Department Of Health & Human Services
Health Care Financing Administration
Center for Health Plans and Providers (CHPP)
Medicare Managed Care
Operational Policy Letter #70
OPL98.070

Date: May 19, 1998

Subject: Hospital Encounter Data Requirements from the Balanced Budget Act (BBA) of 1997

Issue/Question:

How will the Health Care Financing Administration (HCFA) collect hospital encounter data?

Resolution/Answer:

Background

Section 1853(a)(3) of the Social Security Act as enacted by Section 4001 of Subtitle A of the BBA requires Medicare+Choice organizations, as well as eligible organizations with risk-sharing contracts under Section 1876 of the Social Security Act, to submit encounter data. Data regarding inpatient hospital services are required for discharges on or after July 1, 1997. These data may be collected starting January 1, 1998. Section 1853(a)(3) also requires the Secretary to implement a risk adjustment methodology that accounts for variation in per capita costs based on health status. This payment must be implemented no later than January 1, 2000.

Hospital data for discharges from the period July 1, 1997 - June 30, 1998 will serve as the basis for plan level estimates of risk adjusted payments. Health plans that submit sufficient hospital encounter data will use this estimate in their adjusted Community Rate Proposal (ACRP) for calendar year (CY) 2000. Actual payments to plans for CY 2000 will be based on hospital encounter data from a subsequent period.

HCFA distributed OPL 97.064 to plans in December, 1997 that described the general processes for the submission of hospital encounter data. This OPL transmits the list of requirements for plans for submitting data for the period July 1, 1997 - June 30, 1998 and the requirements for data submission after July 1, 1998. These are draft requirements until the Emergency Paperwork Reduction Act package has been approved by the Office of Management and Budget (OMB).

These requirements have been addressed (in draft form) in several previous meetings with selected health plans, as well as a public meeting, held on March 27, 1998, to which all current health plans were invited. Questions and answers were generated from these meetings and are shown in Attachment G.

Plans have also requested that the time limit be extended for submission of an abbreviated UB-92 data set. Currently, the abbreviated data set will be accepted for discharges from July 1, 1997 through June 30, 1998. HCFA is **not** planning to extend the use of the abbreviated data set for discharges beyond June 30, 1998. An extension would involve a number of data processing problems, predominantly related to millennium compliance.

For questions concerning this OPL, contact Cynthia Tudor, Ph.D. via e-mail (ctudor@hcfa.gov) or at (410) 786-6499.

Robert A. Berenson, M.D.
Director

REQUIREMENTS FOR SUBMISSION OF HOSPITAL ENCOUNTER DATA

Note: These are draft requirements. They have been submitted as part of an Emergency Paperwork Reduction Act package to the Office of Management and Budget (OMB).

These requirements are divided into two sections. The first section describes the requirements for the submission of hospital encounter data for discharges from July 1, 1997 - June 30, 1998 (referred to as the "start-up year"). The second section specifically applies to the submission of encounter data from July 1, 1998 forward, but also contains some information that may be helpful to plans[1] for the transmission of data for the start-up year (defined as July 1, 1997 - June 30, 1998).

I. DATA FOR DISCHARGES FROM 7/1/97 - 6/30/98

A. General Approach

1. HCFA has identified three alternatives for the submission of hospital encounter data for discharges during the start-up year, including the following:

   Option 1: The plan will have a hospital submit UB-92s or Medicare Part A ANSI ASC X12 837 records[2] using the traditional HMO 'no pay' bill method.

   Option 2: The plan can currently produce a complete UB-92/ANSI 837 and will hold the data until the fiscal intermediary (FI) can accept it.

   Option 3: The plan will submit an abbreviated UB-92 data set to its selected FI.

   - Data for the start-up year are recognized by a "statement covers thru date" between July 1, 1997 and June 30, 1998.

[1] The term "Plans" refers to Section 1876 risk contracting plans and Medicare +Choice organizations as defined by the BBA.

[2] The "Medicare Part A ANSI ASC X12 837" format will be abbreviated as the "ANSI 837" format in the remainder of this document.

- Encounter data are required for discharges from inpatient hospitals, including facilities reimbursed under the prospective payment system (PPS), long stay hospitals, psychiatric and rehabilitation hospitals, and psychiatric/rehabilitation distinct parts of hospitals. Encounter data are not currently required for discharges from skilled nursing facilities (SNFs).

  1) Every Medicare participating hospital is assigned a distinct provider number. Information within the provider number can assist the plan in identifying whether or not the provider is considered to be an inpatient hospital. The first two digits of the provider number identify the State where the hospital is located, and the third digit identifies the type of hospital. For example, a zero in the third digit of the provider number signifies a short-term hospital paid under the prospective payment system. (For a complete description of HCFA's standards for assigning numbers based on the type of provider, see HCFA's Regional Office Manual, Part 4, section 1060. Plans should contact their RO for a copy.)

  2) In order to participate as a Medicare provider, a hospital must meet certain conditions specified in the Medicare regulations (42 CFR 482.12). Generally, these conditions pertain to such things as compliance with applicable Federal, State, and local laws, makeup of the medical staff; and quality assurance plans.

- Hospital encounter data must be received for each discharge from either a contracted or noncontracted hospital.

2. Applicable sections

   - Requirements for Option 1 are found in this section and Section 1.B.
   - Requirements for Option 2 are found in this section and Section 1.C.
   - Requirements for Option 3 are found in this section and Section 1.D.
   - Because plans may have multiple options they are using to transmit encounter data, they must follow all requirements for each option.

3. Regardless of the option(s) selected for data for the start-up year, plans must work with hospitals to determine the extent to which each hospital can provide data. The plan must determine which method(s) will be used for which hospitals for this period. If necessary, the method may vary by hospital and for different time periods during the start-up year.

- In an effort to determine whether we have received all the encounter data for a plan, HCFA has identified two types of information that the plan **may** provide.

  1) The plan **may** provide HCFA with information on which option(s) it intends to use to provide data for the start-up year. This list should include the plan's identification number (contract number) and for each hospital: the hospital's provider ID and which option applies to that hospital. If a hospital will provide data for only a certain period of time, define that period of time as well. (For example, Hospital A will submit UB-92s for January 1, 1998 forward, but not for July 1, 1997 -December 31, 1997.) This information should be provided to the contact person listed at the end of this OPL by **May 15, 1998.**

  2) After all data for the start-up year has been submitted, plans may also provide information on the aggregate total (unduplicated) of hospital discharges submitted for each annual period. If available, the plan should provide this information separately by option. This information may also be provided to the contact person listed on this OPL by **October 1, 1998.**

4. Plans must select one FI from the list provided by HCFA in early February. This list is attached (Attachment A). Plans were instructed at that time to begin identifying an FI with whom to work. Plans should have contacted and selected an FI by March 6, 1998.

   - Plans must report their selection to the lead RO, along with the location from which the data will be transmitted to the FI. A contact person (and e-mail address where available) should also be provided to the RO. This information was also due to the RO by March 6, 1998.

   - Once a specific FI has been identified, that FI must schedule a training session with the plan. The FI will also provide a set of billing software to the plan and support for that software. The FI is responsible for addressing technical issues concerning processing of the data.

   - The appropriate Regional Office (RO) will monitor the process (or lead RO in the case of multistate plans).

   - Each FI will notify its RO of plans that have successfully tested (and not tested) the submission of data. These reports will begin on June 15, 1998 and will occur approximately every two weeks thereafter, until all plans have successfully transmitted data.

5. Plans should accomplish the linkage to the FI. Information on the linkage, data file transmissions, and schedules are provided in Section II and in the attachments.

6. All data for the period July 1, 1997 - June 30, 1998 must be submitted to the FI no later than **September 18, 1998** to ensure that the encounter data submitted by the plan will be utilized to derive the plan's estimated average payment rate. This date cannot be waived. The estimate will be provided to the plan by March 1, 1999.

7. Specific dates for the start up year are summarized in the table below.

DATE:	ACTIVITY:
March 6, 1998	Plan must select FI.
May 15, 1998	Plan may provide information on options used for each hospital.
June 15, 1998	Option 3 plans must successfully transmit data to selected FI if using UB-92, Version 4.1.[3]
July 15, 1998	Option 1 and Option 2 plans must successfully transmit data to selected FI if using UB-92, Version 4.1 or 5.0. Option 3 plans must successfully transmit data if using Version 5.0.
September 18, 1998	**All data for period July 1, 1997 - June 30, 1998 must be transmitted to selected FI.**

[3]Expected dates of testing and successful transmission of data depend upon which option(s) the plan uses and which version of the UB-92 the plan is using. If the plan uses UB-92 Version 4.1 either for the full or abbreviated UB-92, they can begin submitting test data on June 1, 1998. Option 3 plans that use version 4.1 must successfully transmit data by June 15. Option 3 plans that use version 5.0 can begin testing on July 1 and must successfully transmit data by July 15, 1998. Option 1 and 2 plans that use version 5.0 can begin testing on July 1, 1998. Option 1 and 2 plans that use either version 4.1 or 5.0 must successfully transmit data by July 15, 1998. For an explanation of Version 4.1, see Attachment G, Question 15. Note that UB-92, Version 4.0 is a valid format but is not recommended.

October 1, 1998	Plans provide unduplicated count of hospital discharges for start-up year to CO[4].
October 5, 1998	Plan provides CEO attestation to CO plan manager.

8. Plans should be aware that HCFA is mandating that teaching hospitals submit UB-92/ANSI 837 records for the computation and payment of indirect and direct Graduate Medical Education (GME) costs for inpatients who are plan enrollees. Teaching hospitals will submit these records to the hospital's FI. These records will resemble those submitted by the plan or the hospital as encounter data except that the GME transactions will contain the condition code, "69" -- request by teaching hospital for direct indirect and direct GME payment.

B. ADDITIONAL REQUIREMENTS--OPTION 1 PLANS ONLY

Description of Option: The Plan will have a hospital submit the UB-92/ANSI 837s using the traditional HMO 'No pay' bill method.

1. Plans electing Option 1 for any of its hospitals will have the hospital submit the UB-92/ANSI 837 to the hospital's FI, using the hospital's regular data transmission process. Plans should provide the hospital with the Medicare Identification Number (or Health Insurance Claim (HIC) number) for all discharges of managed care enrollees.

2. Plans may want to verify that the hospital has submitted UB-92/ANSI 837 records for each discharge.

3. Data are submitted from the hospital to the hospital's FI. Normal FI 'no-pay" processing occurs.

4. If a plan is submitting all its data via this Option, the plan must successfully complete the linkage to the FI by July 15, 1998.

C. ADDITIONAL REQUIREMENTS--OPTION 2 PLANS ONLY

Description of Option: The Plan can currently produce a complete UB-92/ANSI 837 and will hold the data until HCFA is ready to accept the data.

1. The plan must add its plan identification number to the UB-92/ANSI 837. The exact placement (or field) for the plan identification number depends upon whether the electronic UB-92 or ANSI 837 format is used.

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[4]CO refers to HCFA Central Office.

2. Plans will hold these UB-92/ANSI 837 records until the FI selected by the Plan is capable of accepting the complete UB-92 from the plan.

   - Each FI is expected to be able to accept a completed UB-92 from all managed care plans no later than June 30, 1998.

3. The plan must transmit the UB-92 to the selected FI. All transmissions to the FI must be electronic. All the usual edits will be done by the FI.

4. If a plan is submitting all its data via this Option, the plan must successfully transmit data to its FI by July 15, 1998.

D. ADDITIONAL REQUIREMENTS--OPTION 3 PLANS ONLY

Description of Option: The Plan will submit an abbreviated UB-92 data set to its selected FI.

1. HCFA has identified a data set for the abbreviated submission. Appendix B shows the data elements to be used by the plan to transmit the abbreviated data set to the FI.

   - Note that the plan identification number must be included (Record type 31, Field #15); the type of bill (shown in Record type 40, Field #04) must be '11Z'; and condition code (Record Type 41, Field #4) '04' -HMO Enrollee must be present.

   - Also note that the data set reflects the specific requirements that must be followed in order for the abbreviated UB-92 to pass the required edits. These requirements cannot be waived by HCFA or the FI.

2. The date for testing linkages and successful transmission of data for Option 3 plans depends upon the version of the UB-92 that is being used. In general, plans using UB-92, version 4.1 must successfully transmit data by June 15, 1998. Plans using UB-92 , version 5.0 must successfully transmit data by July 15, 1998. These dates are laid out in detail in footnote #3.

3. The general description of accomplishing the linkage to the FI is described in Section II.

4. After the plan transmits the file, it is received and uploaded by the FI. The general editing process for data is shown in Section II. However, because the data set is abbreviated only certain edits will be performed on these records; these edits are shown in Appendix C.

5. Records passing all edits are sent from the FI to the Common Working File (CWF). Again, Section II describes these edits.
6. At a minimum, the plan will receive a notice from the FI for abbreviated UB-92 records that failed one or more edits. Some FIs may provide a full accounting of all encounter transactions. The plan should discuss the notices to be provided with the selected FI.
7. Data submitted after September 18, 1998 will **not** be used in the estimate of the plan's average payment rate. The last day an abbreviated UB-92 record may be submitted to the FI for discharges from July 1, 1997 through June 30, 1998 is December 31, 1998. HCFA will monitor the level of late submissions for planning purposes only.

II. DATA FOR DISCHARGES FROM 7/1/98 FORWARD

These requirements provide a description of the process for submitting hospital encounter data from July 1, 1998 forward. They also contain information that may be helpful to plans for transmission of data for the start-up year.

NOTE: Encounter data for hospital discharges on or after July 1, 1998 must be submitted by the plan to its selected FI, beginning October 1, 1998. These data, if submitted by the hospital directly to an FI, will be rejected/returned to the hospital.

A. Data Transmission

1. As discussed in OPL 97.064, in an effort to ensure that HCFA receives encounter data for all hospital discharges that occur on or after July 1, 1997, plans must work with hospitals to develop a procedure that ensures that all hospital discharges of Medicare managed care enrollees are identified.

    - In order to assist hospitals in identifying enrollees who are hospitalized, the plan must provide the Medicare identification (HIC) number to the hospital for each hospitalized enrollee.

    - Plans may also need to modify their contracts with hospitals to ensure that all managed care discharges are identified and that UB-92/ANSI 837 records are provided by the hospital to the plan for each discharge.

    - Plans should submit a record of each discharge of a plan enrollee from contracted, as well as noncontracted, hospitals.

2. For all discharges on or after July 1, 1998, plans must require hospitals to submit a **complete** UB-92/ANSI 837 to the plan for each discharge of a managed care enrollee. Hospitals will no longer be responsible for submitting HMO 'no-pay' bills to the FI.

- Plans should note that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will require plans to accept transactions electronically from those providers that are capable of transmitting electronically. Additional information on the schedule for HIPAA compliance is included in Section II.B.4.

3. Once a hospital encounter record has been transmitted to the plan, the plan must add their plan identification number to the UB-92/ANSI 837 record.

4. As described in Section I.A., plans should have contacted a fiscal intermediary early in 1998 from the list provided by HCFA.

   - Linkage between the plan and the selected FI must be done on a timely basis. Deadlines for the successful transmission of data to the selected FI depend upon the options chosen for the submission of data for the start-up year. These deadlines are explained in Section I.

   - Once the linkage has been established, all data must be transmitted using this route. Each plan and/or contract will use a single FI. Plans with multiple contracts (that is, plans having multiple plan identification numbers) may select more than one FI.

   - The FI you selected is your primary contact for information regarding data transmission, editing, and processing of your data.

5. HCFA will use the Medicare Data Communications Network (MDCN) operated by IBM Global Services (IGS) to support encounter data transmissions and related data traffic. All fiscal intermediaries are already connected to the MDCN.

   - Plans will be given access to the network in one of three ways.

     1). Plans which already have IGS connections will be given HCFA authorization (via net IDs and application IDs) for two-way traffic over the MDCN.

     2). Larger volume plans without current IGS accounts will be authorized Transmission Control Protocol/Internet Protocol (TCP/IP)[5] enabled frame

[5]TCP is responsible for verifying the correct delivery of data from client to server and adds support to detect errors or lost data and to trigger retransmission until the data are correctly and completely received. IP is responsible for moving packets of data from node to node. The IP component provides routing from the enterprise network, to the regional networks, and to

relay leased line connections. Given the nature of encounter data traffic, HCFA believes 56kb circuits will suffice.

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the global Internet.

3). Lesser volume plans will be provided TCP/IP-based asynchronous dial service to the nearest IGS point of presence (POP). Data exchanges using this type of connection will be accomplished using File Transfer Protocol (FTP). (Note that FIs are already required to support TCP/IP and FTP connectivity under HCFA Electronic Data Interchange (EDI) instructions.)

- Access will be via a local call for most plans. Plans outside the local calling area of the nearest IGS POP will receive 800/888 service. IGS will provide these plans with dialer software to facilitate the connectivity.

- The FI can provide the plan with information on the most appropriate method of accessing the network.

- Costs to plans:

  1). HCFA will pay for the installation of leased lines for larger plans (where required) for current plans.
  2). HCFA will also provide the software for medium and smaller current plans that utilize the dial up method.
  3). In addition, HCFA will pay for up to 3 months of line charges for telecommunications between the plan and the FI. The period during which HCFA will pay for line charges is expected to last from May 31, 1998 through August 31, 1998. By the end of that period, the HCFA sponsored account for a plan will be converted to a commercial account for the plan with direct billing by IGS.
  4) The expected plan costs for line charges are estimated to be an average of $7600 per year per plan based on access of 8 hours daily for 22 days per month and 90% of users being local to IGS.

- Additional information on file specifications is shown in Attachment D.

6. The Plan will be connected through MDCN to its FI to transmit the UB-92.

   - The FI will provide the training to the plan on electronic transmission as well as data entry from a paper UB-92.

   - The FI cannot bypass edits on fields included in the UB-92/ANSI 837. Exceptions to this are noted in Attachment E.

7. The plan and the FI agree on a transmission schedule for data. Plans are required to submit data at least monthly to their FI.

8. The plan will transmit the completed UB-92/ANSI 837 to the FI. All transmissions must be electronic. Data to the FI will be sent in batch mode.

9. As an alternative to direct plan transmission to the FI, plans may make arrangements to subcontract to a third party the electronic transmission of data to a FI. Plans that contract with a third party for this function do so with the knowledge that the plan remains responsible for the submission of data.

10. Once the FI receives and uploads the file.

- If the file cannot be read. The FI must notify the plan. The plan must resubmit the entire file.

- The FI performs the usual edits. Attachment E provides additional information on edits. All UB-92/ANSI 837 records will be priced. (Note: Encounter data will be priced only for discharges on or after July 1, 1998.)

- The FI will send a normal edit report electronically to the plan for the failed records. The plan will then resubmit the corrected records with the next batch.

11. Records passing all edits are sent from the FI to CWF. CWF performs many of the same edits that were done at the FI level, but also performs checks to determine whether the beneficiary is a managed care enrollee.

- If records are rejected by the CWF, they are sent back to the plan via the FI.

- The response trailer to the FI will identify the reason(s) for rejection.

    a. If the record was rejected because the beneficiary was not recognized as a managed care enrollee, the plan can resubmit the record with the next batch transmitted to the FI.

    b. Other records will be resubmitted using the process defined in Step 10.

- CWF will generate a response trailer for accepted records which is sent to the FI. The FI will send the response trailer back to the plan.

12. Deadlines for submission of data:

DISCHARGES FROM:	DISCHARGES THRU:	SUBMISSION TO FI NO LATER THAN:
July 1, 1997	June 30, 1998	September 18, 1998
July 1, 1998	June 30, 1999	September 17, 1999
July 1, 1999	December 31, 1999	March 17, 2000
January 1, 2000	December 31, 2000	March 16, 2001

- Data for discharges after these dates must be submitted by close of business on the third Friday in March, following the end of the calendar year.

- In an effort to verify that we have received all the information for a 12 month period, the plan may provide information on the aggregate total (unduplicated) of hospital discharges submitted for annual period. For each year after the start-up year, this information may be provided to the plan manager.

B. Additional Information

1. Hospital encounter data should be submitted over the signature of the Chief Executive Officer (CEO) attesting that the plan has submitted the data as reported by the provider (hospital) and that a record for each encounter (hospital discharge) has been submitted.

   - A sample attestation form is provided (Attachment F). For the start-up year, the attestation varies depending upon whether all data for a plan is submitted via Option 1 (in which case, the CEO attests only to the completeness of the data) or whether any data is submitted via Option 2 or Option 3 (in which case, the CEO attests to the completeness of the data and that the data was submitted by the plan as it was reported by the hospital).

   - Attestation as to the validity of the data must be done on a yearly basis.

   - This attestation, at a later point, may be incorporated into the application process for a plan. At that point, a separate attestation will not be required.

2. Medical record reviews of a sample of hospital encounters may be audited to ensure the accuracy of diagnostic information. Reviews will be conducted by an independent contractor. Plans will be provided additional information on the process for these reviews over the next several months.

- The medical record reviews for hospital encounter data may be integrated at a later point into the audit process for the verification of Health Plan Employer Data and Information Set (HEDIS). Plans will be notified as to these changes.

3. Plans that fail to submit complete and timely information on hospital discharges that occur on or after July 1, 1997, will be subject to contract actions and/or intermediate sanctions. In addition, plans that contract with a third party subcontractor to submit encounter data are still legally responsible for the submission of these data and will be subject to the same contract actions and/or intermediate sanctions if their third party subcontractor does not comply with HCFA requirements.

4. Plans should take note of the following:

   - HIPAA addresses the need for data standards that lead to administrative simplification. It mandates the establishment of these standards for use in the following electronic transactions: health claims, health encounter information, health plan enrollment and disenrollment, health plan eligibility, as well as other types of transactions. The standards are applicable to all health plans and to those health care providers who use electronic transactions. HIPAA stipulates the way in which the standards are to be established and the time schedules for implementation.

   - HCFA expects the Notice of Proposed Rulemaking to be published in the Federal Register by mid 1998, with the final rules to be published in late-1998. Plans are required to implement these standards within 24 months of their adoption (small health plans have 36 months). **HCFA will comply with HIPAA requirements regarding standards and record layouts for all encounter data from managed care plans. However, before HIPAA is effective, we expect hospital data to be transmitted to FIs in UB-92/ANSI 837 format.**

5. Plans should consider the exposure of health plan management information systems to the year 2000 (Y2K) date computation problem. This problem stems from the common practice of abbreviating dates used in computer systems. HCFA provided information to the plans regarding millennium compliance in OPL 98.068.

Attachment A

February 10, 1998

NOTE TO: Medicare Risk Contracting Managed Care Plans

SUBJECT: Fiscal Intermediaries for the Collection of Inpatient Encounter Data--INFORMATION

The purpose of this note is to advise you of the Medicare Fiscal Intermediaries (FIs) that will be available for the collection of inpatient hospital encounter data as authorized by Section 1853(a)(3) of the Balanced Budget Act of 1997. Plans must select one of these FIs to process claims transactions (using either the complete UB-92 or the Medicare Part A ANSI ASC X12 837) for managed care enrollees for discharges from July 1, 1997, forward. These FIs are also available to plans that elect to submit an abbreviated UB-92 for discharges for the period July 1, 1997 - June 30, 1998.

As you may or may not be aware, the Health Care Financing Administration is currently transitioning its FIs to a single, standard claims processing system, known as the Florida Shared System (FSS). These Medicare contractors were selected to process encounter data based on the fact that they are currently operating on the standard Medicare Part A System and on their recent operating experience as FIs under the Medicare Choices Demonstration Project.

At this time, plans should be working with their hospitals to develop procedures to ensure that all managed care discharges are identified and that hospital inpatient data are provided to the plan for each hospitalized enrollee. In addition, plans must select an FI (from the list below) that will be responsible for processing hospital inpatient data from the plan. The plan should provide to the FI the address of the site from which it will be transmitting data. HCFA and the FI will need this address in order install communications equipment. Plans should have selected an FI by **March 6, 1998**. Listed below are the available FIs, along with a contact name and telephone number:

- AdminaStar Federal
  Contact: Shelly Fletcher, (317)-841-4443

- Blue Cross/Blue Shield of Florida
  Contact: Tina Mitrea, (904)-791-8250

- Palmetto Government Benefits Administrators
  Contact: Joe Johnson, (803)-788-0222, ext. 31176

- Summit DataNet, Inc.
  Contact: Rick Yearry, 1-800-447-7828, ext. 8277

- Blue Cross/Blue Shield of Texas
  Contact: Colleen Cobble, (505)-880-1739

- Veritus, Inc.
  Contact: Charlene Cave, (412)-544-1924

Attached are brief Fact Sheets for each of the contractors to assist you in understanding who they are and in making a selection. The contact person is available to answer any questions you may have regarding the FI.

Information regarding the training to be conducted in March will be provided to you by the FI that you select. The training will specifically address issues regarding data communications and transaction processing. In the meantime, please contact your appropriate Regional Office concerning any additional questions you may have regarding the collection of managed care hospital data. Additional information and instructions regarding the hospital encounter data collection effort will be forthcoming in an Operational Policy Letter.

Finally, it is important to note that due to contracting requirements, HCFA will be formally competing this workload among all of the current FIs for the period beginning October 1, 1998. As a result, it is possible this list of FIs performing this function may change at that time. We will ensure timely selection of the contractors and notification to the managed care community, to allow adequate time for any transitions that may be necessary.

Lu Zawistowich, Sc.D.
Director
Program Development and Information Group
Center for Health Plans and Providers

Attachments

cc:
Regional Administrators, Regions I - X
Associate Regional Administrators for
Beneficiary Services and Financial Management

Attachment B

UB-92 Abbreviated Hospital Encounter Data for Interim Collection[6]

On each required record type, all alpha-numeric fields that are not listed below should be filled with blanks; all numeric fields that are not listed below should be filled with zeroes.

UB92 Rec Type	Field No.	Field Name	Length	Picture
01	1	Record Type	2	(X)
01	2	Submitter EIN	10	(9)
01	3	Multiple Provider Billing File Ind.	1	(9)
01	8	**Processing Date** ("Date Bill Submitted" on HCFA-1450) (MMDDYY)	6	(9)
01	9	Submitter Name	21	(X)
01	10	Submitter Address	18	(X)
01	11	Submitter City	15	(X)
01	12	Submitter State	2	(X)
01	13	Submitter ZIP Code	9	(X)
01	16	Submitter Telephone Number	10	(9)
01	17	File Sequence and Serial Number	7	(X)
01	18	Test/Production Indicator	4	(X)
01	22	Version Code (040 or 041)	3	(X)
10	1	Record Type	2	(X)
10	2	Type of Batch (11Z)	3	(X)
10	3	Batch Number	2	(9)
10	6	**National Provider Identifier**[7]	13	(X)
20	1	Record Type	2	(X)
20	3	Patient Control Number	20	(X)
20	4	**Last Name**	20	(X)
20	5	**First Name**	9	(X)
20	6	**Middle Initial**	1	(X)
20	7	**Sex** (F, M)	1	(X)
20	8	**Birth date** (MMDDCCYY)	8	(9)
20	17	**Admission Start of Care Date**	6	(9)

[6] Fields are explained in Appendix B of the hospital manual.

[7] This field is a 6-position Medicare provider number, until the National Provider Identifier (NPI) is implemented.

Attachment B (Continued)

20		**Statement Covers Period Date**		
	19	**From Date** (MMDDYY)	6	(9)
	20	**Through Date** (MMDDYY)	6	(9)
30	1	Record Type	2	(X)
30	2	Sequence Number	2	(9)
30	3	Patient Control Number	20	(X)
30	7	**HIC Number** 19	(X)	
31	1	Record Type	2	(X)
31	2	Sequence Number	2	(9)
31	3	Patient Control Number	20	(X)
31	15	**Contract Number (HMO)**	5	(X)
40	1	Record Type	2	(X)
40	2	Sequence Number	2	(9)
40	3	Patient Control Number	20	(X)
40	4	**Type of Bill** (11Z)	3	(X)
41	1	Record Type	2	(X)
41	2	Sequence Number	2	(9)
41	3	Patient Control Number	20	(X)
41	4 - 13	**Condition Code** (occurs 10x)	2	(X)
		'04'-HMO enrollment, '65'-Non-PPS Hospital		
50	1	Record Type	2	(X)
50	2	Sequence Number	2	(9)
50	3	Patient Control Number	20	(X)
70	1	Record Type	2	(X)
70	2	Sequence Number	2	(9)
70	3	Patient Control Number	20	(X)
70	4	**Principal Diagnosis Code** (ICD-9)	6	(X)
70	5 - 12	**Other Diagnosis Code** (occurs 8x)	6	(X)
70	13	**Principal Procedure Code**	7	(X)
70	15, 17, 19, 21, 23	**Other Procedure Code** (occurs 5x)	7	(X)
90	1	Record Type	2	(X)
90	3	Patient Control Number	20	(X)
90	4	Physical Record Count	3	(9)
90		Record Type nn Count	2	(9)
	5	Record Type 2n Count	2	(9)
	6	Record Type 3n Count	2	(9)
	7	Record Type 4n Count	2	(9)
	8	Record Type 5n Count	2	(9)
	10	Record Type 7n Count	2	(9)
	12	Record Type 91 Qualifier	1	(9)
95	1	Record Type	2	(X)

Attachment B (Continued)

95	5	Type of Batch	3	(X)	
95	6	Number of Claims	6		(9)
99	1	Record Type	2		(X)
99	2	Submitter EIN	10	(9)	
99	5	Number of Batches Billed This File	4		(9)

Notes:

Detailed editing is limited to Field Names in **bold**. However, note the following:

1. Field names not in bold are required to be present; and
2. Information contained on record types 90 and 95 must match the information transmitted.

Attachment C

FI EDITS ON ALTERNATE ENCOUNTER DATA SUBMISSIONS BY PLANS

1. Each record contains all required fields listed on Attachment B.

2. Processing Date field is 6 characters and is equal to or less than the current date.

3. NPI field is 13 characters and contains all numbers (NOTE: Until NPIs are assigned, this field will contain the 6-digit provider number.)

4. Sex field is 1 character and contains either F or M.

5. DOB field is 8 characters, contains all numbers, and is less than the current date.

6. Admission Date field is 6 characters, contains all numbers, and is equal to or less than the current date.

7. From Date field is 6 characters, contains all numbers, and is equal to or greater than the Admission Date field.

8. Thru Date field is 6 characters, contains all numbers, and is equal to or greater than the From Date/Admission Date.

9. Contract Number field contains 5 characters.

10. Type of Bill field is 11Z.

11. Condition Code field is 2 characters and contains at least an '04.'

12. Principal Diagnosis Code field contains 3 - 6 characters and is a valid ICD-9-CM code.

13. If present, Other Diagnosis Code field contains 3 - 6 characters and is a valid ICD-9-CM code.

14. If present, Principal Procedure Code contains 3 - 7 characters.

15. If present, Other Procedure Code contains 3 - 7 characters.

16. HIC Number field contains 10-12 characters and is valid.

Attachment D

This attachment provides pages from the FI manual concerning software and terminal requirements and standards for submission.

6. Claims Review.--Exercise the same vigilance and utilize the same criteria in performing medical necessity and coverage reviews as for hard copy claims for those bill types for which you are responsible. The method of performing this review, whether automated, clerical, or a combination, is at your discretion (unless specified otherwise) so long as it complies with the requirements. An example of an acceptable approach is utilization of an approved automated means of performing review on both hard copy and EMC, e.g., automated screens.

7. Assignment of Benefits.--If a complementary claim is involved, the provider must indicate on the specific claim record whether payment of complementary benefits has been assigned by the beneficiary.

8. Technical Assistance.--Provide all electronic bill submitters with the name and telephone number of a contact on your staff who can offer advice and technical assistance.

B. Personal Computer Software Requirements.--Make available free personal computer (PC) billing software to providers and billing services submitting claims or interested in submitting claims by means of a PC. You may charge up to $25.00 per year to cover postage and handling for the free PC software. Do not provide general purpose translators. Prior to distributing the initial or updated versions, ensure that the software is "virus" free. This software must contain, at a minimum, the following features:

- o Contractor-maintained basic front-line edits;

- o "User friendly" qualities including:

  - A low initial investment on the part of the provider;
  - Low ongoing maintenance costs;
  - Minimal effort for software installation and training for the provider;
  - Clear and understandable software documentation, including information about where to receive additional help, if necessary.
  - The ability to prepare and send HCFA-approved EMC forms of paper attachments (as they are developed and approved).

Provide additional features if desired.

C. Interactive Terminal Requirements.--If you have the ability to offer an interactive terminal option, do not limit its access to a subsidiary of your parent company. Offer it as an option to all bill submitters at a reasonable cost. There will be no differentiation between what it costs those billing through the subsidiary and what it costs all other billers.

1. Provider Representative Certification.--The initial group of claims submitted to you must be accompanied by a covering letter, signed by the provider's representative. (For hospitals and SNFs the appropriate representative is the administrator.) The letter must include the following statement: "In submitting machine readable claims, I understand I am certifying that the required

patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and re-certifications (PRO certifications where applicable) are on file, and anyone who misrepresents or falsifies essential Medicare claims information, may, upon conviction, be subject to fine and imprisonment under Federal law." The statement should be resubmitted annually, or upon a change in provider representative if that occurs first.

2. Claims Submission.--Claims may be submitted individually or in periodic groups/batches at intervals mutually established between you and the provider. Where limitations on frequency of billing are applicable (e.g., monthly billing for ESRD, HHA, or the therapies), providers must comply with established rules.

3. Control.--Provider systems must have the capability to resubmit lost or garbled claims data or unreadable tapes, cassettes, floppy disks, or other medium used, and be able to re-associate data found to be in error with the original claim for correction and resubmission.

4. Retention.--Providers must retain all applicable source data in accordance with existing requirements and make it available for periodic verification.

3602.3 File Specifications, Records Specifications, and Data Element Definitions for EMC Bills.-

A. Electronic UB-92 Version 4 Claims Format.--Support the electronic UB-92 Version 4 claims format. Eliminate local electronic formats by July 1, 1996. Do not offer local formats to new electronic providers. In addition to accommodating the requirements for Medicare claims, the electronic UB-92 specifications are designed to meet the needs of other private and government programs.

Support of the UB-92 electronic format requires you to have the capability to receive all records in the specification. Compliance includes the "attachment records," record types (RT) 71-78. These contain medical documentation data used for medical review. This is not a requirement for providers to submit attachment records. Unless your medical review policy or procedures, such as a development letter, require this data with claim data or independent of claim data, providers should not submit them to you. The attachment records are designed to facilitate the electronic submission of data for medical review, but they are not required to be used by your medical review department. Receipt of these records by all contractors also facilitates coordination of benefits, and they should be included in any coordination of benefits crossover.

For asynchronous communications, you must accept the electronic UB-92 in 192 byte records. Do not require the data to be broken down into 80 byte segments or any other deviation from the 192 byte format requirement. For asynchronous traffic, Medicare flat files are self-enveloped, and the envelope provided should be the only one used.

Within the nationally defined physical segments, where space permits, a portion is set aside for local use. Local use fields are not to be used for Medicare. The File and Record Formats are described in Addendum A. The data elements are listed alphabetically and defined in Addendum B. Addendum D contains the home health plan of treatment data definitions and codes. Addendum E contains MCE edits. Addendum F contains OCE edits.

B. ANSI ASC X12 837 Health Care Claim Transaction Set.--Have in production the ability to receive the current and/or previous release of the American National Standards Institute (ANSI) Accredited Standards Committee X12 (ASC X12) 837 Health Care Claim (837) Transaction Set, and to translate the 837 into the UB-92, electronic version 4, flat-file for processing based on Medicare Part A specifications for the ANSI ASC X12 837, which conforms to the ANSI X12 837 Draft Standard for Trial Use. Maintain all X12 releases and subreleases employed in Medicare specifications, and retain all translation software versions indefinitely. Refer to Medicare Part A Specifications for the ANSI ASC X12 837 for general processing instructions, flat-file and ANSI ASC X12 837 record formats and associated data dictionary. If you need a copy of Medicare Part A Specifications for the ANSI ASC X12 837, request it from your RO. Distribute the specifications to all requesting providers as ASCII text, in commonly used commercial word processing packages or as hard copy. Do not distribute the original program that generates the specifications.

The 837 is a variable-length record designed for wire transmission and is not suitable for use in an applications program. Only accept the 837 over a wire connection. Therefore, the 837 received from providers must be translated into the UB-92, electronic version 4, format for claims processing. Translating claims data does not constitute processing a claim. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols as detailed in the specifications.

For asynchronous communications, you must accept the ANSI X12 837 as a continuous byte stream or as a variable length record. Do not require the data to be broken down into 80 byte segments or any other deviation from the variable length format or the continuous byte stream format. For example, do not force submitters to create each segment as its own record by inserting carriage returns or line feeds. For all X12 transactions, only standard X12 envelopes are to be used.

Beginning October 1, 1996, you must provide the Functional Acknowledgment Standard Format to all requesting providers in response to flat file submissions. By December 1, 1998, the ANSI X12 997 functional acknowledgment and the flat file functional acknowledgment will be the only acceptable formats to generate for providers upon their request.

You are required to:

o Notify all billers of the new formats and asynchronous telecommunications capabilities available to them by means of your scheduled provider bulletins. Immediately notify all providers regarding the implementation of the most current Medicare Part A ANSI ASC X12 837 and the availability of specifications;

o Issue Medicare Part A specifications for the most current and/or previous version of the ANSI ASC X12 837, and your technical interface specifications, to all providers within 3 weeks of request. Interface specifications must contain sufficient detail that a provider can comply with them without buying a product offered only by you or your subsidiary. Receive the 837 from providers over a wire connection. Do not use tapes or diskettes;

o Receive the 837 directly from providers or their designated billing services;

o Have the ability to send the ANSI ASC X12 997 Functional Acknowledgment (997), as detailed in the specifications to providers who submit claims in the ANSI ASC X12 837 format. Inform providers that it is their option to receive the 997. You must return a 997, if requested by the provider, within one business day;

Attachment E

Information on Edits for the UB-92/ANSI 837 Record

1. Plans should receive a set of instructions from their FI, including Section 460 and Addendum A and B of the hospital manual.

2. The edits bypassed under the Medicare Choices Demonstration Project will also be bypassed (e.g., MR/UR, MSP).

3. All claims must have at least two revenue center line items. One line must have a revenue code for accommodations covering the from and through dates. If rates and/or total charges are unavailable to the plan, you may submit a rate of $1 on the accommodations line and total charges equal to the number of units (days) time the rate. Any other revenue codes for which total charges are unavailable should contain total charges of $1. Revenue center code '0001' must be present and represents the sum of all revenue center line item total charges that appear on the claim.

4. For "foreign providers" (defined as providers not located in the U.S., Canada, or Mexico), plans may use the code: 990001.

5. With the exception of the following list, all other fields are either required elements or are required if they are applicable.

   The following fields are not required:

UB92 Rec Type	Field No.	Field Name
10	4	Fed Tax No,
95	2	Fed Tax No.
20	9	Patient Marital Status
20	18	Admission hour
20	22	Discharge hour
30	17	Assignment of benefits certification indicator
20	23	Payments Received
30	25	Payments Received
20	24	Estimated amount due
30	26	Estimated amount due
34	4-12	Authorization
70	26	E-code
70	27	Procedure coding method used

Attachment F

Sample Attestation Form

Complete the following attestation form and return it to your plan manager within 10 business days of the final date for submission of data to the FI (as shown in Item II.12).

The _____(insert name of plan and plan identification number) has complied with the requirements of Section 1853(a)(3)(B) of the Balanced Budget Act of 1997 regarding the submission of encounter data:

(Note: If all data from a plan for the start-up year is submitted via Option 1, choose the attestation in Section I only; if any data is submitted by a plan via Option 2 or Option 3, choose the attestation in Section II. Attestations after the start-up year use Section II only.)

I. ____ A record for each encounter has been submitted.

II. ____ The data provided by the plan were reported as received from the provider(s).

____ A record for each encounter has been submitted.

I certify that I have reviewed the Federal requirement above and that _____ (name of plan) is in compliance with this requirement.

ATTENTION: Read the following provision of Federal law carefully before signing.

> Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both (18 U.S.C. 1001).

CEO Signature_____

Date _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0711. The time required to complete this information collection is estimated to average 2 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Attachment G
Questions and Answers

1. Q: Will HCFA consider changes to the abbreviated data set?

   A: No. The abbreviated data set contains the minimal number of elements necessary for deriving the estimated payment rates to be provided to plans in March, 1999. (These elements are shown in bold on Attachment B). The remaining data elements shown on Attachment B are necessary for electronic processing of the encounter data.

2. Q: Many plans do not have charges submitted by their hospitals. How will UB-92/ANSI 837 records be processed without this information?

   A: Plans should refer to Attachment E, note 3 for information on this issue. Plans should also note that HCFA intends to price the encounter data using Medicare fee-for-service pricing. Charge information is necessary to identify outliers. Without this information, cost outliers cannot be identified nor priced correctly. However, in response to concerns raised by plans concerning the difficulties in getting this information, HCFA identified an approach that may be used by plans that do not receive charge information from their hospitals.

3. Q: Are all fields required for the full UB-92/ANSI 837? Are any edits "turned off"?

   A: Fields not required for the full UB-92/ANSI 837 are shown in Attachment E. Attachment E also indicates which edits are "turned off."

4 Q: Is a UB-92/ANSI 837 record required for hospital discharges from non-contracted hospitals, as well as from contracted hospitals?

   A: Yes. The plan should ensure that HCFA receives a record for each hospital discharge of a managed care enrollee, regardless of whether the hospital is a contracted facility or a non-contracted facility.

5 Q: If my hospitals are submitting all the UB-92/ANSI 837 records for hospital discharges for my enrollees, do I have to also submit the same records using either Option 2 or Option 3?

   A: No. If the plan is certain that its hospitals have submitted a record for each discharge, the plan does not need to submit any additional records. If a record of a discharge has not been submitted by a hospital, the plan should submit that record using either Option 2 or Option 3.

6 Q: What will plan's use to identify "foreign" providers--that is, providers who are not located in the U.S., Canada, or Mexico?

A: HCFA has identified a generic code to be used for all providers that are located in these areas. The code is: 990001.

7. Q: Can Plans use the provision outlined in the MIM/Hospital manual that allows use of a special "dummy" provider number? Some Plans thought that the requirement of an assigned Medicare provider number for a facility such as a Children's Hospital might require the use of this HCFA-approved dummy number.

   A: In general, no. This dummy number is only used when the provider is not a Medicare participating hospital and the services were rendered on an emergency basis. Section 3698.1 of the Medicare Intermediary Manual (MIM) details establishing the emergency. This requires that the attending or referring physician complete a HCFA-177, or that the FI request, obtain, and review medical records from the hospital.

   In addition, Section 3698.10 of the MIM states nonparticipating US hospitals that meet the requirements for an emergency hospital are expected to file an annual election with the FI to bill for such services. This election can only be filed if the nonparticipating hospital has not charged the beneficiary for covered services in that year. When the hospital files the election, it promises not to bill any beneficiary beyond deductibles, coinsurance, and noncovered services for that year. If the hospital does not file the election, the beneficiary may file for those services. Further, when the FI receives a claim from the beneficiary, it must contact the hospital and determine if the provider is willing to make such an election.

   The following information is not in the Medicare Hospital Manual, or the MIM. It comes from the State Certification Manual. If the provider makes the election he is assigned a "dummy" provider number. The use of "dummy" provider numbers is controlled by the ROs, and they are assigned in strict numeric sequence. The structure of these numbers is as follows: the first 2 digits are the State code used for Medicare providers. The third, fourth and fifth digits represent the sequence number. If the provider is a Federal hospital (e.g., VA), the sixth position is an "F". If the provider is a non-Federal emergency provider, the sixth digit is an "E".

8. Q: Our plan's claims system does not capture the HIC number. Can HCFA modify its requirements so we do not have to submit HIC numbers?

   A: No, our requirements cannot be modified to satisfy this request. HCFA's systems must have the HIC number in order to accurately identify the beneficiary.

9. Q: If a hospital codes a specific diagnosis for a discharge to a plan and the plan disagrees with that diagnosis, should the UB-92/ANSI 837 that is sent to the FI reflect the original (hospital submitted) diagnosis, or the diagnosis the plan believes is accurate? How does any change in the diagnosis affect the CEO attestation and the medical record reviews?
   A: The record submitted to the FI should reflect the original diagnosis as reported on the UB-92/ANSI 837 that was submitted to the plan. The CEO attestation verifies that the plan has submitted the data as reported by the hospital. The medical record review examines the similarity between the encounter data record and the medical record review. Any adjudication

between the plan and the hospital does not need to be reported to the FI. In this way, the original UB-92/ANSI 837 record will "match" the hospital's medical record.

10. Q: What should the plan do if the diagnosis as submitted by the hospital is rejected by the FI? How does a change in diagnosis affect the CEO's attestation?

    A: If a hospital submits an invalid diagnosis and it is rejected by the FI, the plan must contact the hospital and require the hospital to submit a corrected record to the plan. This change would not affect the CEO attestation, since the attestation requires that the plan submit the data as reported by the provider (hospital).

11. Q: How are adjustment records handled?

    A: Adjustment records originate at the provider (hospital). Adjustments are handled differently for the start up year and for ongoing data transmissions.

    a. During the start-up year only, adjustments for encounter data submitted from the hospital (for Option 1 plans) will be submitted directly from the hospital to the hospital's FI.

    b. If an adjustment is required for data that was submitted from the plan to its selected FI using the full UB-92/ANSI 837 (for Option 2 plans), the plan must forward the document control number (DCN) for that adjustment to the hospital. The hospital must provide a corrected record to the plan which will then transmit the adjustment to its FI. Adjustment claims for the complete UB-92/ANSI 837 record will use normal type of bill (TOB) coding.

    c. If an adjustment is required for data that was submitted using the abbreviated UB-92 data set (for Option 3 plans), the plan must submit an adjustment record which will serve as a "replacement" for the original record. Adjustment claims for the abbreviated data set must contain an "11Z" in record 40, field #4.

    d. Adjustment records for ongoing data transmissions are handled the same way as adjustment records for Option 2 plans (see b above).

12. Q: Can a plan submit an encounter record for an enrollee who is a member of another plan?

    A: No. The plan will need to send the encounter to the enrollee's "home" plan for processing.

13. Q: Can the Common Working File (CWF) be modified to send back response trailers that indicate the fact that the beneficiary is both Working Aged and enrolled in an HMO at the same time, rather than recycling the transaction multiple times and getting each response back separately from CWF?

    A: The CWF is investigating the situation outlined above and will make changes accordingly, but not prior to 7/1/98.

14. Q: Our plan has developed special diagnoses coding systems that our contracted hospitals use when sending claims for hospital stays to our plan. Can we crosswalk these "home grown" codes to the correct ICD-9-CM code?

A: No. The hospital will need to provide the correct ICD-9-CM code to the plan.

15. Q: Can we have the Plans begin transmitting version 5.0 of the flat file, or do they have to start out with version 4.0 or 4.1? If they can start with version 5.0, can they use version 5.0 for the abbreviated submission, adding fields as they are more comfortable with them? What are the earliest date for acceptance of version 5.0 and the latest date for acceptance of versions 4.0 or 4.1?

A: The abbreviated UB-92, Version 4.1 will be available for use concurrent with the installation of FSS' April 17, 1998 release which is scheduled for production May 11, 1998. The UB-92, Version 5.0-- both the full UB-2 and the abbreviated format-- will be released by FSS on 6/5/98 for a planned production date of 7/1/98. The latest date Version 4.1 will be accepted is 12/31/98. HCFA will cease to support any non-Y2k compliant formats as of January, 1999.

16. Q: How do I generate a list of provider code numbers for my FI?

A: Plans must provide a list of contracted providers to their selected FI, including name and provider code number. While a published list of providers, including their provider numbers, does exist, the list does not allow one to distinguish among providers with the same name. The plan must contact the specific provider in order to determine the correct provider number.