ENCOUNTER DATA ELEMENTS (DEs)
for Medi-Cal Managed Care Plans: GMC and 2-Plan Models
(as of 7-25-06)

Plans are required to submit complete, accurate, and timely encounter data for all services for which the plan has incurred any financial liability, whether directly or through subcontracts or other arrangements. These monthly encounter data submissions generally include the elements listed below. However, depending on the type of encounter reported, not all elements may be required.

DE	PURPOSE
1	**Claim Reference Number (CRN)** –identifies any record documenting an encounter so record can be located & retrieved
2	**Plan Code** – identifies each health plan relative to each record
3	**Format Code** – identifies the record format code on each record for one of 5 general types of encounters: medical outpatient, pharmaceutical, long-term care, hospital inpatient acute care & dental services
4	**Program Code** – identifies specific DHS program services rendered & included in the capitation amount
5	**Adjustment Code for CRN** – indicates whether a previously submitted record is voided or corrected
6	**Adjustment CRN** – identifies the CRN of previously submitted record that was adjusted
7	**Medi-Cal Beneficiary Identification (BID)** – identifies a Medi-Cal recipient's eligibility for month of services (includes county residence code, aid code & State or county assigned #)
8	**Social Security (SSN) or Client Index Number (CIN)** – identifies same recipient as indicated in DE7 by SSN or CIN
9	**Name** of Medi-Cal Recipient
10	**Birth Date** of Medi-Cal Recipient (DOB)
11	**Sex** code of Medi-Cal Recipient
12	**Ethnic/Race Code** of Medi-Cal Recipient – uses following codes: 0 unknown, 1 White, 2 Hispanic, 3 Black, 4 Other Asian or Pacific Islander, 5 American Native or American Indian, 7 Filipino, 8 No Valid Data reported, A Amerasian, C Chinese, H Cambodian, J Japanese, K Korean, M Samoan, N Asian Indian, P Hawaiian, R Guamanian, T Laotian & V Vietnamese
13	**Provider Number** (Reporting/Billing) – identifies the Medi-Cal provider number or state license number of individual, group,

DE	PURPOSE
	clinic or facility that has billed a health plan or reported a capitated encounter service
14	**Provider Name** (Reporting/Billing)
15	**ZIP Code of Rendering Provider**
16	**County Code of Rendering Provider** – identifies county of encounter
17	**Provider Type Code** – identifies type of provider; must be consistent with type of license held
18	**Physician & Dental Specialty Code**
19	**Beginning Date of Service**
20	**Ending Date of Service**
21	**Referring/Prescribing/Admitting Provider**
22	**Prior Authorization or PCP Referral Indicator** – identifies whether service required a referral or prior authorization from PCP or health plan
23	**Primary Diagnosis** (ICD -9- CM) – identifies the diagnosis code for patient's principle condition
24	**Secondary Diagnosis** (ICD-9-CM) – identifies the diagnosis code for patient's secondary condition, if any
25	**Tertiary Diagnosis** (ICD-9-CM)
26	**Family Planning Indicator** – identifies provision of family planning services (sterilization or other)
27	**Adjudication Status Code** – identifies whether service rendered was provided on capitated or non-capitated basis. (If non-capitated, indicates whether plan paid or denied payment.)
28	**Adjudication Date** – identifies date record was adjudicated
29	Date of Payment by Plan (Check Date) – identifies data payment was issued to billing provider by plan for non-capitated FFS services
30	**Billed Amount** – amount provider billed the plan for service provided on record
31	**Reimbursement Amount** – amount paid to provider by plan for service provided on record
32	**Patient Liability Amount** – amount owed to the provider by recipient of services or supplies
33	**Medicare Deductible Amount** – amount of Medicare deductible for services reported on record
34	**Medicare Co-Insurance Amount** – co-insurance amount for Medicare services
35	**Other Health Coverage Amount** – amount paid by insurance

DE	PURPOSE
	carrier or third party for services report on record
36	Not used at this time
37	**Tooth Surface Locations**
38	**Place of Services** – identifies where service was rendered (e.g., school, homeless shelter, office, home, mobile unit, urgent care facility, inpatient or outpatient hospital, ER, ambulatory surgical center, birthing center, military treatment facility, skilled nursing facility, custodial care facility, hospice, ambulance/land, air or water, federally qualified health center, inpatient psychiatric facility, psychiatric facility-partial hospitalization, community medical center, intermediate care facility/mentally retarded, residential substance abuse or psychiatric treatment facility, mass immunization center, comprehensive inpatient or outpatient rehabilitation facility, end-stage renal disease treatment facility, state or local public health clinic, rural health clinic, independent laboratory & other place of service)
39	**Procedure Code** (CPT-4, HCPCS or Dental Codes) – identifies specific medical or dental services and procedures performed & medical supplies or materials provided
40	**Procedure Modifier or Tooth Code** – for medical records, determines any special external circumstances re: DE 39; for dental record, identifies tooth or area of mouth treated
41	**Medical Outpatient & Dental Procedure Quantity** – identifies the quantity or number of units of services, procedures or supplies provided
42	**Rendering Provider Number** – identifies the individual provider who directly rendered the service reported on record
43	**Drugs/Medical Supplies** – identifies the drug & whether a medical supply was dispensed
44	**Drug/Medical Supply Indicator Code** – identifies whether a prescription drug or medical supply was provided
45	**Drug/Medical Supply Quantity** – identifies quantity dispensed
46	**Days Supply** – identifies number of days covered by RX or medical supply
47	**Long Term Care Accommodation Codes** – identifies type of accommodation for stays in LTC facilities
48	**Days Stay** – patient's number of days stay in hospital or LTC facility

DE	PURPOSE
49	**Admission Date** – patient's date of admission to acute care hospital or LTC facility
50	**Discharge Date** – patient's date of discharge from hospital or LTC facility
51	**Patient Status Code** – patient's inpatient or outpatient status as of ending DOS reported on record (e.g., inpatient -- discharged to home, transferred to another facility, expired, still patient, etc.; LTC – still under care, admitted, expired, discharged to home or another facility, leave of absence, etc.; outpatient – referred to another physician, return to referring physician, referred to CHDP, CCS, CPSP or WIC, etc.)
52	**Admission Necessity Code** – reason for patient's admission into acute care hospital (emergency, elective, newborn)
53	**Primary Surgical Procedure** – identifies primary surgical procedure performed during hospital inpatient stay
54	**Secondary Surgical Procedure Code** – identifies secondary surgical procedure performed during hospital inpatient stay
56	**Number of Claim Lines** – identifies number of complete hospital claim lines (detail segments) appended to header segment of each hospital inpatient record
57	**Accommodation & Ancillary Codes** – identifies type of accommodation and/or ancillary services provided by hospital for inpatient records only

NOTE:

Further Encounter Data submission specifications for GMC and 2-Plan contractors are available in the *Encounter Data Element Dictionary for Managed Care Plans, Version 1.5* via the following link: http://www.dhcs.ca.gov/provgovpart/Documents/DED2006ver1_5.pdf

Claims and encounter data elements and submission specifications for COHS contractors are available in the *Paid Claims and Encounters Standard 35C-File Data Element Dictionary* via the link below. http://www.dhcs.ca.gov/provgovpart/Documents/PdClms_S35C_FileDED_2.pdf