_NPI	Char	The Referring Provider NPI

MCO: managed care organization; MMIS: Medicaid Management Information System; ID: identifier; Char: characters; Num: numerals; DRG: diagnosis-related group; ICD-10-CM: International Classification of Diseases, 10th Edition, Clinical Modification; TPL: Third Party Liability; CPT: Current Procedural Terminology; CDT: Current Dental Terminology; HCPCS: Healthcare Common Procedure Coding System; ICD-10-PCS: International Classification of Diseases, 10th Edition, Procedure Coding System; NPI: National Provider Identifier.

Institutional Outpatient Encounters and Claims

Table 3: Institutional Outpatient Claims File Fields

Data Element/Field Name	Type	Description
MCO_NAME	Char	MCO name
PLAN_CODE	Char	
MEDICAID_MEMBER_ID	Char	Unique number assigned to the recipient received on daily 834 eligibility files
ICN	Char	Internal control number (ICN), if available, if encounter was submitted and accepted by state's MMIS
MCO_ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)), including any leading zeros
DTE_FIRST_SVC_HDR	Date	Date on which the statement period on the claim began from the header paid claims (mm/dd/yyyy)
DTE_LAST_SVC_HDR	Date	Date on which the statement period on the claim ended from the header paid claims (mm/dd/yyyy)
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
TYPEBILL	Char	Type of bill (three-digit code)
ICD-10-CM diagnosis codes (based on the header-level diagnosis)		
DIAGCD1	Char	Primary Diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
DIAGCD13	Char	Thirteenth diagnosis
DIAGCD14	Char	Fourteenth diagnosis
DIAGCD15	Char	Fifteenth diagnosis
DIAGCD16	Char	Sixteenth diagnosis
DIAGCD17	Char	Seventieth diagnosis
DIAGCD18	Char	Eighteenth diagnosis
DIAGCD19	Char	Nineteenth diagnosis
DIAGCD20	Char	Twentieth diagnosis
DIAGCD21	Char	Twenty-first diagnosis
DIAGCD22	Char	Twenty-second diagnosis
DIAGCD23	Char	Twenty-third diagnosis
DIAGCD24	Char	Twenty-fourth diagnosis
DIAGCD25	Char	Twenty-fifth diagnosis

Data Element/Field Name	Type	Description
ICD-10-PCS codes		
SURG1	Char	Surgical code 1
SURG2	Char	Surgical code 2
SURG3	Char	Surgical code 3
SURG4	Char	Surgical code 4
SURG5	Char	Surgical code 5
SURG6	Char	Surgical code 6
SURGDTE1	Date	Surgical date 1 (mm/dd/yyyy)
SURGDTE2	Date	Surgical date 2 (mm/dd/yyyy)
SURGDTE3	Date	Surgical date 3 (mm/dd/yyyy)
SURGDTE4	Date	Surgical date 4 (mm/dd/yyyy)
SURGDTE5	Date	Surgical date 5 (mm/dd/yyyy)
SURGDTE6	Date	Surgical date 6 (mm/dd/yyyy)
Payment information		
PTMT_ADJ_DATE	Date	MCO adjudication date (mm/dd/yyyy)
PAIDDATE_HDR	Date	Paid date (mm/dd/yyyy) from the header for header paid claims
AMT_MCO_PAID_HDR	Num	This is the MCO paid amount from the header for header paid claims; total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
PAIDDATE_DTL	Date	Paid date (mm/dd/yyyy) from the detail for detail paid claims
AMT_MCO_PAID_DTL	Num	The MCO paid amount from the detail for detail paid claims; total paid amount of the line item (Number (12,2))
AMT_OTH_INS_PD_DTL	Num	The TPL paid amount from the detail (Number (12,2))
Procedure code, revenue code, and national drug code		
PROCEDURE_CODE	Char	Procedure/supplies/service code (i.e., CPT-4, CDT, and/or HCPCS), if present
UNITS_BILLED	Num	Units of service billed for payment (Number (9,2))
MODIFIER1	Char	The first of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER2	Char	The second of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER3	Char	The third of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER4	Char	The fourth of up to four procedures/services/supplies modifiers (if applicable)
REVENUE_CODE	Char	Revenue center code (including any leading zeros)
NDC_CODE	Char	The national drug code for the drug dispensed on the institutional claim (if present)
Provider information		
BILLING_PROV_ID	Char	The Billing Provider Medicaid ID
BILLING_PROV_NPI	Char	The Billing Provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider Medicaid ID
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider Medicaid ID
REFERRING _PROV_NPI	Char	The Referring Provider NPI
OPERATING_PROV_ID	Char	The Operating Provider Medicaid ID, if available
OPERATING_PROV_NPI	Char	The Operating Provider NPI, if available

MCO: managed care organization; MMIS: Medicaid Management Information System; ID: identifier; Char: characters; Num: numerals; ICD-10-CM: International Classification of Diseases, 10th Edition, Clinical Modification; TPL: Third Party Liability; CPT: Current Procedural Terminology; CDT: Current Dental Terminology; HCPCS: Healthcare Common Procedure Coding System; NPI: National Provider Identifier.

Dental Encounters and Claims

Table 4: Dental Claims File Fields

Data Element/Field Name	Type	Description
MCO_NAME	Char	MCO name
PLAN_CODE	Char	
MEDICAID_MEMBER_ID	Char	Unique number assigned to the recipient received on daily 834 eligibility files
ICN	Char	Internal control number (ICN), if available, if encounter was submitted and accepted by state's MMIS
MCO_ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)), including any leading zeros
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
PLACESVC	Char	A code to indicate where the service was provided (place of service)
Payment information		
PTMT_ADJ_DATE	Date	MCO adjudication date (mm/dd/yyyy)
AMT_MCO_PAID_HDR	Num	The MCO paid amount from the header for header paid claims; total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
Procedure code information		
CDT	Char	Procedure code (i.e., CDT)
QTY_UNITS_BILLED	Num	The units of service billed at the detail (Number (9,2))
TOOTHNUMBER	Char	Code to indicate the tooth on which the service was performed
MODIFIER1	Char	The first of up to four procedure/service/supplies modifier (if applicable)
MODIFIER2	Char	The second of up to four procedure/service/supplies modifier (if applicable)
MODIFIER3	Char	The third of up to four procedure/service/supplies modifier (if applicable)
MODIFIER4	Char	The fourth of up to four procedure/service/supplies modifier (if applicable)
Provider information		
BILLING_PROV_ID	Char	The Billing Provider Medicaid ID
BILLING_PROV_NPI	Char	The Billing Provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider Medicaid ID
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider Medicaid ID
REFERRING _PROV_NPI	Char	The Referring Provider NPI

MCO: managed care organization; MMIS: Medicaid Management Information System; ID: identifier; Char: characters; Num: numerals; TPL: Third Party Liability; CDT: Current Dental Terminology; NPI: National Provider Identifier.

Pharmacy Encounters and Claims

Table 5: Pharmacy Claims File Fields

Data Element/Field Name	Type	Description
MCO_NAME	Char	MCO name
PLAN_CODE	Char	
MEDICAID_MEMBER_ID	Char	Unique number assigned to the recipient received on daily 834 eligibility files
ICN	Char	Internal control number (ICN), if available, if encounter was submitted and accepted by state's MMIS
MCO_ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	This is the ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	Number of the detail on the claim
DTE_FIRST_SVC	Date	Date on which the statement period on the claim began (mm/dd/yyyy)
DTE_LAST_SVC	Date	Date on which the statement period on the claim ended (mm/dd/yyyy)
Payment information		
PAIDDATE_HDR	Date	The date on which the PBM/MCO paid the provider for the claim (mm/dd/yyyy)
AMT_PAID_MCO_HDR	Num	The PBM/MCO paid amount from the header (Number (11,2))
AMT_TPL_SUBM_HDR	Num	This is the TPL submitted from the header (Number (15,2))
AMT_NDC_PROFEE	Num	Amount that the provider receives for dispensing a prescription drug (Number (11,2))
Prescription/Provider/Prescribing date information		
PRESC_PROV_ID	Char	The Prescribing Provider Medicaid ID
PRESC_PROV_NPI	Char	The Prescribing Provider NPI
BILLING_PROV_ID	Char	The Billing Provider Medicaid ID
BILLING_PROV_NPI	Char	The Billing Provider NPI
PRESC_DATE	Date	Date on which prescription was prescribed (mm/dd/yyyy)
NUM_PRESCRIPTION_ID	Char	The number assigned to the prescription by the provider
DISPENSE_DATE	Date	Date on which prescription was filled (mm/dd/yyyy)
NDC_CODE	Char	National drug code for the drug dispensed
QTY_DISPENSE_HDR	Num	This is the quantity dispensed at the header (Number (10,3))
QTY_DISPENSE_DTL	Num	This is the quantity dispensed at the detail of the claim (Number (10,3))
NUM_DAY_SUPPLY	Num	The number of days the prescription should last (Number (9))

MCO: managed care organization; MMIS: Medicaid Management Information System; ID: identifier; Char: characters; Num: numerals; PBM: pharmacy benefit manager; TPL: Third Party Liability; NPI: National Provider Identifier.

Findings

The UHC Dental EDV study call was conducted on June 6, 2023. UHC Dental's system was reviewed for discrepancies of data elements present in the encounter types between the submitted EDV data file and the data submitted to EOHHS. The attendees of the EDV study call included EOHHS, UHC Dental, Skygen USA, IPRO. Data elements with less than a 90% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type. Findings are summarized in **Tables 6–7**.

Surplus and Omitted ICNs

For CY 2023, IPRO identified the omitted and surplus ICNs. The omitted ICNs were identified as the encounters in the MCO's encounter extract data file that were not present in EOHHS's Gainwell encounter data file. The surplus ICNs were identified in Gainwell's encounter data for the audit period that were not present or included on the MCO's encounter extract data file. Percentages were identified by encounter type for the discrepant records in **Table 6.**

Surplus and omission counts were noted for the CY 2021 EDV study; however, due to the timing of the review of 2021 dates of service and system issues related sequential reordering of line numbers, the detailed review of omitted and surplus discrepancies was not conducted. IPRO will clarify the instructions to modify the scope of work on how to submit the sequential line numbers on the encounter files for future EDV studies.

Table 6: Count of Surplus and Omitted ICNs per Encounter Type

Encounter Type[1,2]	Surplus (#)	Omitted (#)
Dental	154,551	145,657

[1] Surplus internal control numbers (ICNs) are encounters present in EOHHS's MMIS but not submitted in MCO's claim/encounter EDV study file.

[2] Omitted ICNs are encounters in MCO's claim/encounter EDV study file but not present in EOHHS's MMIS.

EOHHS: Executive Office of Health and Human Services; MMIS: Medicaid Management Information System; MCO: managed care organization; EDV: encounter data validation.

Dental Encounters and Claims

Table 7: Dental Data Element Discrepancies and Findings

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
MCO_NAME	NV	The MCO name was not validated and will be removed from future EDV studies.
PLAN_CODE	NV	Gainwell data included the trading partner ID. For future studies. IPRO will indicate that MCOs should submit the trading partner ID.
MEDICAID_MEMBER_ID	30.12	The companion guide indicates that the Rhode Island Medicaid identification number is 10 numerical characters for the Rhode Island Medicaid Recipient Identification Number (MID). UHC Dental is mapping and providing the recipient's state-issued Medicaid identification number that was in place and assigned at the time the claim encounter was adjudicated and reported to EOHHS. The correct value for the Medicaid member identification is the Rhode Island MID, but UHC Dental provided the other/alternate ID on the EDV study file. The discrepancy is associated to an EDV reporting study data extraction issue.
ICN	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the Gainwell data.
MCO_ICN	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
NUM_ADJ_ICN	98.79	
LINE_NUMBER	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the Gainwell data.
DTE_FIRST_SVC_DTL	99.94	
DTE_LAST_SVC_DTL	99.94	
PLACESVC	99.23	
PTMT_ADJ_DATE	0	The Gainwell file did not contain any values. On the EDV study file, the MCO submitted the MCO payment adjudication date, and there is no distinction between the MCO adjudication date and payment date. During the remote meeting, the MCO confirmed the value provided on the EDV study file was present on the claim system screens and the 837D string. IPRO followed up with Gainwell after the remote meeting. Gainwell advised that the header paid date is only required when the MCO is reporting header only paid claims If reporting detail service line is a paid claim, the MCO should not report header paid date, as reporting both dates will cause a compliance issue. For future EDV studies, IPRO will modify the scope of work requirement for the payment adjudication date.
AMT_MCO_PAID_HDR	98.90	
AMT_OTH_INS_PD_HDR	0.33	The Gainwell data file appears to be summarizing the MCO paid amount and the other insurance amount. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that the value on the Gainwell data extract includes what is provided by the MCOs and not a calculated/summarized value. IPRO further followed up with Gainwell and provided MCO examples for review.
CDT	90.65	
QTY_UNITS_BILLED	NV	Gainwell's date extract did not clearly identify the data field for QTY_UNITS_BILLED, and as a result, IPRO was unable to identify discrepancies. Quantity units billed will be reviewed in future EDV study.
TOOTHNUMBER	NV	Gainwell's date extract did not clearly identify the data field for TOOTHNUMBER values, and as a result, IPRO was unable to identify discrepancies. Tooth number will be reviewed in future EDV study.
MODIFIER1	100	
MODIFIER2	100	
MODIFIER3	100	
MODIFIER4	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
BILLING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
BILLING_PROV_NPI	99.96	
RENDERING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
RENDERING_PROV_NPI	100	
REFERRING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
REFERRING_PROV_NPI	NV	The Gainwell data file did not contain any Referring Provider NPI value. IPRO followed up with Gainwell after the remote meeting. Gainwell advised that the Referring Provider NPI was not required to be submitted by the MCOs on the 837D extract.

Yellow shading: < 90% match with MCO reporting study data extraction issue; light green shading: < 90% match and IPRO to follow up with Gainwell; NV: not validated; MCO: managed care organization; EDV: encounter data validation; ID: identifier; EOHHS: Executive Office of Health and Human Services; NPI: National Provider Identifier; UHC: UnitedHealthcare Community Plan of Rhode Island.

Summary of Findings

For the CY 2023 EDV study, based on IPRO's discussion with EOHHS, the following data elements were not validated for this study and will be re-evaluated in future studies:

- MCO_NAME and PLAN_CODE data elements were not validated due to naming convention issues and inclusion of trading partners.
- ICN and LINE_NUMBER data elements were not validated. However, they were utilized to match the EDV study records and the Gainwell data.
- QTY_UNITS_BILLED was not validated. The quantity units billed data will be reviewed in the next EDV study.
- TOOTNUMBER was not validated, since the data field was not identified on EOHHS's Gainwell data extract. IPRO followed up with Gainwell after the remote meeting, and the tooth number will be in the next EDV study.
- All PROV_ID data elements (BILLING_PROV_ID, RENDERING_PROV_ID, REFERRING _PROV_ID) have not been validated for any claim type, as the MCOs do not submit provider identification numbers on encounter data files to EOHHS.

Follow-up and Next Steps

Based upon IPRO's review of the MCO's EDV study file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from the MCOs, and discussions with the MCOs and EOHHS during and following the teleconferences, there are no major encounter data issues. However, there are areas that require further research by encounter type by the MCOs, EOHHS, and IPRO.

EDV reporting study data extraction issues were identified across encounter types. It is expected that the MCO will address and resolve the data extraction issues with future EDV studies.

IPRO will work closely with EOHHS to revise and clarify the scope of work and data elements requested for future EDV studies. IPRO will provide additional guidance on the reporting of service line reordering on the 837 extracts due to denials of service lines and the reordering of the sequential line numbers, which also impacted the detailed omission and surplus discrepancy analysis.

IPRO will continue to work closely with Gainwell, EOHHS's MMIS, to review the following outstanding discrepancies not resolved by the finalizing of the EDV study report:

- PTMT_ADJ_DATE data elements will be re-evaluated, as MCOs provide paid date information only on the detail level. They also do not provide the adjudication date (PTMT_ADJ_DATE); only the paid date (PAIDDATE_DTL) is submitted. IPRO will modify the instructions to replace PTMT_ADJ_DATE with PAIDDATE_DTL.
- IPRO recommends NUM_ADJ_ICN be removed from future EDV studies, since Gainwell confirmed that Gainwell assigns a new ICN to the data element when received and that the new ICN is not available to the MCOs.
- IPRO will work with Gainwell to re-evaluate and advise logic for AMT_MCO_PAID_HDR and AMT_OTH_INS_PD_HDR based on 837 submissions, and IPRO will clarify the instructions and modify the scope of work requirements on how to submit these data elements.
- All PROV_ID data elements (BILLING_PROV_ID, RENDERING_PROV_ID, and REFERRING _PROV_ID) will not be requested in future EDV studies.
- IPRO will work with Gainwell and re-evaluate populating provider NPI by encounter type when the billing, rendering, and referring NPIs need to be submitted by the MCOs on the encounter data extracts. IPRO will clarify the instructions and modify the scope of work requirements on when to submit these data elements based on encounter type.
- Surplus and omission counts were noted for the CY 2023 EDV study; however, due to the timing and system issues related to the sequential reordering of line numbers, IPRO will clarify the instructions and modify the scope of work on how to submit the sequential line numbers on the encounter files for the EDV study.
- For future EDV studies, IPRO will include additional logic to identify if the match is on non-missing values.