FEHB Program Carrier Letter
All Community-Rated Carriers

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2008 - 09 Date: April 15, 2008

Fee-for-service [n/a] Experience-rated HMO [n/a] Community-rated HMO [7]

SUBJECT: Audit Requirements for Adjusted Community-Rating Plans

Many community-rated carriers participating in the Federal Employees Health Benefits Program (FEHBP) use an Adjusted Community Rating (ACR) methodology, which utilizes group-specific experience data to develop the FEHBP and Similarly Sized Subscriber Groups (SSSG) rates. The Office of Personnel Management's (OPM) Rating Instructions for Community-Rated Carriers state that carriers must keep on file all data necessary (i.e., claims utilization) to justify the ACR rate and save back-up tapes of their claims databases for audit purposes. To ensure that the experience figures are appropriately supported and the rates are developed in accordance with the contract, Federal regulations and rating instructions, the OPM Office of the Inspector General (OIG) requires submission of this supporting data annually. The information will be used for audit and investigative purposes.

Carriers that use an ACR methodology and base their FEHBP rates on group-specific claims or utilization data are required to submit this data as follows:

- Carriers that submit their rates as large carriers and use an ACR methodology to develop the FEHBP rates for 2009 **must submit this data to the OIG when they submit their 2009 proposals.** Carriers with more than 1,500 FEHBP contracts at the time of the rate proposal (by plan code) must file as large carriers.
- Carriers with fewer than 1,500 enrollees that do not elect to submit their rates as large carriers are not required to submit this data at the time they submit their 2009 proposals. However, any carriers that submitted the data for their 2008 proposals are required to submit the data for 2009. Their systems should already be established so that they can readily submit this data each year. While other small carriers are not required to submit the data, they are encouraged to do so.
- We remind all community-rated carriers of the requirement to retain and/or submit this data in order to avoid the potential for audit findings and subsequent penalties for defective pricing as outlined in Section 3.3 of the standard community rated contract.

Attachments 1 and 2 to this carrier letter contain lists of the fields that are requested for medical claims (professional, facility, dental, etc.) and for pharmaceutical claims. Please include at the end of the listed fields any additional fields that you believe contain pertinent information. Normally these files should contain a separate record for <u>each line/charge</u> that is contained in each claim. For carriers that use a method other than actual, adjudicated claims (i.e., encounters,

utilization, etc.), please include the **detailed** experience data you used to determine the experience factor for the FEHBP.

All claims data should be submitted on CD, DVD, USB Memory Stick, or electronically transmitted to the OIG. The OIG's preference is to receive the claims data in ASCII Comma delimited text files.

To meet OPM security requirements, you should *encrypt each file* by using the encryption option in WinZip 9.0 to compress and encrypt the data. In the Encrypt dialog box where you enter a password, you must select 256-bit AES encryption. Make sure that you select a *strong* password (minimum 8 characters of which at least one should be a numeric digit, at least one should be an uppercase letter and at least one should be a lowercase letter). The password should be provided (emailed) separately from the encrypted and zipped file.

Certain documentation must also be provided for each file. Specifically, complete Attachment 3, the Media Specifications Form for each file. Also provide a list of codes for fields requiring one (i.e. data dictionary) and descriptions of additional fields that are provided. Additionally, provide documentation for all rebates (e.g. drug rebates) received since this is typically at an aggregate level.

Please send the requested data and documentation to:

Melissa D. Brown
Office of Personnel Management
Office of the Inspector General
1900 E Street, NW
Room 6400
Washington, D.C. 20415-1100

All community-rated carriers must maintain, in the same format as the FEHBP data, the group-specific claims or utilization data for the SSSGs. The carriers must keep this data at their offices and make it available for review during OIG audits. This data (for the FEHBP and the SSSGs) should be downloaded from a central database at the time the rates are developed.

Questions regarding audit objectives or requirements should be directed to Melissa Brown, Chief, Community-Rated Audits Group on 202-606-4714 or at melissa.brown@opm.gov. Technical questions regarding the claims database or requirements for data submission should be directed to Lewis Parker, Chief, Information Systems Audit Group, on 202-606-4738 or at lewis.parker@opm.gov.

Sincerely,

Kay T. Ely
Associate Director
for Human Resources Products and Services

Attachments

Attachment 1
MEDICAL CLAIM FIELD REQUIREMENTS

Field #	Field Name	Field Description
1	Group Number	Unique identifier for the group.
2	Group Name	Name of the group.
3	Member/Subscriber Number	Unique identifier of the Member/Subscriber.
4	Patient Identifier	Unique identifier of the patient within the Member Number.
5	Patient Date of Birth	Patient age as of date of service or complete date of birth.
6	Patient Gender	F=Female; M=Male
7	Claim Number	The unique number assigned to this claim by the plan.
8	Claim/Charge Line #	The line number assigned to this charge. If the claim only has one charge line, the value will usually be 1.
9	Claim Type	Indicates the type of claim being reported (i.e. I = Inpatient Hospital, O = Outpatient Hospital, P = Physician, etc.)
10	First Date of Service	The first billed date/incurred date of service for the charge.
11	Last Date of Service	The last date of service/discharge date for the charge.
12	Number of Services/Days	The number of times the same service, etc. was rendered.
13	Service Units Code	Identifies the unit of measurement for the Number of Services field (i.e. DA = Days; DH = Ambulance Miles; MA = Therapeutic Dosage Amount; MJ = Minutes; UN = Units; VS = Visits; etc.)
14	Place of Service Code	Code that identifies where the services were rendered (i.e. inpatient hospital, outpatient hospital, ambulatory surgical center, physician's office, patient's home, ambulance, etc.)
15	Type of Service Code	Code that indicates the type of service rendered (i.e. surgery, anesthesia, diagnostic radiology, diagnostic pathology, physical therapy, speech therapy, home health care, etc.)
16	Diagnosis Code	The primary diagnosis for the charges on this line. Use ICD-9 or equivalent code.
17	Procedure Code	The primary procedure performed by the provider for the charges on this line. Use CPT-4 or HCPCS codes for professional claims, ADA codes for dental claims, ICD-9 procedure codes or revenue codes for facility claims, etc.
18	Procedure Modifier Code	Code that indicates additional information about the procedure (i.e. a specific body part, who performed the procedure, etc.)
19	Performing Provider ID	ID assigned to the performing provider for the service. The Federal Tax ID Number (FTIN), National Provider ID (NPI) or other ID used by the plan.
20	Performing Provider Name	Name of the Performing Provider (Last Name as a minimum).
21	Performing Provider Zip Code	Zip code of the provider who performed the service or rendered the care.
22	Performing Provider Specialty Code	Code that identifies the specialty of the Performing Provider.

23	Performing Provider Network Status	Code to indicate whether the performing provider is in the network (Y), out of the network (N), etc.
24	Date Paid	Date the plan paid the claim.
25	Payee	Code to indicate the recipient of the insurance payment. P = Provider; S = Subscriber; T = 3rd party
26	Billed Charges Amount	Total amount charged by the performing provider for the service.
27	Allowed/Covered Amount	The amount of the billed charges that are covered by the plan.
28	Other Carrier Coverage Code	Code to indicate which, if any, other insurance has primary liability. Field is blank if this insurance is primary.
29	Medicare Payment Disposition Code	Code to indicate if patient is enrolled in Medicare and which part of Medicare was primary. Field is blank if this insurance is primary.
30	Amount Paid by Other Insurance	Amount paid by another insurance for this service.
31	Pricing Method Code	C = Encounter/Capitated Service; D = Per Diem; G = Diagnostic Related Grouping (DRG); M = Maximum Allowable Charge (MAC); P = Percentage; U = Usual, Customary & Reasonable (UCR); etc.
32	Patient Liability Amount	The patient's out-of-pocket expense for this charge. It is comprised of the remaining calendar year deductible amount, copayment amount and coinsurance amount, depending on the plan's benefit structure for the service.
33	Insurance Amount Paid	The amount paid to the payee by this insurance company for the service on this line.

Attachment 2
PHARMACEUTICAL CLAIM FIELD REQUIREMENTS

Field #	Field Name	Field Description
1	Group Number	Unique identifier for the group.
2	Group Name	Name of the group.
3	Member/Subscriber Number	Unique identifier of the Member/Subscriber.
4	Patient Identifier	Unique identifier of the patient within the Member Number.
5	Patient Date of Birth	Patient age as of date of service or complete date of birth.
6	Patient Gender	F=Female; M=Male
7	Claim Number	The unique number assigned to each prescription by the plan.
8	Mail Order/Retail Claim Code	M=Mail Order; R=Retail Pharmacy in Network; O=Other
9	Prescription Number	Prescription number assigned by the pharmacy.
10	Date Filled	Date the drug was dispensed by the pharmacy.
11	NDC Number	National Drug Code (NDC) for the dispensed drug.
12	Generic/Name Brand Code	Code to indicate if the drug dispensed is G = Generic or B = Name Brand.
13	Refill Number	The number of times this prescription has been refilled. Use zero for a new prescription.
14	Drug Quantity	Total quantity dispensed expressed in metric decimal units as submitted by the pharmacy.
15	Days Supply	The estimated number of days the prescription will last.
16	Pharmacy NABP Number	Unique ID number assigned by the National Association of Boards of Pharmacy (NABP) to the pharmacy that dispensed the prescription.
17	Pharmacy Name	Name of the pharmacy that dispensed the drug.
18	Pharmacy Zip Code	Zip code of the pharmacy location that dispensed the drug.
19	Prescribing Physician ID	ID assigned to the prescribing physician for the drug dispensed. Provide the physician's Federal Tax ID Number (FTIN), the National Provider ID (NPI) or DEA Number.
20	Prescribing Physician Name	Name of the Prescribing Physician (Last Name as a minimum).
21	Date Paid	Date the plan paid for the dispensed drug.
22	Payee	Code to indicate the recipient of the insurance payment. P = Provider; S = Subscriber; T = 3rd party
23	Amount Billed	Total amount of the submitted prescription.
24	Dispensing Fee	The dispensing fee submitted by the pharmacy.
25	Other Carrier Coverage Code	Code to indicate which, if any, other insurance has primary liability. Field is blank if this insurance is primary.
26	Other Carrier Amount Paid	Amount paid by another insurance for this service.
27	Pricing Method Code	Method for pricing the dispensed drug A=Average Wholesale Price (AWP); M=Maximum Allowable Charge (MAC); U=Usual, Customary & Reasonable (UCR); etc.
28	Patient Liability Amount	The patient's out-of-pocket expense for the dispensed drug.
29	Insurance Amount Paid	The amount paid to the payee by this plan for dispensed drug.

Attachment 3
US OPM, OFFICE OF THE INSPECTOR GENERAL, OFFICE OF AUDITS
MEDIA SPECIFICATIONS FORM

Insurance Company & Plan:_____

File Name:_____
(maximum 31 character name)

File Format:

___ Microsoft Access

___ Microsoft Excel

___ Tab-delimited Text

___ Other, describe _____

Data Compression/Encryption:

___ WinZip, encryption and compression, Version 9.0

___ Other, explain _____

Media Type & Recording Format:

___ CD

___ DVD

___ USB Memory Stick

___ Other, please describe:
_____

Record Size: _____ **Record Count**: _____ **Amount Control Total:** **$**_____

Signature: _____ **Phone:** _____ **Date:** _____