# FEHB Program Carrier Letter
## All Community-Rated Carriers

**U.S. Office of Personnel Management**
**Insurance Services Program**

**Letter No. 2009 - 06** Date: **April 10, 2009**

Fee-for-service [n/a ] Experience-rated HMO [ n/a ] Community-rated HMO [ 4]

### SUBJECT: Audit Requirements for Adjusted Community-Rating Plans

Many community-rated carriers participating in the Federal Employees Health Benefits (FEHB) Program utilize an Adjusted Community Rating (ACR) methodology, which uses group-specific experience data to develop the FEHB and Similarly Sized Subscriber Groups (SSSG) rates. The Office of Personnel Management's (OPM) Rating Instructions for Community-Rated Carriers state that the 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 that the rates are developed in accordance with the contract, federal regulations and rating instructions, the 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 FEHB 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 FEHB rates for 2010 **must submit this data to the OIG when they submit their 2010 proposals.** Carriers with more than 1,500 FEHB contracts at the time of the rate proposal (by plan code) must file as large carriers.
- Carriers with less than 1,500 enrollees that do not submit their rates as large carriers are not required to submit this data at the time they submit their 2010 proposals. However, carriers which submitted the data for their 2008 and 2009 proposals are required to submit the data for 2010. 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 carriers to retain and/or submit their 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 required for medical claims (professional, facility, dental, etc.) and for pharmaceutical claims. If you cannot provide a certain field, please explain why. Please include at the end of the listed fields any additional fields you feel contain pertinent information **and return an updated copy of Attachments 1 and 2 with your data submission**. Normally these files should contain a separate record for

each line/charge 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 FEHB.

All claims data should be submitted on CD, DVD, USB Memory Stick, or electronically transmitted to the OIG. The OIG's preference is for plans to electronically transmit the claims data in encrypted ASCII comma delimited text files. For plans that have not established an electronic transmission process, please contact the OIG technical representative (details below).

To meet recent security requirements, you should *encrypt each file* by using the encryption option in WinZip 9.0 (or higher) 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 is a numeric digit, at least one is an uppercase letter and at least one is a lowercase letter). The password is provided (emailed) separately from the encrypted and zipped file.

Certain documentation must also be provided for each file. Specifically, complete **and return** 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. Please provide the OIG with a file layout, as shown in the example below. Additionally, if you are sending the data in an access database format, all fields should be formatted as a text data type and date fields should be formatted as in the example below (row 3 column 6) without including time. Finally, provide documentation for all drug rebates received since this is typically at an aggregate level.

| Field Number | Field Name - | Field Format: include size of field and whether it is a number, character or date | Starting Position of the field | Ending Position of the field | Field Description and Code Value Sets – information describing the field as well as the code value sets (for example M = Male or F = Female) | Variable Name – Name of the field in the field |
|---|---|---|---|---|---|---|
| 1 | Subscriber - Unique Identification | Character (10). | 1 | 10 | This is the identifier for a specific enrolled individual | id |
| 2 | Type of Claim Indicator | Character (1) | 11 | 11 | This field indicates the type of claim where:<br>1 = Inpatient Facility; 2 = Outpatient Facility; else Blank = All other claims. | typclaim |
| 51 | Charge Incurred/Service Begin Date | Character (08). | 12 | 19 | This is the beginning date of service:<br>Date Format: YYYYMMDD | incurred |

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

In addition, carriers must maintain, in the same format as the FEHB 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 FEHB 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

* Do not include the time in date fields

| Field # | Field Name | Field Description and Code Value Sets |
|---|---|---|
| 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 (i.e., month, date, year)** date of birth. Date Format: YYYYMMDD |
| 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. Date Format: YYYYMMDD |
| 11 | Last Date of Service* | The last date of service/discharge date for the charge. Date Format: YYYYMMDD |
| 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. Date Format: YYYYMMDD |
| 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. Date Format: YYYYMMDD |
| 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. Date Format: YYYYMMDD |
| 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. Date Format: YYYYMMDD |
| 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 (or higher)

___ Other, explain _____

**Media Type & Recording Format**:

___ CD

___ DVD

___ USB Memory Stick

___ Other, please describe:
_____

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

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