PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. A-00-83 **Date NOVEMBER 9, 2000**

CHANGE REQUEST #1193

SUBJECT: Business Requirements for Processing Outpatient Encounter Data in the HCFA Data Center

Background

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

The purpose of this Program Memorandum is to provide the Business Requirements for processing outpatient encounters in the Part A Standard System (FISS) which will be run in the HCFA Data Center (HDC). These requirements are to be in place (in the production environment) effective April 1, 2001, when M+COs begin submitting outpatient encounter data to the HCFA Data Center Encounter Intermediary. There are also four requirements (specified below) that relate to inpatient (as well as outpatient) encounter processing.

I. General Requirements

Medicare+Choice organizations will begin submitting hospital outpatient encounter data for production processing at the HCFA Data Center on April 1, 2001, for services rendered on or after January 1, 2001. Encounter data are required for all outpatient services for which **hospitals** would bill using the UB-92 form, including outpatient surgery, emergency room services, clinics, and x-ray services. The following services are excluded: DMEPOS (durable medical equipment, prosthetics, orthotics and supplies); transportation services including ambulance; and laboratory services. Deductible and coinsurance will not be applied.

Outpatient encounter data must be submitted electronically for processing. Data can be transmitted using a complete UB-92, ANSI 837, or an abbreviated UB-92 format. Specific requirements for the abbreviated UB-92 (version 6.0) format are shown in Attachment A. Note that detail editing should only occur on bolded fields. (Attachment B has the revised required data necessary for the abbreviated inpatient UB-92.)

In addition, there must be a mechanism to allow for processing of encounter data for those beneficiaries that are not eligible for Part A benefits; i.e., beneficiaries that are only entitled to Medicare Part B benefits. The data submitted for these beneficiaries will need to be available (through the FISS and CWF claims processes) for risk adjustment. The following requirements that

are also applicable to inpatient processing are detailed below and relate to: processing of duplicate encounters, adjustments, the provider file, the provider specific file, and the retention of abbreviated records in CWF.

II. Specific Requirements

Transaction Processing

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

Data Transmission

MCOs will continue to use the Medicare Data Contractor (MDCN) to support data transfers and other related data traffic. MCOs will utilize the existing connectivity and front-end process with which they submit physician encounter data (to Palmetto GBA).

Encounter Data Pricing

Pricing will not differ from normal outpatient pricing logic. That is, outpatient prospective payment will be applicable just as in fee-for-service processing.

Use of Revenue Codes

The Encounter Data Front End System (EDFS) will provide default revenue codes (only for abbreviated UB-92s) for all services billed under HCPCS procedure codes.

Use of Condition Codes

The EDFS will provide default condition codes (whenever necessary, again, only for abbreviated UB-92s) for all services billed under HCPCS procedure codes. The condition code "04," which is required for all encounter services, will be defaulted by the EDFS. In addition, condition code "69" (Indirect Medical Education, IME) will be rejected by the EDFS.

Receipt of Transactions

Outpatient encounter data transactions will be verified upon receipt in the same manner as currently occurs in inpatient encounter processing. The abbreviated UB-92 data set will be accepted as complete. Individual transactions or batches of transactions may be returned or rejected based on the absence of required data fields or because of transaction errors, format errors, or invalid data, e.g., invalid diagnosis codes. Criteria for rejection may change to improve operational efficiency.

M+COs will receive notification of transaction status just as in inpatient encounter processing. M+COs will only be notified of those encounters which have been rejected by the front end; all other encounters not specifically identified as rejected have been accepted for further processing.

All inpatient and outpatient encounters (including either line item or claim denials) will be posted to CWF.

Editing of Data - General

Editing will occur both in the front-end of the system and in the standard system itself. All data will be edited for:

Presence of data in all required fields
Logical edits (e.g., birth date is in 8 byte numeric format)
Look-up table edits to ensure that data match valid values, e.g.,
- Diagnosis codes
- Procedure codes

HICs
"H" numbers
Valid Provider ID

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

The Outpatient Code Editor (OCE) will function as it does in normal bill processing; however, the system will not utilize any additional medical review (MR), utilization review (UR), coverage policy, or Medicare Secondary Payer (MSP) edits or logic.

Functions/Editing that Will Occur

Pricing

As already discussed above, only certain edits are to be performed on M+CO encounters. All transactions that are accepted will have a price developed under the following rules:

OCE and PRICER will function as they do in fee-for-service pricing.

Submitted charges will be provided by the EDFS and will be in the amount of $1 for each line item. The FISS will price the service ignoring any computer logic that is based on the lower of submitted charges against amount to be paid.

No local HCPCS codes will be accepted.

NOC codes will be monitored for excessive use based on fee-for-service submittal rates.

Duplicate Transactions

Duplicate inpatient and outpatient encounter data transactions will be identified in the same manner as fee-for-service processing identifies duplicate line items and claims. Exact duplicate transactions will be rejected. Potential duplicate transactions will suspend for review; if the transaction is a true duplicate, it will be rejected. Duplicate checking will occur for both UB-92 data sets; that is, full UB-92s against full UB-92s; full UB-92s against abbreviated UB-92s; abbreviated UB-92s against abbreviated UB-92s; and abbreviated UB-92s against full UB-92s.

Use of Provider Files

Provider File The FISS provider file will be set up initially to reflect only that data which may affect payment (e.g., certification as a heart-lung transplant facility) and/or pricing. Locality and carrier number fields (for physician fee schedule pricing) will be populated with the initial load of the file. Ongoing maintenance of the provider file will be done manually.

Provider Specific File The data set of the national provider specific file (available on a quarterly basis) will be utilized in processing for both inpatient and outpatient encounters. This file will be initially loaded into FISS via program logic that minimizes the complexity of both the load process as well as ongoing maintenance. Updates will occur quarterly (as soon as the national file is available) and will require that FISS allows for more than one provider specific record for an individual hospital (as it does in fee-for-service), as well as minimal manual intervention in the update process. In addition, there will need to be a mechanism to price those hospitals (e.g., VA hospitals) that do not currently have a provider specific file. The ongoing maintenance for these types of facilities may be done manually.

Beneficiary Eligibility

All routine beneficiary eligibility checks will be performed. In addition, beneficiary eligibility will be checked against the beneficiary record to determine if a beneficiary was enrolled in the submitting

M+CO for the dates of service on the encounter data transaction.

Adjustment Processing

FISS and CWF will provide for the processing and retention of adjustment claims for both inpatient and outpatient services. Data that may be adjusted include: date of service, place of service, diagnosis, procedure, days/units, provider identifier, and provider location information.

Bill Types

Abbreviated UB92s for outpatient services will be recognized when the following codes are present:

1. Type of bill is a three-digit code. The first digit will be either 1, indicating hospital or 8 indicating special facility (i.e., non-PPS hospital). The second digit is 2, indicating hospital based, 3, indicating outpatient, or 4, indicating other. **The third digit must be X, Y, or Z, indicating abbreviated format (indicating an initial transaction (Z), replacement (Y), or a void/cancel (X));**

2. Condition code (Record Type 41, Field #4)=04 -HMO Enrollee; and

3. The M+CO identification number must be included (Record Type 31, Field #15).

History Retention

History for encounter transactions will be maintained in FISS, CWF, and in the NCH. If a transaction is adjusted, the original will be maintained along with the adjusted transaction as in fee-for-service processing. Two years of history should be maintained, to cover the current encounter processing year and the reconciliation (prior) processing year.

Reports

The system will generate the same reports for the CSSC that it already generates for fee for service intermediaries as well as the special reports created for FIs which process encounter claims. There may also be additional reports that the CSSC will require on a routine basis (e.g., daily, weekly, etc.).

In addition, the CSSC will have the capability of producing ad hoc reports. Examples of potential ad hoc reports include data runs based on error code frequency across all M+COs, M+CO specific data errors, and distributions of diagnosis codes submitted for encounters across M+COs. Reports will be exportable as data files or flat files that can be manipulated by the CSSC data analysis staff.

There will also be a monthly report produced by the CSSC that will provide a record of all finalized encounters processed during each calendar month. The report will provide sufficient details so that all M+COs can readily identify and/or research any finalized encounters. At a minimum the following data elements for each encounter will be provided: HIC; dates of service; provider ID, allowed amount, and patient account number.

The effective date for this Program Memorandum (PM) is April 1, 2001

The implementation date for this PM is April 1, 2001

These instructions should be implemented within your current budget

This PM may be discarded December 31, 2001

Contact Person for this PM is Ed Lain, (410) 786-0848

Attachments

ATTACHMENT A

UB-92 Abbreviated Outpatient Hospital Encounter Data
Version 6.0

UB 92 Rec Type	Field No.	Field Name	Length	Picture	Paper Form Item Number
01	1	Record Type '01'	2	XX	
01	2	Submitter EIN	10	9	
01	3	Multiple Provider Billing File Indicator	1	9	
01	9	**Submitter Name**	21	X	1
01		**Submitter Address**			1
	10	**Address**	18	X	1
	11	**City**	15	X	1
	12	**State**	2	XX	1
	13	**ZIP Code**	9	X	1
01	16	**Submitter Telephone Number**	10	9	1
01	17	File Sequence and Serial Number	7	X	
01	18	Test/Production Editor	4	X	
01	20	**Processing Date ("Date Bill**	8	9	
01	22	Version Code (A60)	3	X	
10	1	Record Type '10'	2	XX	
10	2	Type of Batch/Bill (12Z, 13Z, 14Z, 83Z)	3	XXX	4
10	3	Batch Number	2	99	
10	6	**National Provider Identifier (Medicare ID)**	13	X	51

20	1	Record Type '20'	2	XX	
20 20	4	**Last Name**	20	X	12
20	5	**First Name**	9	X	12
20	7	**Sex (F,M)**	1	X	15
20	8	**Birth Date (CCYYMMDD)**	8	9	14
20		**Statement Covers Period Date**			
	19	**From Date (CCYYMMDD)**	8	9	6
	20	**Through Date (CCYYMMDD)**	8	9	6
30	1	Record Type '30'	2	XX	
30	2	Sequence Number	2	99	
30	3	Patient Control Number	20	X	3
30	7	**HIC Number**	19	X	60
31	1	Record Type '31'	2	XX	
31	2	Sequence Number	2	99	
31	3	Patient Control Number	20	X	3
31	14	Cross Reference ICN/DCN (for adjustment and cancel bills only)	23	XX	37
31	15	**Contract Number**	5	X	
40	1	Record Type '40'	2	XX	
40	2	Sequence Number	2	99	
40	3	Patient Control Number	20	X	3
40	4	Type of Batch/Bill (12Z, 13Z, 14Z, 83Z)	3	X	4
41	1	Record Type '41'	2	X	
41	2	Sequence Number	2	99	
41	3	Patient Control Number	20	X	3
41	4-13	**Condition Code (occurs 10 times), "04"-HMO enrollment**	2	X	24-30
61	1	Record Type '61'	2	X	
61	2	Sequence Number	3	9	

61	3	Patient Control Number	20	X	3
61	6	**HCPCS Procedure Code**	5	X	44
61	7	Modifier 1 (HCPCS & CPT-4)	2	X	44
61	8	Modifier 2 (HCPCS & CPT-4)	2	X	44
61	9	**Units of Service**	7	9	46
61	11	Outpatient Total Charges	8	9	47
61	12	Outpatient Noncovered Charges	8	9	48
61	13	**Date of Service (CCYYMMDD)**	8	9	45
70	1	Record Type '70'	2	XX	
70	2	Sequence Number	2	99	
70	3	Patient Control Number	20	X	3
70	4	**Principal Diagnosis Code**	6	X	67
70	5-12	**Other Diagnosis Code (occurs 8 times)**	6	X	68-75
90	1	Record Type '90'	2	XX	
90	3	Patient Control Number	20	X	3
90	4	Physical Record Count	4	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	
	9	Record Type 6n Count	4	9	
	10	Record Type 7n Count	2	9	
95	1	Record Type '95'	2	X	
95	5	Type of Batch/Bill (12Z, 13Z, 14Z, 83Z)	3	X	
95	6	Number of Claims	6	9	
99	1	Record Type '99'	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 B

UB92 Abbreviated Hospital Inpatient Encounter Data
Version 6.0

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	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/Prod Indicator	4	(X)
01	20	**Processing Date** (Date Bill Submitted on HCFA 1450) (CCYYMMDD)	8	(9)
01	22	Version Code (A60) (see note 1)	3	(X)
10	1	Record Type	2	(X)
10	2	Type of batch (11X,Y,or Z)	3	(X)
10	3	Batch Number	2	(9)
10	6	**National Provider Identifier**	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	7	**Sex**	1	(X)
20	8	**Birth Date (CCYYMMDD)**	8	(9)
20	17	**Admission Start of Care Date**	8	(9)
20	19	**Statement Covers Period From Date (CCYYMMDD)**	8	(9)
20	20	**Statement Covers Period Thru Date (CCYYMMDD)**	8	(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)
Rec Type	**Field No.**	**Field Name**	**Length**	**Picture**
31	14	Form Locator 37 (x-reference ICN/DCN)	23	(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 (11X,Y,or Z)**	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)** 04 – HMO Enrollment, 65 – Non-PPS Hospital	2	(X)
50	1	Record Type	2	(X)
50	2	Sequence Number	3	(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	**Principle Diagnosis Code (ICD-9)**	6	(X)
70	5 – 12	**Other Diagnosis Code (occurs 8x)**	6	(X)
70	13	**Principle 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	4	(9)
90	5	Record Type 2n Count	2	(9)
90	6	Record Type 3n Count	2	(9)
90	7	Record Type 4n Count	2	(9)
90	8	Record Type 5n Count	3	(9)
90	10	Record Type 7n Count	2	(9)
90	12	Record Type 91 Qualifier	1	(9)
95	1	Record Type	2	(X)
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.

Summary of Differences between the Abbreviated version 5.0 and 6.0

1. Record 50, field 2 – sequence number has been expanded to 3 bytes from 2.
2. Record 50, field 3 – patient control number begins in column 6 instead of 5.
3. Record 90, field 4 – physical record count has been expanded to 4 bytes from 3.
4. Record 90, field 5 – record type 2n count begins in column 29 instead of 28.
5. Record 90, field 6 – record type 3n count begins in column 31 instead of 30.
6. Record 90, field 7 – record type 4n count begins in column 33 instead of 32.
7. Record 90, field 8 – record type 5n count has been expanded to 3 bytes from 2 and begins in column 35 instead of 34.
8. Record 90, field 10 – record type 7n count begins in column 41 instead of 38.
9. Record 90, field 12 – record type 91 qualifier begins in column 45 instead of 42.