Operational Policy Letter

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Date Issued: August 31, 2000

OPL #: 2000.124

To:	**Current M+C Organizations**	**X**
	CHPP Demonstrations:	
	Evercare	
	DoD (TriCare)	
	SHMO I & II	
	PACE	**X**
	Medicare Choices	
	OSP Demonstrations:	
	MSHO	**X**
	W.P.S.	**X**
	HCPPs	
	Federally Qualified HMOs	
	Section 1876 Cost Plans	

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

Effective Date: Upon release

Implementation Date: October 1, 2000

NOTE: This operational policy letter (OPL) is pending approval by the Office of Management and Budget.

This OPL contains revisions to prior draft instructions regarding the collection and submission of physician encounter data. These revisions, based upon consultations with Medicare+Choice organizations (M+CO) relax and clarify requirements for UPINs, ZIP codes, diagnostic pointers, and not otherwise classified (NOC) codes.

Issue/Question:

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

Resolution/Answer:
M+COs are required to collect and submit physician encounter data to HCFA, beginning October 1, 2000, for physician services rendered on or after October 1, 2000.

Background

Section 1853(a)(3)(B) of the Social Security Act (the Act) as enacted by Section 4001 of Subtitle A of the BBA requires M+COs, as well as eligible organizations with risk-sharing contracts under section 1876 of the Act, to submit encounter data. The collection of encounter data is necessary to identify beneficiary's health status, formulate the risk adjustment payment factor, and maintain the risk adjustment model over time.

The Medicare Program; Medicare+Choice Program Final Rule [42 Code of Federal Regulations, Parts 417 and 422] was published in the *Federal Register* June 29, 2000 (Volume 65, Number 126, Pages 40169-40218) and includes M+CO encounter data requirements.

Section 1853(a)(3)(A) requires the Secretary to implement a risk adjustment methodology that accounts for variation in per capita costs based on health status. Encounter data from physician services will be used in a comprehensive risk adjustment system. This system is scheduled for implementation January 1, 2004.

The requirements for submission of physician encounter data have been addressed (in draft form) in several previous meetings with M+COs, as well as three public meetings, held in November 1999, March 2000, and June 2000, to which all M+COs were invited and a series of regional training sessions.

Please note: An operational policy letter regarding the collection and submission of hospital outpatient department (OPD) encounter data will be forthcoming. M+COs are to submit hospital outpatient encounter data beginning April 1, 2001, for dates of service retroactive to January 1, 2001.

Definition of Physician Services

The definition of "physician" for the purposes of encounter data collection, is based upon the original Medicare program (traditionally referred to as Medicare fee-for-service (FFS)) definition of "physician services," section 1861(q and r) of the Act (see Attachment I). Physician services cover a wide range of services, and this definition has meaning regardless of who (physician, nonphysician practitioner, or other supplier) furnishes the services. A listing of specialty codes covered under physician encounters is shown in Attachment A.

Encounter data are required for all physician services that would be billed using the National Standard Format (NSF) electronic form. Physician encounter data must be submitted by the M+CO for all services provided by either network or non-network physician/non-physician practitioners. Data are required to be submitted to HCFA, by the M+CO via Palmetto Government Benefits Administrator (PGBA), the encounter data network subcontractor at least monthly.

Note: all demonstrations are required to submit physician encounter data. Demonstration sites should check with their HCFA contact person for further details on encounter data collection and submission requirements.

Requirements for Submission of Physician Encounter Data

I. Timeframe for Submission of Physician Encounter Data

M+COs are required to collect and submit encounter data regarding physician services beginning October 1, 2000, for all physician services rendered on or after October 1, 2000. The period from October 1, 2000 to June 30, 2001 is a start-up period for the submission of physician encounters**.**

HCFA views this period as both a developmental and problem resolution phase for M+COs submitting physician encounter data. During this period, M+COs are expected to resolve issues related to the acquisition of physician encounters; improve the quality of diagnostic and procedure coding; and resolve any problems in the submission of encounter data to HCFA. HCFA will monitor the data, work with M+COs to improve performance, and provide feedback to M+COs. HCFA will monitor all aspects of encounter data systems processing performance to ensure maximum efficiency. We anticipate that some M+COs will have difficulties with the submission of physician data during the start-up period. HCFA will work with M+COs to resolve these problems as well as provide technical resources for assistance. HCFA continues to believe that a 9-month start-up period is critical to ensure that physician encounters are of sufficient quality for use in determining risk-adjusted payments. A schedule of the submission requirements for the start-up period follows.

Schedule for the Start-up Period of Physician Encounter Data Submission

M+CO Submissions	**Dates**
Submission of test data	August 16, 2000 – October 31, 2000
Initial production submission (M+COs accomplish at least a first submission)	November 1, 2000 – December 31, 2000
Submission of at least 10%-20% of physician encounters (for the period October 1, 2000 to June 30, 2001)	By March 31, 2001
Submission of at least 30%-40% of physician encounters (for the period October 1, 2000 to June 30, 2001)	By June 30, 2001
Submission of at least 80% of physician encounters (for the period October 1, 2000 to June 30, 2001)	By November 9, 2001

Please note that benchmark submission volumes are based on the total submission of encounter data for the period October 2000 through June 2001 (or nine months of encounter data) . The total volume of physician encounter data is expected to be about 60-80% of the volume of Medicare fee-for-service.

Deadlines for the submission of physician data on an annual basis are as follows:

Services from:	Services through:	Submission to HCFA no later than:

October 1, 2000	June 30, 2001	November 9, 2001
July 1, 2001	June 30, 2002	September 6, 2002
July 1, 2002	June 30, 2003	September 5, 2003
July 1, 2003	June 30, 2004	September 3, 2004

II. Medicare +Choice (M+C) Requirements for Physician Encounter Data

A. Submission of Physician Encounters

1. M+C National Standard Format

The M+C NSF is based on the National Standard Format utilized in Medicare fee-for-service (FFS). However, the M+C NSF is unique for the purposes of encounter data. Detailed information about the NSF can be found at the following website: http://www.hcfa.gov/medicare/edi/edi3.htm

M+COs are required to electronically submit only the data elements included on the M+C National Standard Format (M+C NSF), Version 003.01. These data elements represent the minimum data required to process the encounter, as well as for reporting the beneficiary's health status, and for calculating the risk adjustment factor. See Attachment B for the format for the M+C NSF, Version 003.01.

Editing will be done only on those elements included in the M+C NSF (see Attachment D for a description of the edits on the M+C NSF). While M+COs may submit additional data beyond those elements included in the M+C NSF, only those elements included in the M+C NSF will be edited. Thus, organizations will not be penalized for submitting additional data elements beyond what is required in the M+C NSF.

The M+C NSF is a subset of data elements included in the NSF typically used in Medicare FFS. However, there are several unique M+C data elements, which include the following: M+CO identification number (also known as the "H-number"); the Unique Physician Identification Number (UPIN) for the rendering physician, nonphysician practitioners, non-network physicians, or other suppliers (see Attachment F for revisions and guidance on UPINs); the state for the site where the services were rendered; and the ZIP code for the site where services were rendered (if applicable). (Note: see Attachment C for more detailed information, including the list of states where no additional ZIP code information is required.)

2. Diagnostic Coding

Physicians and non-physician practitioners (referred to as "physicians" throughout this OPL) should generally use Medicare FFS coding rules when completing encounter forms. Those rules permit physicians to code other coexisting conditions. All physicians must use valid International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) codes and code to the highest level of specificity. Highest level of specificity is defined in the ICD-9-CM coding guidelines for outpatient services (including physician offices) as follows:

> "ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and or fifth digits, which provide greater specificity. A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code."

ICD-9-CM codes are updated on an annual basis. Physicians must begin using the updated ICD-9-CM codes for encounters submitted on or after October 1, 2000. It is very important that physicians use the most recent version of the ICD-9-CM coding book and code to the highest level of specificity. Information regarding ICD-9-CM codes is available on the Internet at www.hcfa.gov. (Additional guidance on diagnostic coding practices will be provided to Medicare fee-for-service providers and M+COs sometime in the near future.)

B. Data Completeness

M+COs must submit physician encounter data that are substantiated by the physician's full medical record. The encounter should reflect the original diagnosis as reported on the M+C NSF that was submitted by the rendering physician.

M+COs must supply physician encounters that comply with Medicare coding requirements. The M+C NSF will require that plans include ICD-9-CM diagnostic codes and HCFA's Common Procedure Coding System (HCPCS) E&M and other procedure codes fields. Information related to the HCPCS can be found at the following website: http://www.hcfa.gov/medicare/hcpcs.htm

Critical fields included on the M+C NSF, such as the place of service, service from date, service to date, and diagnoses should not be modified by the M+CO. If the M+CO receives an encounter that contains an incorrect code in one of these critical fields, the organization must ensure that its database matches and supports the physician's medical record for these fields. In such a case, it is recommended that the organization return the encounter to the physician for correction and re-submission. Alternatively, the M+CO must obtain and maintain written documentation of the required changes that were obtained from the physician. This change would not affect the encounter data attestation, since the attestation requires that the M+CO submit the data as reported by the physician.

M+COs may submit encounter data for services that have been processed through HCFA's correct coding initiative (CCI) edits or other commonly used coding editors.
If M+COs change evaluation and management (E&M) codes or other procedure codes as part of the adjudication process, they shall send the E&M and other procedure codes to HCFA that were the basis for payment.

M+C organizations may change E&M and other procedure codes on physician encounter data only in certain circumstances. As discussed earlier, they may change E&M and other procedure codes as a result of adjudicating claims. The adjudication process would typically change the E&M and procedure code within a related series to reflect a service with a different price. The process also might bundle together to assign a lower price to a group of services than would be

the case if each service were paid for separately. M+C organizations using this type of software must send in encounters that reflect the procedures that were paid for.

The M+CO may only make changes in procedure code modifiers if the change is based solely on the information available on the claim (e.g. by adding a -26 modifier to a physician bill for a radiologic service performed in a facility where the facility would bill for the technical component). If further information is required to make a change, then the M+C organization must contact the physician (e.g., to add the -80 or -62 modifier to a claim for a surgical procedure where two surgeons have submitted a claim for the same procedure).

If the encounter is denied due to coverage reasons but the information is valid (i.e., physician services were rendered), then the encounter should be submitted. Therefore, the M+CO shall submit encounters for which coverage was denied by the M+CO if they represent valid encounters, i.e. the encounter was denied by the M+CO on the basis of the M+CO's own coverage limitations (e.g., lack of pre-authorization for the service).

M+COs are not required to submit encounter data for clinical laboratory services. If an M+CO receives an encounter for laboratory services only, the encounter data should not be submitted. If the M+CO submits this service as an independent encounter, the entire encounter will be denied, and the diagnoses will not be utilized for risk adjustment.

If an M+CO receives a laboratory service within a physician encounter that also contains other services than lab services, the M+CO may include the service on the encounter data transaction. Within the processing systems, the laboratory service will be denied at the line level. The M+CO will not need to take any action on a denied laboratory encounter. Diagnoses found on the denied encounter will be used for purposes of calculating the risk adjustment factor, but the encounter will not be assigned a Medicare FFS equivalent price.

C. Data Transmission

All encounter data processing will be processed through one data network contractor. AT&T Global Network Services LLC is the prime contractor for this data network. Their subcontractor, Palmetto Government Benefits Administrator (PGBA), will receive all M+COs' encounter data. Inpatient encounter processing, currently performed by six select fiscal intermediaries, will be transitioned to HCFA via PGBA, the encounter data network subcontractor.

Currently, HCFA and its encounter systems processors are refining and finalizing data processes and structures. Information specific to data submittal and processing will be distributed to the M+COs through scheduled regional and national training sessions. This training, through Aspen Systems, will educate the attending M+COs on encounter data requirements, formats, encounter processes, etc. Four technical training sessions, attended by M+COs, were held during June - July 2000.

A list of upcoming training sessions can be found in Attachment H. All HCFA sponsored encounter data training information can be found at the following website: http://www.hcfa.gov/events/events.htm

PGBA will provide traditional customer support services, as well as technical advice and guidance to M+COs, as part of the Customer Service and Support Contract (CSSC). Feedback from the M+COs will be shared with the CSSC, and utilized in succeeding training sessions.

HCFA requires that all M+COs establish electronic media communications with PGBA, for the submission of encounter data. The standard Electronic Data Interchange (EDI) enrollment form, establishes the necessary requirements and protections for the electronic submission of managed care encounter data. M+COs who do not currently have a signed/submitted Managed Care EDI enrollment form (Attachment E) with PGBA, are required to sign and submit this form to the CSSC.
As an alternative to direct M+CO transmission of encounter data to PGBA, M+COs may make arrangements to subcontract to a third party the electronic transmission of data to PGBA. M+COs who contract with a third party for this function do so with the knowledge that the M+CO remains responsible for the submission and accuracy of data.

D. Edits

There are three stages of data editing. The M+CO will transmit the file to Palmetto Government Benefits Administrator, a subcontractor to AT&T Global Network Systems (Medicare Data Communications Network). Upon receipt at Palmetto, the data is checked against a series of "front-end" edits. These edits check the validity of data, with edits including: correct file, batch, and encounter record formats; correct type of data (numeric or alphanumeric) and correct lengths in specific fields; specific values for certain codes, such as diagnosis codes, E&M and other procedure codes, and ZIP codes. Files, batches, and encounters will be rejected for failure to pass the front-end edits. Rejected transactions will come back to the M+CO as submitted, with codes indicating the reason for the rejection. The M+CO should correct these records and resubmit only the rejected records. Some of the edits that will occur appear in Attachment D.

Once the data has passed the front-end edits, it is passed to the Multi-Carrier System (MCS) which performs a second series of edits. These edits check consistency between field values, such as diagnosis and E&M and other procedure codes. The edits also check against beneficiary demographics, such as age and gender. The encounter will also be edited against previously received encounters; duplicate checks are performed during this process. Please note that Medical Review (MR), Utilization Review (UR), coverage policy and the Medicare Secondary Payer (MSP) edits are bypassed. Encounters will be priced under the applicable methodology used in original Medicare (traditionally referred to as "FFS").

Within MCS, there are also a series of coding edits. These edits utilize approximately 100,000 code pairs to check for proper coding. The coding edits are incorporated in HCFA's correct coding initiative (CCI). The CCI edits detect when a component code is reported with the E&M and other procedure codes, for which it is an inherent or integral part of the comprehensive code. The edits also detect the reporting of E&M and procedures which cannot be performed during the same operative session or which are mutually exclusive. Note: It is necessary to append a modifier whenever it is required. If the modifier is not appended, then such encounters may be suspended or rejected as incorrect.

Information regarding coding edits may be found in the Medicare Carriers Manual, Sections 4630 and 15068. The Medicare Carriers Manual is available on the Internet at www.hcfa.gov,

under Medicare Publications and Technical Information. CCI software is available from the United States Department of Commerce's National Technical Information Service (NTIS). For further information, refer to the NTIS Internet site located at www.ntis.gov under "Health Collection"; "Health Care Financing Administration (HCFA) products."

If M+COs are concerned that CCI coding edits may negatively impact their encounter submissions, they may wish to purchase the CCI edits to check for proper coding prior to submitting their encounters. Using this software to check encounter data transactions prior to submission will eliminate many common errors, rejections, and denials.

HCFA believes that any M+COs that utilize coding edits should not find the Medicare edits in conflict with their own coding software package. Furthermore, many coding edits check for "fragmentation" of procedures. Fragmentation occurs when codes that are included within comprehensive E&M and other procedure codes are submitted as separate procedures on the same encounter. Generally speaking, in these circumstances the comprehensive code will be correctly priced, and the component E&M and other procedure codes will be denied. This will not affect diagnosis codes used for risk adjustment.

Records passing all front-end and MCS edits are sent to the common working file (CWF) host. Here data will again be subject to certain editing and, if there are no problems, the encounter data will be directed to the national claims history (NCH) file. All duplicate encounters will not be approved and will not go through CWF to history.

If data fail to pass MCS or CWF edits, in many cases the encounters will suspend in the system. The resolution of many suspended encounters will not require any intervention by the M+CO. Suspended encounters will need to be corrected at the Customer Service and Support Center (CSSC). The M+CO will need to work with the CSSC to provide information to pass those edits that may have caused the suspension. It is the responsibility of the M+CO to ensure that the CSSC has all necessary information to correct encounter errors that have caused suspension.

E. Diagnostic Pointers

Diagnostic pointers are used to relate the line item procedure code to the (header level) diagnosis and, in Medicare fee-for-service, relate to coverage and medical review. The following instructions apply for diagnostic pointers:

- If a diagnosis pointer is received from a physician, include that pointer.
- If multiple pointers are received, our system will accept all line items without error and drop all but the first pointer.
- For any line item missing a pointer, insert a "1" as the pointer.

F. Not Otherwise Classified (NOC) Codes

The NOC field in Medicare fee-for-service allows a physician to bill for a procedure that is not assigned a specific HCPCS code. HCFA has determined that for the M+C NSF, where the procedure is a NOC code, the M+CO is not required to provide the narrative that summarizes the services performed. Each NOC procedure will be priced at $1.00.

Because we are concerned that NOC codes may be used when specific procedure codes are available, HCFA will monitor their use (e.g., setting a threshold based on patterns in Medicare fee-for-service).

G. Electronic Remittance Advice

The system will generate an electronic remittance advice (ERA) that will inform the M+CO regarding which transactions were accepted and which were denied. Denials will have a code indicating the reason for denial. Duplicate rejections will appear on the ERA. The ERA will contain information including, but not limited to:

HIC
Patient Control Number
Service from and Service to dates of physician services
Medicare FFS price

H. Certification

M+COs are required to submit an encounter data attestation as determined under the conditions of the M+C contract. HCFA will issue instructions for preparing and submitting the certifications in a separate notice to M+COs.

I. Data Validation Activities

A sample of physician encounters may be validated against physician medical records to ensure the accuracy of medical information. Reviews will be conducted by an independent contractor. M+COs will be provided with additional information as the process for these reviews is developed.

J. Health Insurance Portability and Accountability Act

HCFA will comply with requirements established by the Health Insurance Portability and Accountability Act (HIPAA) regarding standards, and record layouts for all encounter data from M+COs. However, before HIPAA is effective, we expect physician data to be transmitted to HCFA in the standard format as described in these instructions.

K. Clean Claims

Encounter data is subject to the "clean claims" provisions of the Medicare program, M+C program final rule (see Attachment G).

III. Process for Submission of Physician Encounters

We anticipate that M+COs may receive encounters in one of five different ways, including the following:

- a HCFA paper form 1500 (i.e. a paper physician encounter);
- an original Medicare compliant claim (i.e. an encounter, resembling a Medicare FFS claim, which could be processed by a Medicare carrier for Medicare payments);
- a “homegrown” encounter (i.e. an encounter which was developed by an M+CO for use by its physicians);
- an electronic media claim (i.e. an encounter which is electronically submitted to an M+CO but which is in a non-standard Medicare format);
- a format initiated in response to the encounter data requirements for M+COs (i.e. the M+CO initiates physician encounter data collection using the M+C NSF); or
- an American National Standards Institute (ANSI) 837 format.

A description of the process to be undertaken by an M+CO for each format is provided below.

1. If the M+CO receives a HCFA form 1500:

- The organization must scan or key the M+C NSF data set.
- At the batch level, the organization must provide the H-number.
- At the claim level, the M+CO must provide the state for the site where the services were rendered. If there is more than one locality code for a state, the M+CO must also provide the ZIP code for the site where the services were rendered (see Attachment C).
- At the line level, the M+CO must provide the UPIN (see Attachment F for guidance on UPINs). They must provide the state for the site where services were rendered, if the state is different from that supplied at the claim level. The M+CO must also include the ZIP code

for the site where services were rendered (if applicable - see Attachment C), if it is different from the state information provided at the claim level.

2. If the M+CO receives an original Medicare compliant claim:

- The organization must ensure that the required M+C NSF is present;
- At the batch level, the organization must provide the H-number.
- At the claim level, the M+CO must provide the state for the site where the services were rendered. If there is more than one locality code for a state), the M+CO must also provide the ZIP code for the site where the services were rendered (see Attachment C).
- At the line level, the M+CO must provide the UPIN (see Attachment F for guidance on UPINs). They must provide the state for the site where services were rendered, if the state is different from that supplied at the claim level. The M+CO must also include the ZIP code for the site where services were rendered (if applicable - see Attachment C), if it is different from the state information provided at the claim level.

3. If the M+CO receives a "homegrown" encounter:

- The M+CO must ensure that the data definitions comply with Medicare requirements;
- The M+CO must scan or key the required M+C NSF;
- At the batch level, the organization must provide the H-number;
- At the claim level, the M+CO must provide the state where the services were rendered. If there is more than one locality code for a state, the M+CO must also provide the ZIP code for the site where the services were rendered (see Attachment C).
- At the line level, the M+CO must provide the UPIN (see Attachment F for guidance on UPINs). They must provide the state for the site where services were rendered, if the state is different from that supplied at the claim level. The M+CO must also include the ZIP code for the site where services were rendered (if applicable - see Attachment C), if it is different from the state information provided at the claim level.

4. If the M+CO receives an electronic media claim:

- The M+CO must ensure that the definitions used comply with Medicare requirements;
- The M+CO must scan or key the required M+C NSF;
- At the batch level, the organization must provide the H-number.
- At the claim level, the M+CO must provide the state where the services were rendered. If there is more than one locality code for a state, the M+CO must also provide the ZIP code for the site where the services were rendered (see Attachment C).
- At the line level, the M+CO must provide the UPIN (see Attachment F for guidance on UPINs). They must provide the state for the site where services were rendered, if the state is different from that supplied at the claim level. The M+CO must also include the ZIP code for the site where services were rendered (if applicable - see Attachment C), if it is different from the state information provided at the claim level.

5. If the M+CO receives the M+C NSF:

- The M+CO must scan or key the M+C NSF;
- At the batch level, the organization must provide the H-number.
- (**NOTE:** If the M+CO initiates the M+C NSF as the encounter data requirement, then the addition of the UPIN, state and ZIP codes (if applicable), may not be necessary.)
- At the claim level, the M+CO must provide the state where the services were rendered. If there is more than one locality code for a state, the M+CO must also provide the ZIP code for the site where the services were rendered (see Attachment C).
- At the line level, the M+CO must provide the UPIN (see Attachment F for guidance on UPINs). They must provide the state for the site where services were rendered, if the state is different from that supplied at the claim level. The M+CO must also include the ZIP code for the site where services were rendered (if applicable - see Attachment C), if it is different from the state information provided at the claim level.

6. If the M+CO receives an ANSI X12 837:

- HCFA is currently working on ANSI 837 requirements for submittal.
- The M+C NSF information will be required.

Contact: HCFA Regional Office Managed Care Staff.

This OPL was prepared by the Center for Health Plans and Providers.

Attachment A

Physician Services Specialty Codes
for Physician Encounter Data Submission

CODE NUMBER	SPECIALTY
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal medicine
12	Osteopathic manipulative therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/gynecology
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic surgery
22	Pathology
24	Plastic and reconstructive surgery
25	Physical medicine and rehabilitation
26	Psychiatry
28	Colorectal surgery
29	Pulmonary disease
30	Diagnostic radiology
33	Thoracic surgery
34	Urology
35	Chiropractic
36	Nuclear medicine
37	Pediatric medicine
38	Geriatric medicine
39	Nephrology
40	Hand surgery

- continued –

Attachment A

Physician Services Specialty Codes
for Physician Encounter Data Submission
- continued -

CODE NUMBER	SPECIALTY
41	Optometry (specifically means optometrist)
42	Certified Nurse Midwife
43	Crna. Anesthesia assistant
44	Infectious disease
48	Podiatry
50	Nurse practitioner
62	Psychologist (billing independently)
64	Audiologist (billing independently)
65	Physical therapist (independently practicing)
66	Rheumatology
67	Occupational therapist (independently practicing)
68	Clinical psychologist
70	Multispecialty clinic or group practice
76	Peripheral vascular disease
77	Vascular surgery
78	Cardiac surgery
79	Addiction medicine
80	Licensed clinical social worker
81	Critical care (intensivists)
82	Hematology
83	Hematology/oncology
84	Preventative medicine
85	Maxillofacial surgery
86	Neuropsychiatry
89	Certified clinical nurse specialist
90	Medical oncology
91	Surgical oncology
92	Radiation oncology
93	Emergency medicine
94	Interventional radiology
97	Physician assistant
98	Gynecologist/oncologist
99	Unknown physician specialty

- end of physician services specialty code listing -

Attachment B

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

[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) (see Attachment F for guidance on UPINs).

- continued -

Attachment B

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
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
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 "FB2"	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

- continued -

Attachment B

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
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 -

Attachment B
Place of Service

HCFA CODE	DEFINITION
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/MHMR
55	Residential Substance Abuse Treatment
56	Psychiatric Residential Treatment Center
60	Mass Immunization Centers
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehab Facility
65	ESRD Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinics
81	Independent Laboratory
99	Other Unlisted Facility

*This is not an all inclusive list, for further reference see:

http://www.hcfa.gov/medicare/poscode.htm

Attachment C

Medicare+Choice Physician Encounter Single Pricing Locality Listing

The Medicare+Choice National Standard Format (M+C NSF) requires that the state and ZIP code for the site where physician services were rendered be provided. Pricing localities (based upon the Medicare physician fee schedule) have been developed, for the purposes of M+C NSF physician encounter data collection. There are 91 pricing localities within the 50 states, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

Of the states/territories, 36 have one pricing locality. For those states/territories/countries that have one and only one pricing locality, the M+CO is required to provide only the state/territory/country information for the site where physician services were rendered. The following listed states/territories/countries have only one pricing locality (includes anesthesiology pricing localities).

Alabama
Alaska
Arizona
Arkansas
Colorado
Connecticut
Delaware
District of Columbia
Hawaii/Guam/American Samoa/Northern Mariana Islands
Idaho
Indiana
Kansas
Kentucky
Minnesota
Mississippi
Montana
Nebraska
Nevada
New Hampshire
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Puerto Rico
Rhode Island
South Carolina
South Dakota
Tennessee
Utah
Vermont
Virgin Islands
Iowa
West Virginia
Wisconsin
Wyoming
Canada
Mexico

- continued –

Attachment C

Medicare+Choice Physician Encounter
Single Pricing Locality Listing
- continued -

Please Note: HCFA reserves the right to evaluate the number of encounters submitted for services rendered in Canada and Mexico. The volume of encounters from Canada and Mexico may be reviewed in order to determine if single pricing localities are appropriate for these countries.

Revised STATE and ZIP CODE INSTRUCTIONS

The Medicare+Choice National Standard Format (M+C NSF) requires the submittal of the state and ZIP code that best approximates the site where the physician service was rendered. The following rules should be employed when the site of service is not evident on the source of physician encounter data (e.g. HCFA-1500, electronic claim, etc.) submitted by the physician or non-physician practitioner:

1) If the state is a single pricing locality state, then enter the state. No further action is necessary.

2) For multiple pricing locality states, use the state and ZIP code (if available) where the service was rendered.

3) If the ZIP code is not available, then:

   — For **network physicians and network non-physician practitioners,** enter the ZIP code for the location where the greatest number of services is rendered (or the highest number of dollars are reimbursed by the M+CO).

   — If this information is not available for network physicians and non-network practitioners (also for non-physician practitioners), then enter the ZIP code of your local (not corporate) M+CO location for all those services or the ZIP code of the primary care physician.

Attachment D

Edits on M+C NSF and ANSI 837
Physician Encounter Data Submissions

1. Each electronic M+C NSF encounter must contain all required fields listed on Attachment B. Substantive data and conditional data requirements for the M+C NSF are also required for the ANSI 837.

   Submitted data will be edited for required encounter processing and substantive data as identified in Attachment B. Medicare+Choice organizations will not be penalized for submitting additional data beyond the M+C NSF (minimum dataset). In addition, edits have been turned off for medical review (MR), utilization review (UR), and Medicare Secondary Payer (MSP).

2. Each Record/Field identified must be completed in accordance with NSF guidelines. Information on such guidelines is available on the Internet at http://www.hcfa.gov/medicare/edi/edi.htm

   The NSF is mapped to the HCFA form 1500 paper format. The ANSI 837 is mapped to the NSF. For additional information on the NSF records/fields, please review electronic data interchange information located on the Internet, at www.hcfa.gov/medicare/EDI. ANSI 837 information is also available at the aforementioned site.

   Medicare+Choice Organizations need to review the Medicare Carrier's Manual (MCM) located on the Internet at www.hcfa.gov/Medicare, under Professional and Technical Information. The MCM contains information on the physician data, coverage and limitations, as well as the CCI.

3. AA0 15.0 Creation Date field is 8 characters and is equal to or less than the current date.

4. AA0 19.0 Version Code - National is the current NSF version 003.01, dated 07/01/1997. Do not submit a decimal point.

5. BA0 02.0 EMC Provider ID must match YA0 02.0 EMC Provider ID.

6. BA0 09.0: National Provider ID is the Medicare+Choice Organizations's "H" number. The H number consists of 1 Alpha and 4 Numeric characters.

7. CA0 03.0 Patient Control Number has a field length of 17 characters.

- continued -

Attachment D

Edits on M+C NSF and ANSI 837
Physician Encounter Data Submissions
- continued -

8. CA0 08.0 Patient Date of Birth field is 8 characters, contains all numbers, and is less than the current date.

9. CA0 09.0 Patient Sex field is 1 character and contains either F or M.

10. DA0 18.0 Insured Identifier Number is the Health Insurance Claim identifier (HIC).

11. EA0 07.0 Accident/Symptom Date is a conditional record/field that is to be used to identify that chiropractic services were rendered.

12. EA0 32.0 - EA0 35.0 Diagnosis Code fields contain 3 - 5 characters and are valid ICD-9-CM codes. The diagnosis code must be the most specific/precise code allowed for in the ICD-9-CM coding format. Do not submit a decimal point. The decimal point is implied because each ICD-9-CM code is unique.

13. EA0 53.0 Care Provider Oversight Provider Number is a conditional field. If the rendering provider provides Home Health Agency or Hospice physician services, then this field must be completed.

14. FA0 05.0 Service From Date field is 8 characters, contains all numbers, and is equal to or less than the current date.

15. FA0 06.0 Service to Date field is 8 characters, contains all numbers, and is equal to or greater than the Service From Date field.

16. FA0 09.0 HCPCS Procedure Code contains 5 characters. This is a valid HCPCS code that describes the service.

17. FA0 10.0 - FA0 12.0 HCPCS Modifier fields contain 2 characters. These are HCPCS modifier codes that identify special circumstances related to the performance of the service.

18. FA0 18.0 Units of Service must be at least 1.

19. FA0 19.0 Anesthesia /Oxygen Minutes is a conditional field. If anesthesiology physician services are provided, then this field must be completed in units of minutes.

- continued –

Attachment D

Edits on M+C NSF and ANSI 837
Physician Encounter Data Submissions
- continued -

20. FA0 23.0 Rendering Provider National Provider Identifier is the unique physician identification number (UPIN) for the physician, nonphysician practitioner, non-network provider, or other supplier who rendered physician services. See Attachment F for guidance on UPINs.

21. FB2 09.0 and 10.0 Provider A State and Provider A Zip Code are conditional fields. At the line level, the M+CO must provide the state for the site where services were rendered, if the state is different from that supplied at the claim level. The M+CO must also include the ZIP code for the site where services were rendered (if applicable, see Attachment C).

22. Local codes (commonly known as local carrier codes) will not be accepted, and will be rejected back to the M+CO as invalid data.

Attachment E

Medicare+Choice Organization
Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM
ONLY for the Collection of Encounter Data and/or
With Medicare+Choice Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare encounter data electronically to HCFA or to HCFA's contractors.

A. **The Eligible Organization Agrees:**

1. That it will be responsible for all Medicare encounter data submitted to HCFA by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except HCFA and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:

   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness, and
   - Procedure/service performed.

4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organizations's submissions, including the beneficiary's authorization and signature.

5. That it will submit encounter data that are accurate, complete, and truthful.

6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare encounter data for a period of at least 6 years, 3 months after the encounter data is received and processed.

7. That it will affix the HCFA-assigned unique identifier number of the eligible organization on each encounter data electronically transmitted to the contractor.

8. That the HCFA-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from HCFA or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

11. That it will research and correct encounter data discrepancies.

12. That it will notify the contractor or HCFA within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. HCFA Agrees To:

1. Transmit to the eligible organization an acknowledgment of encounter data receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.

3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that HCFA requires Medicare contractors to make available to eligible

organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by HCFA under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare encounter data are submitted to HCFA or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's Name _____

Title

Address

City/State/ZIP

By

Title

Date

cc: Regional Offices

Attachment F

Unique Physician Identification Number (UPIN) Instructions

- M+COs must submit individual UPINs for all network physicians for all encounters with dates of service on or after **July 1, 2001**. The period from October 1, 2000 through June 30, 2001 will serve as a transitional period during which time a higher level of surrogate UPIN usage will be permitted. HCFA will monitor surrogate usage and work with M+COs to increase the level of individual UPIN submission to ensure compliance with the July 1, 2001 deadline.

- Network physicians are defined as anyone with whom you have contracted or subcontracted for services. However, for physicians where credentialing is delegated, we have extended the deadline for use of individual UPINs until July 1, 2002.

- HCFA has extended the deadline for M+COs to request UPINs for network physicians to **May 1, 2001.** This extension is intended to allow M+COs more time to collect the required information from their network physicians.

- Mandatory submission of provider identifiers for non-network physicians and non-physician practitioners will commence **no earlier than July 2002.**

UPIN Schedule

UPIN Type	Date Required
Request UPINs for network physicians	May 1, 2001
Submit UPINs for network physicians where delegated credentialing is **not** used	July 1, 2001
Submit UPINs for network physicians where delegated credentialing is used	July 1, 2002
Submit UPINs for non-network physicians and non-physician practitioners	No earlier than July 2002

- If the UPIN is available, whether it is a network/non-network physician or non-physician practitioner, then submit the UPIN for all physician encounters.

Attachment F

Unique Physician Identification Number (UPIN) Instructions

- If the UPIN is unavailable, then the appropriate HCFA authorized surrogate UPIN must be used when a "physician service" is rendered. The following is the list of HCFA authorized surrogate UPINs:

AA0000	Anesthesia Assistant
CNA000	Certified Registered Nurse Anesthetist
CNM000	Certified Nurse Midwife
CNS000	Clinical Nurse Specialist
CP0000	Clinical Psychologist
CSW000	Clinical Social Worker
FOR000	Foreign Doctor (for all non-United States physicians)
MD0000	Medical Doctor (includes DO, CH, DDM, DDS, DPM, OD)
NP0000	Nurse Practitioner
OT0000	Occupational Therapist
PA0000	Physician Assistant
PT0000	Physical Therapist

- A revised UPIN OPL will be released in the near future and will reflect the changes described in this communication, including a complete UPIN matching and assignment schedule. M+COs should not submit UPIN requests, matching files, or matching reports until receipt of the revised UPIN OPL.

- These UPIN instructions do not in any way change the requirement that M+COs obtain the medical record that supports the data submitted on each encounter, if requested by HCFA.

IMPORTANT NOTE: Since CCI edits are typically based on the same provider identifier (in this case, UPINs), inappropriate denials may occur because of surrogate UPIN usage. Therefore, all CCI edits will be turned off until June 30, 2001 when UPINs for network providers will be required.

While we have attempted to reduce requirements related to surrogate UPIN usage, we must maintain the integrity of the data that will be utilized in the risk adjustment process. For example, it is possible that two physicians may see a patient on the same day and use the same procedure code, but if both physicians are using surrogate UPINs, one of the services will be denied as an exact duplicate. The only way to assure payment for both services would be to submit one of the bills with an actual UPIN (not a surrogate). In addition, there are other processing rules (e.g. post-op care) that may be affected by surrogate usage that will remain in place. We will work with the CSSC to assure minimal impact for these services.

Attachment G

Medicare Program; Medicare+Choice Program; Final Rule

42 CFR Parts 417 and 422

Risk Adjustment and Encounter Data (Secs. 422.256 through 422.258; begins page 40246)

Clean Claims and Encounter Data (page 40250)

First, we will make explicit in Sec. 422.257 that M+C organizations are required to obtain from providers,

[[Page 40250]]

suppliers, physicians, or other practitioners information sufficient to submit the required encounter data. (Currently the regulation states that M+C organizations must submit encounter data, but leaves the requirement of obtaining the necessary information from providers and others to inference.)

Second, we will specifically state in the rules that M+C organizations may include a requirement for submission of complete and accurate encounter data, conforming to the format used under original **Medicare**, in their contracts with providers, suppliers, physicians, and other practitioners. Contracts with providers and others may impose financial penalties, including withholding payment, for failure to submit complete and accurate data conforming to all requirements for submission. We have revised Sec. 422.257 of the regulations to reflect these two changes.

Third, as discussed below in section K, we have modified the definition of ``clean claim'' in Sec. 422.500 to specify that a claim must include information necessary for purposes of encounter data requirements, and must conform to the requirements for a clean claim under original **Medicare**. This will exempt claims that do not, for example, meet accurate coding requirements from the application of the ``prompt payment'' standard that applies to claims submitted by non-contracting providers. This standard requires that ``clean claims'' submitted by non-contracting providers be paid within 30 days, or interest will be owed. M+C organizations will therefore be able to withhold payment in cases in which non-contracting providers submit claims with inadequate coding or other deficiencies that make the claims impossible to use for encounter data purposes.

Fourth, we are providing a reconciliation process which will give M+C organizations additional time to submit encounter data before final payment determinations are made. M+C organizations have approximately 3 months after the end of a data collection year to submit the encounter data that will be used to develop beneficiary risk scores to their fiscal intermediary. For example, M+C organizations must submit encounter data for the period July 1, 1998 through June 30, 1999 to their fiscal intermediary by September 17, 1999. If organizations submit encounters after this date, they will not be incorporated into payments for CY 2000. However, in response to concerns expressed by M+C organizations over this short time frame, we expect to institute a reconciliation process that will take into account late data submissions. M+C organizations should attempt to have all data in by the annual deadline of September 10. However, if organizations receive UB-92s from hospitals after this date, they may submit the encounter to their fiscal intermediary and the data will be processed. M+C organizations should note that the deadline for submission of all data from a payment year will be June 30 of the payment year for the period

ending the previous June 30 (for example, the final deadline for the period of July 1, 1998 to June 30, 1999, which is used for payment in 2000, will be June 30, 2000). After that date, the fiscal intermediary will no longer accept these data. After the payment year is completed, we will recalculate risk factors for individuals who have late encounters submitted. Then, we will determine any payment adjustments that are required. This reconciliation will be undertaken after the close of a payment year and will be a one-time only reconciliation for each payment year. We are adding Sec. 422.256(g) to provide for this reconciliation process.

Clean Claims (begins page 40263, Section K)

K. Contracts with M+C Organizations (Subpart K)

Subpart K sets forth provisions relating to the contracts that are entered into by M+C organizations, including a description of terms that must be included in the contract, the duration of contracts, provisions regarding the nonrenewal or termination of a contract, and minimum enrollment, reporting, and prompt payment requirements.

1. Definitions (Sec. 422.500)

Comment: As discussed above in section II.F.2, we received comments suggesting that we impose requirements on providers to cooperate with M+C organizations in their collection of encounter data to be used in implementing risk adjustment.

Response: As discussed in section II.F.2, in response to this comment, we have taken several steps to facilitate the cooperation of providers in supplying valid data that can be used by M+C organizations to comply with encounter data requirements. In the case of contracting providers, we have specified under Sec. 422.257 that M+C organizations may include in their provider contracts provisions requiring submission of valid data. Therefore, an M+C organization could provide in its contract that it will not make payment if claims do not meet the standards specified. In the case of noncontracting providers, however, Sec. 422.520 requires M+C organizations to pay 95 percent of ``clean claims'' within 30 days, or pay interest on the amount. Also, based on the existing definition of ``clean claims,'' an M+C organization could not withhold payment based on a failure to submit a claim in the form required for use in complying with encounter data requirements. As noted in section II.F.2, we are revising the definition of ``clean claim'' in Sec. 422.500 to require that clean claims include the substantiating documentation needed to meet the requirements for encounter data submission, and meet the original **Medicare** ``clean claim'' requirements. This change will, in effect, also require noncontracting providers submitting claims to an M+C organization to provide the organization with the information it needs to be able to use the claim in encounter data submissions, by exempting claims that do not meet these requirements from application of the 30-day ``prompt payment'' standards articulated at Sec. 422.520. M+C organizations will therefore be able to withhold payment longer than the 30-day prompt payment standard in cases where noncontracting providers submit claims that do not contain substantiating documentation necessary for encounter data submissions or have other deficiencies (for example, inadequate coding). We believe that this clarification of the clean claim definition at Sec. 422.500 is consistent with section 1957(f)(1) of the Act, which incorporates the **Medicare** fee-for-service prompt payment provisions in sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Act, and simply fleshes out the concept in the existing definition that a claim is not clean if it lacks ``any required substantiating documentation.'' Providers should note that submission of claims with complete and accurate encounter data is ultimately in their best interest, since M+C organizations must submit complete and accurate

encounter data in order to get the full payment to which they are entitled under the risk adjustment system. While HCFA does not regulate payments to providers by M+C organizations, we believe that M+C organizations should share appropriately with providers any gains under the risk adjustment system.

Prompt Payment (begins page 40271, #17)

17. Prompt Payment by M+C Organization (Sec. 422.520(a))

Section 422.520 indicates that contracts between M+C organizations and HCFA must specify that the M+C organization agrees to provide prompt payment of claims that have been submitted by providers for services and supplies furnished to **Medicare** enrollees when these services and supplies are not furnished by an organization-contracted provider. Specifically, 95 percent of ``clean claims'' must be paid within 30 days of receipt. While this provision closely follows requirements already in place for section 1876 contractors, (including provisions pertaining to interest to be paid if timely payment is not made), section 1857(f) of the Act extends similar prompt payment requirements to claims submitted by **Medicare** beneficiaries enrolled in M+C private fee-for-service plans. Section 422.520(a) incorporates this requirement of new section 1857(f), as well as the general 30-day requirement that applied to noncontracting providers under section 1876. In the preamble to the June 1998 interim final rule, we indicated that pursuant to our authority under section 1856(b)(1) to establish standards under Part C, M+C organizations would be required to act upon (either approve or deny, not necessarily pay) all claims not subject to the 30-day standard within 60 calendar days from the date of request.

Comment: Commenters noted that the ``approve or deny'' language in Sec. 422.520(a)(3) was inconsistent with rules regarding M+C organization determinations and reconsiderations as described in subpart M. Also, it has been brought to our attention that the requirement that ``non-clean'' claims (and up to 5 percent of clean claims) be ``approved or denied,'' but not necessarily paid, within 60 calendar days from the date of the request for payment, is inconsistent with the

[[Page 40272]]

standard that applied to contractors under section 1876 of the Act. Under the **Medicare** risk program, HCFA traditionally required that HMOs or CMPs with **Medicare** risk contracts pay or deny non-clean claims within 60 calendar days from the date of the request for payment. The ``approve or deny'' language may permit gaps of time between when an organization approved a claim for payment and when the organization actually paid a claim.

Response: After further review of this issue, we agree that M+C organizations should be required to either pay or deny non-clean claims (and clean claims not subject to the 30-day standard) within 60 calendar days from the date of the payment request. This standard removes the possible ambiguity associated with ``approving'', but not necessarily paying, a claim for payment, and any related ambiguities pertaining to M+C organization determination and reconsideration policies articulated in subpart M of this final rule. Thus, we are revising Sec. 422.520(a)(3) to indicate that claims for services that are not furnished under a written agreement between M+C organization and its network providers, and that are not paid within 30 days, must be either paid or denied within 60 calendar days from the date of the request.

Attachment H

Schedule of Encounter Data Training Sessions		
Date	**Location**	**Purpose**
September 7, 2000 **CHICAGO, IL**	Hyatt Regency Woodfield 1800 East Golf Road Schaumburg, IL 60173 (847)605-1234	Medicare+Choice Encounter Data Seminar for Physicians
September 13, 2000 **TAMPA, FL**	Hyatt Regency Westshore on Tampa Bay 6200 Courtney Campbell Causeway Tampa, FL 33607 (813)874-1234	Medicare+Choice Encounter Data Seminar for Physicians
September 15, 2000 **BALTIMORE, MD**	Health Care Financing Administration HCFA Auditorium 7500 Security Blvd. Baltimore, MD 21244	National Hospital Outpatient Encounter Data Training Session
September 18-19, 2000 **SAN FRANCISCO**	San Francisco Airport Marriott 1800 Old Bayshore Highway Burlingame, CA 94010 (650) 692-9100	Regional Hospital Outpatient Encounter Data Training Session
September 20, 2000 **SAN DIEGO, CA**	San Diego Marriott Hotel and Marina 333 West Harbor Drive San Diego, CA 92101-7700 (619)234-1500	Medicare+Choice Encounter Data Seminar for Physicians
September 21-22, 2000 **ATLANTA, GA**	Wyndham Atlanta 160 Spring Street Atlanta, GA 30303 (404) 688-8600	Regional Hospital Outpatient Encounter Data Training Session
October 16-17, 2000 **CHICAGO**	Westin O'Hare 6100 River Road Rosemont, IL 60018 (847) 698-6000 **Room Rate until 9/25/00: $130/night** (Ask for HCFA - Encounter Data)	Regional Hospital Outpatient Encounter Data Training Session
October 19-20, 2000 **BOSTON, MA**	Boston Park Plaza Hotel 64 Arlington Street Boston, MA 02116 (617) 426-2000 **Room Rate until 9/18/00: $192/night** (Ask for HCFA - Encounter Data/Aspen Systems Corporation)	Regional Hospital Outpatient Encounter Data Training Session

Attachment I

Definition of Physician Services

Social Security Act, Section 1861(q):

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation [352]) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.