Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-23 **Date: MAY 2000**

CHANGE REQUEST 1183

SUBJECT: Business Requirements For Processing Physician Encounter Data In The HCFA Data Center

Background

Section 1853(a)(3) of the Social Security Act (the Act) requires Medicare+Choice organizations (M+COs), as well as eligible organizations with risk-sharing contracts, to submit encounter data. In order to assure that all the types of data (hospital inpatient, hospital outpatient, and physician) are being effectively gathered by January 1, 2001, hospital inpatient and physician data are being phased in prior to this date.

The purpose of this Program Memorandum is to provide the business requirements for processing physician encounters in the Part B Standard System (MCS) which will be run in the HCFA Data Center (HDC). These requirements are to be in place (in the production environment) effective October 1, 2000, when M+COs begin submitting physician encounter data (with dates of service October 1, 2000 and later) to the HDC encounter carrier.

General Requirements

M+COs will begin submitting physician encounter data for production processing at the HDC on October 1, 2000. All M+CO encounter data transactions must be processed in HDC, including those submitted for Railroad Retirement Board beneficiaries. Workload is estimate at 60-70 million transactions annually, but may be as high as 100 million transactions per year over time. Peak volume may reach 1 million transactions per day at the end of an encounter processing year.

For encounter processing, the definition of "physician" is based upon the fee for service definition of physician services, §1848(j)(3) of the Act. This is the definition used for the physician fee schedule and it covers a wide range of services. This definition includes any eligible individual (physician, nonphysician practitioner, or other supplier) who furnishes the services.

The required data set will be an abbreviated version of that used for fee-for-service processing with one major exception, the inclusion of pricing locality information on the transaction record. The minimum data fields required for physician encounters data are listed below. M+COs must submit that minimum set, but will be allowed to submit the complete fee-for-service data set. All data will come in electronically, either on ANSI 837 or the National Standard Format (NSF) version of the 1500.

The full set of required fields for NSF submission are included on Attachment A. The fields include those that are required for NSF electronic submission and those that pertain to the encounter between the physician and the beneficiary. The required data fields that pertain to the encounter, and the data required to be present in those fields (if different from fee-for-service Medicare rules), are as follows:

Transaction (Claim) Level Data

Field Name	Required Value (if applicable)
Type of Health Insurance	
Insured ID Number	
Patient Name	
Patient Sex	
Date of Current Injury, etc.	
Diagnosis	
Provider Identifier	M+CO H number (H plus 4 digits)
Provider State	State where services on transaction rendered, if State has one pricing locality
Provider Zip	Zip code where services on transaction rendered, if State has multiple pricing localities

Line Item Data	
Field Name	**Required Value (if applicable)**
Date of Service	
Place of Service	
Procedure	
Diagnosis Pointer	
Days or Units	
Identifier for Rendering Physician	UPIN (6 digits)
State	State of facility where service rendered, if different than that provided on claim
Zip Code	Zip code of facility where service rendered, if in State with more than one pricing locality

Transaction Processing

Support for the transaction processing and development shall be provided by a Customer Service and Support Center (CSSC). The CSSC contract has been awarded to Palmetto GBA which is also the front and back end processor for this initiative.

Receipt of Transactions

Encounter data transactions shall be verified upon receipt in the same manner as currently occurs in fee-for-service claims processing. The abbreviated M+CO data set shall be accepted as complete. Individual transactions or batches of transactions may be returned or rejected based on the absence of required data fields or because of transaction, field level format errors, or invalid data, e.g., non-specific diagnosis codes. Parameters for return/rejection shall be adjustable to improve operational efficiency. M+COs shall receive notification of transaction status as occurs in fee-for-service claims processing. At a minimum, M+COs shall be notified as to which claims are accepted by the system and which have been returned/rejected.

Editing of Data - General

Some editing will occur in the front-end of the system and/or in the standard system itself. All of the above data are required for encounter processing and shall be edited for:

Presence of data in all required fields
Logical edits to ensure that data meet basic requirements (e.g., UPIN is 6 characters with first character alpha)
Look-up table edits to ensure that data match valid values
- Diagnosis codes
- Procedure codes
- HICs
- UPINs
- "H" numbers

Functions/Edits to Eliminate, By-pass, or Turn Off

The system shall not edit for medical review (MR), utilization review (UR), coverage policy, or Medicare Secondary Payer (MSP). MR edits are those that suspend or deny claims based on procedures that are determined not to be medically necessary. UR edits suspend or deny claims that represent excess utilization of a particular service.

Functions/Editing that Shall Occur

Pricing
All transactions that are accepted shall have a price developed under the following constraints. All pricing shall be calculated as though every physician is participating. All pricing shall be calculated only from physician fee schedule amounts, i.e., no reasonable charge and no submitted charge calculations shall affect the price calculation. Submitted charges carry no significance in the encounter data environment. Submitted charges are required on the transaction; however, the amounts will be defaulted to $1.00 per line item at the front end. After a price is developed from the fee schedule, that price shall be substituted for the submitted charge. No reasonable charge tables will be developed.

The pricing locality will be developed from data present in the transaction. HCFA will provide a crosswalk table that will: 1) link State and pricing locality for States with only one pricing locality, and 2) link zip code and locality for States with more than one pricing locality. Locality information will come in at either the transaction level or the line item of service level, depending on whether the all line items on the transaction represent services rendered in one pricing locality, or whether the line items on the transaction cross multiple pricing localities.

No local HCPCS codes will be accepted. NOC codes shall be priced manually, as in fee-for-service Medicare, and will require an explanation in the appropriate field on the electronic record HA0. HCPCS modifiers shall be accepted as submitted, i.e., assistant at surgery and co-surgery transactions shall not suspend awaiting documentation. For all services (with or without HCPCS modifiers), the system will utilize normal fee schedule pricing.

Diagnosis and Procedure Code Editing
All diagnoses and procedures shall go through common logical edits, such as diagnosis or procedure to gender. Additionally, to ensure pricing commensurate with that in fee-for-service Medicare, correct coding initiative edits shall be applied. None of the edits listed here are for MR, but rather edits that determine proper bundling of services for pricing purposes or the validity of diagnoses or procedures.

Duplicate Transactions
Duplicate encounter data transactions shall be identified in the same manner as fee-for-service processing identifies duplicate claims. Exact duplicate transactions shall be denied. Potential duplicate transactions shall suspend for review; if the transaction is a true duplicate, it will be denied. Duplicate denials will not be sent through to claims history.

Beneficiary Eligibility
All routine beneficiary eligibility checks shall be performed. In addition, beneficiary eligibility shall be checked against the beneficiary record to determine if a beneficiary was enrolled in the submitting M+CO for the dates of service on the encounter data transaction.

Remittance Advice Generation
Electronic remittance advice notices (ERA) shall be generated for each transaction. The ERA format and information provided will be the same as in fee for service. The ERAs shall indicate whether a transaction was accepted or denied. Accepted is the encounter transaction equivalent of a paid claim in fee-for-service processing. For all transactions that are accepted, the ERAs shall indicate the price that the system calculated for each service on the transaction, but no paid amount.

Adjustment Processing

MCS shall provide the capacity for the CSSC to adjust manually any transaction that has been processed and accepted. The determination that a transaction should be adjusted will be made at the CSSC. Data that may be adjusted includes date of service, place of service, diagnosis, diagnosis pointer, procedure, days/units, provider identifier, and provider location information. After manual adjustment, the transaction shall be reprocessed to ensure that it passes all edits and is appropriately priced.

History Retention

History for encounter transactions shall be maintained in MCS, CWF, and in the NCH. In CWF, the encounter history file shall be maintained separately from claims processing history. If a transaction is adjusted, the original shall be maintained along with the adjusted transaction. HCFA prefers that two years of history be maintained, to cover the active encounter processing year and the reconciliation processing year.

Provider File Maintenance

The provider file will consist of data supplied via three external files, the Plan Information Control System (PICS), the Unique Physician Identification Number (UPIN) Registry, and the Medicare Exclusion Database (MED). The file will contain two distinct types of providers: M+COs and individuals practitioners. M+COs will be identified by their HCFA-assigned "H" numbers, and individuals by their UPINs. The UPIN registry will assign UPINs to all individual practitioners covered under the "physician" encounter data processing requirements. All individuals and M+COs will default to participating status. The option codes that set up appropriate billing arrangements will also need to be defaulted to allow development of a price based on the location of the service at the line level. Credentials from the UPIN Registry must translate to provide type in MCS.

The provider file must be maintainable, either through submission of updated files or through an online transaction. Updated information on M+COs will be entered by the FMC. The file update process can be via a separately created update file that is loaded into the online system. MED information will come from monthly file updates. Updates from MED must utilize the UPIN from the MED file, apply the action/reason code for exclusions to that UPIN in the provider file, and apply appropriate effective dates to that action reason code. H number information will be updated as new

information becomes available. HCFA will provide updates to the UPIN data on at least a monthly basis. HCFA will provide updated exclusion information from the Medicare Exclusion Database on a separate monthly cycle. Some information for the provider file will be default values.

Information from PICS regarding the M+COs will be as follows:

Field Name	**Description/Length**
Provider Number	H Number, 5 digits
Name	One combined field for business name

Information from the UPIN Registry for individuals will be as follows:

Field Name	**Description/Length**
UPIN	6 characters
Last Name	20 characters
First Name	14 characters
Middle	6 characters
Suffix	3 characters (e.g., JR, SR)
Date of Birth	MMDDYYYY
Date of Death	MMDDYYYY
Credentials	3 characters (e.g., MD, DO, CH, CSW)
Opt out date	8 characters
Action taken flag	Identifies what type action is being taken for opt out or date of death, e.g., add, update, delete
Primary Specialty	2 characters (HCFA-defined specialty codes)
SSN/EIN	

Information from the MED on excluded individuals will be as follows:

Field Name	**Description/Length**
UPIN	6 characters
Effective date	Present for all exclusions, 8 characters
Reinstatement date	Applies only when individual reinstated, 8 characters
Action taken flag	Identifies what type action is being taken for opt out or date of death, e.g., add, update, delete

Reports

The processing systems shall generate the same reports for the CSSC that are normally generated for Medicare carriers. There will also be additional reports that the CSSC will require on a routine basis (e.g., daily, weekly, etc.). These will report, by billing provider (H number), status of transactions that have finalized, transactions that are pending CWF, and transactions that have rejected out of the system. Additionally HCFA requires a report of surrogate UPIN usage by billing provider, with a total of line items submitted, total line items with surrogate UPINs, percentage of surrogates to total line items, total surrogate usage by each surrogate number, and those individual surrogate totals expressed as a percentage of total surrogates submitted. Reports will be exportable as data files or flat files that can be manipulated by the CSSC data analysis staff and HCFA staff.

The *effective date* for this Program Memorandum (PM) is October 1, 2000.

The *implementation date* for this PM is October 1, 2000.

Funding is available through this contract's regular budget process for costs required for implementation.

If you have any questions, contact Ed Lain at 410-786-0848.

This PM may be discarded May 31, 2001.

Attachment A

Medicare+Choice National Standard Format for Physician Encounter Data

(NSF VERSION 003.01 - 07/01/1997)

RECORD TYPE	FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	POSITIONS THRU
AA0	01.0	RECORD ID "AA0"	3	X	01	03
AA0	02.0	SUB ID	16	X	04	19
AA0	05.0	SUBMISSION NO	6	X	35	40
AA0	15.0	CREATION DATE	8	X	213	220
AA0	17.0	RECEIVER ID	16	X	227	242
AA0	19.0	VERSION CODE-NATIONAL	5	N	244	248
AA0	21.0	TEST/PROD IND	4	X	254	257
AA0	31.0	ACKNOWLEDGMENT REQUEST	1	X	308	308
AA0	33.0	FILLER-NATIONAL	4	X	317	320
BA0	01.0	RECORD ID "BA0"	3	X	01	03
BA0	02.0	EMC PROV ID	15	X	04	18
BA0	04.0	BATCH NO	4	N	22	25
BA0	**09.0**	**NATIONAL PROV ID**	**15**	**X**	**48**	**62**
BA0	28.0	FILLER-NATIONAL	26	X	295	320
CA0	01.0	RECORD ID "CA0"	3	X	01	03
CA0	03.0	PAT CONTROL NO	17	X	06	22
CA0	**04.0**	**PAT LAST NAME**	**20**	**X**	**23**	**42**
CA0	**05.0**	**PAT FIRST NAME**	**12**	**X**	**43**	**54**
CA0	**08.0**	**PAT DATE OF BIRTH**	**8**	**X**	**59**	**66**
CA0	**09.0**	**PAT SEX**	**1**	**X**	**67**	**67**
CA0	30.0	FILLER-NATIONAL	87	X	234	320
DA0	01.0	RECORD ID "DA0"	3	X	01	03
DA0	02.0	SEQUENCE NO	2	X	04	05
DA0	03.0	PAT CONTROL NO	17	X	06	22
DA0	**18.0**	**INSURED ID NO**	**25**	**X**	**157**	**181**
DA0	32.0	FILLER-NATIONAL	33	X	288	320
EA0	01.0	RECORD ID "EA0"	3	X	01	03
EA0	03.0	PAT CONTROL NO	17	X	06	22
EA0	**07.0**	**ACCIDENT/SYMPTOM DATE**	**8**	**X**	**26**	**33**
EA0	**32.0**	**DIAGNOSIS CODE-1**	**5**	**X**	**179**	**183**
EA0	**33.0**	**DIAGNOSIS CODE-2**	**5**	**X**	**184**	**188**
EA0	**34.0**	**DIAGNOSIS CODE-3**	**5**	**X**	**189**	**193**
EA0	**35.0**	**DIAGNOSIS CODE-4**	**5**	**X**	**194**	**198**
EA0	**53.0**	**CPO PROV NO**	**6**	**X**	**290**	**295**
EA0	55.0	FILLER-NATIONAL	10	X	311	320
EA1	01.0	RECORD ID "EA1"	3	X	01	03
EA1	02.0	RESERVED (EA1-02.0)	2	X	04	05
EA1	03.0	PAT CONTROL NO	17	X	06	22
EA1	**09.0**	**FACILITY/LAB STATE**	**2**	**X**	**133**	**134**
EA1	**10.0**	**FACILITY/LAB ZIP CODE**	**9**	**X**	**135**	**143**
EA1	30.0	FILLER-NATIONAL	2	X	319	320

[1] Please note the following: All records/fields as presented in the M+C NSF are required to be submitted (except for conditional fields). **Bolded record/fields are directly/indirectly related to risk adjustment**. Records and Fields are explained in detail in the National Standard Format (NSF) materials available on the Internet, at www.hcfa.gov. At the HCFA Home Page, select "Medicare", then "Professional/Technical Information". Once in the Professional/Technical Information section, select "Electronic Data Interchange (EDI)".

[2] At the Batch level, the provider identifier is the Medicare+Choice organization's "H" number, whereas at the Line level the provider identifier is the rendering physician's Unique Physician Identification Number (UPIN).

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Attachment A

Medicare+Choice National Standard Format for Physician Encounter Data

(NSF VERSION 003.01 - 07/01/1997)

- continued -

RECORD TYPE	FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	POSITIONS THRU
FA0	01.0	RECORD ID "FA0"	3	X	01	03
FA0	02.0	SEQUENCE NO	2	X	04	05
FA0	03.0	PAT CONTROL NO	17	X	06	22
FA0	04.0	LINE ITEM CONTROL NO	17	X	23	39
FA0	**05.0**	**SVC FROM DATE**	**8**	**X**	**40**	**47**
FA0	**06.0**	**SVC TO DATE**	**8**	**X**	**48**	**55**
FA0	**07.0**	**PLACE OF SVC**	**2**	**X**	**56**	**57**
FA0	**09.0**	**HCPCS PROCEDURE CODE**	**5**	**X**	**60**	**64**
FA0	**10.0**	**HCPCS MODIFIER 1**	**2**	**X**	**65**	**66**
FA0	**11.0**	**HCPCS MODIFIER 2**	**2**	**X**	**67**	**68**
FA0	**12.0**	**HCPCS MODIFIER 3**	**2**	**X**	**69**	**70**
FA0	**14.0**	**DIAG CODE POINTER1**	**1**	**X**	**78**	**78**
FA0	**18.0**	**UNITS OF SVC**	**4**	**N**	**82**	**85**
FA0	**19.0**	**ANESTHESIA/OXYGEN MIN**	**4**	**N**	**86**	**89**
FA0	**23.0**	**RENDERING PROVI NPI**	**15**	**X**	**93**	**107**
FB2	01.0	RECORD ID AFB2"	3	X	01	03
FB2	02.0	SEQUENCE NO	2	X	04	05
FB2	03.0	PAT CONTROL NO	17	X	06	22
FB2	04.0	LINE ITEM CONTROL NO	17	X	23	39
FB2	**09.0**	**PROV A STATE**	**2**	**X**	**122**	**123**
FB2	**10.0**	**PROV A ZIP**	**9**	**X**	**124**	**132**
FB2	23.0	FILLER-NATIONAL	2	X	319	320
HA0	01.0	RECORD ID "HA0"	3	X	01	03
HA0	02.0	SEQUENCE NO	2	X	04	05
HA0	03.0	PAT CONTROL NO	17	X	06	22
HA0	04.0	LINE ITEM CONTROL NO	17	X	23	39
HA0	**05.0**	**EXTRA NARRATIVE DATA**	**281**	**X**	**40**	**320**
XA0	01.0	RECORD ID "XA0"	3	X	01	03
XA0	02.0	RESERVED (XA0-02.0)	2	X	04	05
XA0	03.0	PAT CONTROL NO	17	X	06	22
XA0	04.0	RECORD CXX COUNT	2	N	23	24
XA0	05.0	RECORD DXX COUNT	2	N	25	26
XA0	06.0	RECORD EXX COUNT	2	N	27	28
XA0	07.0	RECORD FXX COUNT	2	N	29	30
XA0	09.0	RECORD HXX COUNT	2	N	33	34
XA0	10.0	CLAIM RECORD COUNT	3	N	35	37
XA0	23.0	FILLER-NATIONAL	61	X	260	320
YA0	01.0	RECORD ID "YA0"	3	X	01	03
YA0	02.0	EMC PROV ID	15	X	04	18
YA0	04.0	BATCH NO	4	N	22	25
YA0	08.0	BATCH SVC LINE COUNT	7	N	47	53
YA0	09.0	BATCH RECORD COUNT	7	N	54	60
YA0	10.0	BATCH CLAIM COUNT	7	N	61	67
YA0	12.0	FILLER-NATIONAL	244	X	77	320
ZA0	01.0	RECORD ID "ZA0"	3	X	01	03
ZA0	02.0	SUB ID	16	X	04	19
ZA0	04.0	RECEIVER ID	16	X	29	44
ZA0	05.0	FILE SVC LINE COUNT	7	N	45	51
ZA0	06.0	FILE RECORD COUNT	7	N	52	58
ZA0	07.0	FILE CLAIM COUNT	7	N	59	65
ZA0	08.0	BATCH COUNT	4	N	66	69
ZA0	12.0	FILLER-NATIONAL	218	X	103	320

- end of M+C NSF