FEHB Program Carrier Letter
All Community-Rated Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2015-11 **Date: June 5, 2015**

Fee-for-service [n/a] Experience-rated HMO [n/a] Community-rated HMO [9]

SUBJECT: Claims Data Requirements for Non-Traditional Community-Rated Carriers

Medical Loss Ratio (MLR) Claims Data Requirement

Beginning in 2013, all carriers who are not mandated by their state to use Traditional Community Rating (TCR) to rate the Federal Employees Health Benefits Program (FEHBP) are required to follow the medical loss ratio (MLR) requirements. This letter provides detailed instructions to non-TCR carriers regarding claims data submission to the Office of Personnel Management's (OPM) Office of the Inspector General (OIG).

All MLR carriers must submit to the OIG detailed FEHBP claims data used in its MLR calculation. The data should include FEHBP claims incurred during calendar year 2014, and paid through June 30, 2015. No other claims will be considered. Completion factors should not be included. Only FEHBP claims associated with benefits covered may be included in the MLR claims. Please read the attached specifications and provide the supporting documentation by **September 30, 2015**. The information may be used for audit and investigative purposes only.

Rate Build Up Claims Data Requirement

Carriers using Adjusted Community Rating (ACR) to rate the FEHBP are required to backup and save claims data used in the FEHBP rate build up. Carriers should use the data layout and specifications included in this letter and attachments to meet this requirement. Carriers must submit Attachment 3 from this letter with the information related to the FEHBP rate build up claims data. Additionally, the carrier is required to submit an updated copy of Attachments 1 and 2 illustrating the carrier's rate build up claims data file layout. **Carriers are <u>not</u> required to submit the actual rate build up claims data to the OIG.** Carriers must keep this data and make it available during OIG rate build up audits. The claims data for the FEHBP should be downloaded from a central database at the time the rates are developed. The information may be used for audit and investigative purposes only. We remind carriers to retain the data in order to avoid the potential for future audit findings.

Questions regarding audit objectives or requirements should be directed to Jim Tuel, Jr., Chief, Community-Rated Audits Group on (724) 741-0713 or at Jim.Tuel@opm.gov. Technical questions regarding technical requirements should be directed to the OIG -Technology HELP DESK at OIG-TechnologyHELPDESK@opm.gov.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

Attachments

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL (OIG)
OFFICE OF AUDITS
COMMUNITY-RATED AUDITS GROUP

CLAIMS DATA REQUIREMENTS

FOR

NON-TRADITIONAL COMMUNITY RATED CARRIERS

ATTACHMENTS

DUE DATE: SEPTEMBER 30, 2015

Contact for questions:

Nekitra T. Tuell, OPM/OIG
1900 E Street, NW, Room 6400
Washington, D.C. 20415-1100
Office Number (202) 606-0120
Fax Number (202) 606-4823
E-mail: OIGCRAGCLAIM@opm.gov

INSTRUCTIONS FOR FORMATTING AND SUBMITTING CLAIMS

OIG has a mandatory claims data layout that must be used. Please contact Nekitra Tuell at OIGCRAGCLAIM@opm.gov to receive the mandatory claims data layout in Excel. Attachments 1 and 2 contain the mandatory data fields that are required for medical claims (professional, facility, dental, etc.) and for pharmaceutical claims, respectively.

NOTE: If certain mandatory fields are not captured or are unavailable, please contact Nekitra Tuell at OIGCRAGCLAIM@opm.gov prior to the submission. If data for certain fields are unavailable, please include the field, but leave the field empty. Please include any additional fields that you feel contain pertinent information at the end of the mandatory fields. If any required fields are missing and the OIG has not been contacted, your claims submission will be considered incomplete.

Please return an updated copy of Attachments 1, 2, and 3 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 FEHBP's MLR numerator.

REQUIRED DOCUMENTATION

All carriers are required to submit Attachments 1, 2, and 3. However, only carriers using the MLR methodology are required to submit claim files to the OIG.

Claims Data Submission – For MLR Carriers only, provide in an OIG-approved file format as follows:

- **Fixed Width Flat File (Text)**
  Note: The OIG should receive a separate file for medical and pharmaceutical claims.

- Any other format must be pre-approved by contacting the OIG (OIGCRAGCLAIM@opm.gov)

Attachments 1 and 2 – For all Carriers, update Attachments 1 and 2 with any additional fields included in the claims data submission (if applicable).

Attachment 3 – For all Carriers, complete the Media Specification Form, Attachment 3, for each claims data file submitted.

Data Dictionary – For all Carriers, submit a data dictionary that includes code sets and definitions for fields as required below:

- Field # 11 - Patient Relationship Code
- Field # 29 - Place of Service Code

- Field # 30 - Type of Service Code
- Field(s) # 33, 34, 36, 38 - Diagnosis Code - Please provide a list of any non- ICD codes used for these fields
- Field # 51 - Performing Provider Specialty Code

CLAIMS DATA SUBMISSION REQUIREMENTS

Effective immediately, all Community-Rated carriers that submit Federal Employees Health Benefits Program claims data to the Office of Personnel Management (OPM), Office of the Inspector General (OIG), must do so using a Secure File Transfer Protocol (SFTP) account. Submitting claims data using any other method (i.e., DVD, flash drive, secure mail, FTP), is **no longer permitted**.

Existing File Transfer Protocol (FTP) Account Holders:

All existing FTP account holders will need to obtain a SFTP account **immediately**.

New SFTP Account Holders:

All Community-Rated carriers will be required to set up a SFTP account by **August 3, 2015**. SFTP accounts are now required for MLR claims submissions which will be due on **September 30, 2015**.

The OPM/OIG SFTP transfer consists of several steps involving, but not limited to, OPM firewall access, OIG server user ID and password generation, and data compression and encryption. To acquire a SFTP account through OPM/OIG, please follow the steps outlined below.

OIG SFTP Transfer Steps:

All SFTP technical questions or issues should be directed to the:

OIG SFTP ADMINISTRATORS

- Rohit Kapoor, Chief, OPM OIG Information Systems Technology Group, 202-606-1280 or at Rohit.Kapoor@opm.gov

- Jason Cooper, IT Specialist, OPM OIG Information Systems Technology Group, 202-606-9505 or at Jason.Cooper@opm.gov

1. Public IP Address of Internal Server – To gain access through the OPM Firewall, the carrier must provide the public IP address of the server sending the file to OPM. Once this information is obtained and ready to be given to OPM/OIG, proceed to Step 2.

2. Initiate Account Set-up – To request a SFTP account or update an existing FTP account, contact the OIG SFTP Administrators via phone or email (previously listed). Provide them with the public IP address of the server sending the file to OPM. This information will be entered into the OPM firewall for access.

3. Obtain Username and Password - Once firewall access has been obtained, the OIG SFTP Administrators will work with the point of contact from the carrier to provide a username and password to the SFTP server.

4. File Specifications – All transmitted files must be in ASCII or SAS format based on the agreed upon fixed length format.

5. Select Encryption Software - The OIG SFTP process requires that all transmitted data be **compressed and encrypted**. The carrier must use the same software as the OIG. File encryption software performs data compression and data encryption. Coordinate with the OIG SFTP Administrator to determine which software will be used. The OIG SFTP server can accept:

    - PGP (or GPG) Encryption (preferred method), or
    - PKZIP Encryption (using highest encryption level possible)

6. File Testing - Coordinate with the OIG SFTP Administrators to transmit test files. Once testing has been completed, the carrier will be assigned a date and time for the initial data transfer and recurring transmissions. The OIG prefers that the carrier send an email to Rohit.Kapoor@opm.gov and Jason.Cooper@opm.gov each time a test file has been transmitted.

7. File Naming Conventions – We request the following naming conventions be placed on the transmitted files:

    Medical Claims
    - Medical.CLAIMS.PlanCode.Y2015.pgp [2015 is the time frame the file covers not when it was transmitted] [Plan Code is the two digit alphanumeric plan code assigned by the FEHBP.] **Example:** Medical.CLAIMS.AZ.Y2015

    Pharmacy Claims
    - Pharmacy.CLAIMS.PlanCode.Y2015.pgp [2015 is the time frame the file covers not when it was transmitted] [Plan Code is the two digit alphanumeric code assigned by the FEHBP.] **Example:** Pharmacy.CLAIMS.AZ.Y2015

8. Confirmation Email – We request that an email be sent after each file/group of files has been transmitted. The purpose is to notify us that a specific file(s) has been transmitted and to provide us with the file name, the necessary record counts and amounts necessary to confirm that the complete file(s) was received. For example, we should receive an email every time a claim file is transferred to us. The email should include the name of

the file, number of records in the file, and total amount paid by plan. We request that the following OIG staff members be copied on each transmission email:

- OIG-Technology Helpdesk (OIG-TechnologyHELPDESK@opm.gov)
- Nekitra Tuell (Nektira.Tuell@opm.gov)
- Lindsay Haber (Lindsay.Haber@opm.gov)

Attachment 1

US OPM, OFFICE OF THE INSPECTOR GENERAL, OFFICE OF AUDITS
MANDATORY MEDICAL CLAIM FIELD REQUIREMENTS

Field #	Field Name	Field Type	Length	Field Description and Code Value Sets
1	Plan Code	Character	02	The two digit alphanumeric plan code assigned by the FEHB. (e.g. JP, CY, 63, etc.) Left justified.
2	Plan Name	Character	40	Plan Name – Brochure Name (e.g. Coventry Health Care of Kansas, Dean Health Plan, etc.)
3	Group Number	Character	12	Unique identifier for the group. Left justified.
4	Group Name	Character	40	Name of the group. Left justified.
5	Subscriber ID Number	Character	12	Unique identifier of the Subscriber. Left justified.
6	SSN-Patient	Character	09	SSN of Patient, left justified with appropriate leading zeros, no hyphens.
7	Subscriber First Name	Character	25	First name of the subscriber. Left justified.
8	Subscriber Middle Name	Character	25	Middle name of the subscriber. Left justified.
9	Subscriber Last Name	Character	25	Last name of the subscriber. Left justified.
10	Subscriber Name Suffix	Character	05	Name suffix that follows subscriber's last name. (e.g. Jr., Sr., III, IV, etc.) Left justified.
11	Unique Patient Identifier Code/Number	Character	02	Unique alphabetic code (A-Z) or sequential number to differentiate each person covered on this contract. Left justified.
12	Patient Relationship Code	Character	02	Code to define/identify the relationship of the patient to the subscriber/contract holder. Please provide code set for this field. Left justified.
13	Patient ID Number	Character	12	Unique identifier of the Patient. Left justified.
14	Patient Date of Birth*	Date	08	Complete Date of birth. **Date Format:** YYYYMMDD.

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15	Patient First Name	Character	25	First name of the patient. Left justified.
16	Patient Middle Name	Character	25	Middle name of the patient. Left justified.
17	Patient Last Name	Character	25	Last name of the patient Left justified.
18	Patient Name Suffix	Character	05	Name suffix that follows patient's last name. (e.g. Jr., Sr., III, IV, etc.) Left justified.
19	Patient Gender	Character	01	**Values**: **F**=Female; **M**=Male; else **Blank** = unknown. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
20	FEHB Enrollment Code	Character	03	Use OPM assigned 3 position enrollment code. (e.g. 321, 322) Left justified.
21	Claim Number	Character	20	The unique number assigned to this claim by the carrier. Left justified.
22	Claim/Charge Line #	Numeric	03	The line number assigned to this specific charge line. If the claim only has one charge line, the value will usually be 1. Left justified.
23	Claim – Number of Charges	Numeric	03	Total number of line items/charges for this claim. Left justified.
24	Claim Type (I/P,O/P, Professional)	Character	01	Indicates the type of claim being reported. **Values: I** = Inpatient Hospital; **O** = Outpatient Hospital; **P** = Physician. Left justified. **Note**: If a claim has any value other than I, O, or P, please leave the field empty. *Do not add the actual word "blank"*.
25	Claim Disposition/Status Code	Character	01	Code to indicate the status of the record such as original claim, adjustment, void/reversal, etc. Please use the codes **(1-4)** ► See

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				Attachment 4 for Code Value Definitions.
26	First Date of Service *	Date	08	The first incurred date of service for the charge. **Date Format:** YYYYMMDD. Left justified.
27	Last Date of Service*	Date	08	The last date of service/discharge date for the charge. **Date Format:** YYYYMMDD. Left justified.
28	Number of Services/Days	Numeric	04	The number of times the same service, etc. was rendered. Left justified. ***If this field is populated then field # 28 should be populated***.
29	Service Units Code	Character	02	Identifies the unit of measurement for the Number of Services field. **(DA, DH, MA, MJ, MO, UN, VS, WK, YR) else Blanks ►** See **Attachment 4** for Code Value Definitions. Left justified.
30	Place of Service Code	Character	03	Please provide code set for this field. Left justified. This field should be populated for all types of claims (Inpatient, Outpatient and Professional).
31	Type of Service Code	Character	03	Indicates the type of service such as Surgery, Anesthesia, Diagnostic Radiology, etc. Please provide code set for this field. Left justified.
32	Diagnosis Code Type (1)	Character	01	The primary diagnosis for the charges on this line. **9** = ICD-9 codes; **0** = ICD-10 codes; **S** = Special Codes by this carrier; **Blank** = no diag code reported. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
33	Diagnosis Code (1) [=**Principal Diag** for Facil]	Character	08	For Facility claims, provide the **Principal Diagnosis Code** followed by the **Admitting Diagnosis Code** and first 2 Other Diagnosis Codes. For Professional claims, provide the first 4

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				Diagnosis Codes for the charge line. Left justified, no decimal. **1st position = (0-9, V or E) and field length 3 to 5 positions** for ICD-9 codes. The 8th position should always be the Present on Admission (POA) Indicator. **Values = Y, N, U, W, 1.**
34	Diagnosis Code Type (2)	Character	01	**9** = ICD-9 codes; **0** = ICD-10 codes; **S** = Special Codes by this carrier; **Blank** = no diagnosis code reported. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
35	Diagnosis Code (2) [=**Admitting Diag** for Facil]	Character	08	Please provide a list of any non ICD codes used for these fields. Left justified.
36	Diagnosis Code Type (3)	Character	01	**9** = ICD-9 codes; **0** = ICD-10 codes; **S** = Special Codes by this carrier; **Blank** = no diagnosis code reported. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
37	Diagnosis Code (3)	Character	08	Please provide a list of any non ICD codes used for these fields. Left justified.
38	Diagnosis Code Type (4)	Character	01	**9** = ICD-9 codes; **0** = ICD-10 codes; **S** = Special Codes by this carrier; **Blank** = no diagnosis code reported. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
39	Diagnosis Code (4)	Character	08	Please provide a list of any non ICD codes used for these fields. Left justified.
40	Procedure Code Type Primary	Character	01	Indicates the type of code set that appears in the Procedure Code field. **Values**: (**C, D, H, I, J, R, S,**

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				Blank). **C** =CPT-4 Codes; **D** = American Dental Assoc. Codes; **H** = HCPCS Codes; **I** = ICD-9 Procedure Codes; **J** = ICD-10 Procedure Codes; **R** = Revenue Code; **S** = Special Codes by this carrier; or **Blanks** = Unknown. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
41	Procedure Code Primary	Character	07	Primary Procedure. **HCPCS** or **CPT-4** Medical Procedure Code or the **ADA Dental** Procedure Code. **Blanks** or **ICD-9** for Facility claims. Left justified. Please provide a list of any other codes used for this field.
42	Procedure Modifier Code (1)	Character	02	Code that indicates additional information about the procedure (i.e. a specific body part, who performed the procedure, etc.) CPT-4 Medical Procedure Code Modifier (**Blanks, 21-99, A1-VP**) for the Primary Procedure. This field can be populated for facility and professional claims. Left justified.
43	Procedure Modifier Code (2)	Character	02	Second Procedure Code Modifier for the Primary Procedure. Left justified.
44	Procedure Modifier Code (3)	Character	02	Third Procedure Code Modifier for the Primary Procedure. Left justified.
45	Procedure Modifier Code (4)	Character	02	Fourth Procedure Code Modifier for the Primary Procedure. Left justified.
46	Patient Discharge Status Code	Character	02	HIPAA numeric values (**00-72**) for facility claims only, otherwise **Blanks**. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.* ► See **Attachment 4** for Code

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				Value Definitions. Left justified.
47	Performing Provider ID	Character	10	ID assigned to the performing provider for the service. Left justified.
48	Performing Provider ID Type	Character	02	Blank=Not Specified Ø1=Medicare Ø2=Medicaid Ø3=UPIN Ø4=State License Ø5=Champus Ø6=Health Industry Number (HIN) Ø7=Federal Tax ID Ø8=Drug Enforcement Administration (DEA) Ø9=State Issued 1Ø=Carrier Specific 11= Social Security Number 12=Federal Tax Payers Identification Number (FTIN) 99=Other Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
49	Performing Provider - NPI ID	Character	10	National Provider Identifier (NPI) reported by the Performing Provider. Left justified.
50	Performing Provider Name	Character	40	Name of the Performing Provider (Last Name at a minimum). Left justified. ***Free form or First Name-Middle Name-Last Name*.**
51	Performing Provider Zip Code	Character	09	Zip code of where the service or care was rendered. Left justified.
52	Performing Provider Specialty Code	Character	07	Code that identifies the specialty of the Performing Provider. Please provide code set for this field. Left justified.
53	Performing Provider Network Status	Character	01	Code to indicate whether the performing provider is in the network = **(Y),** out of the network = **(N)**. Left justified.
54	Debarred Provider -	Character	01	Indicate whether provider is

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	Indicator			debarred (**Y** = Yes; **N=**No; **Blank** = Unknown/Unavailable). Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
55	Debarred Provider - Payment Reason Code	Character	01	**(C,D,G,M,U,X,Blank)** ► See **Attachment 4** for Code Value Definitions. Left justified.
56	Date Paid *	Date	08	Date the carrier paid the claim. **Date Format:** YYYYMMDD
57	Payee	Character	01	Code to indicate the recipient of the insurance payment. **P** = Provider; **S** = Subscriber; **T** = 3rd party. Left justified.
58	Billed Charges Amount	Amount	PIC X, PIC S9(07)V99	Total amount charged by the performing provider for the service for this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating with an amount.*
59	❖ Allowed/Covered Amount	Amount	PIC X, PIC S9(07)V99	The amount of the billed charges that are covered by the carrier for this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive,

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				there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating with an amount.*
60	Medicare Payment Disposition Code Applicable to whichever one has primary.	Character	01	Code to indicate if patient is enrolled in Medicare and which part of Medicare was primary. Field is blank if this insurance is primary. **A-H, J, K, N, P, U, Blank ►** See **Attachment 4** for Code Value Definitions. Left justified.
61	Other carrier – Paid Indicator (1)	Character	02	**(16, BL, C1, MA, MB, MU, NF, SP, SU, WC)** otherwise **Blanks** if this carrier paid as Primary. ► See **Attachment 4** for Code Value Definitions. Left justified.
62	Other Carrier -Amount Paid (1)	Amount	PIC X, PIC S9(07)V99	Report the amount paid by the primary other insurance carrier when applicable on this line item. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating with an amount.*
63	Other carrier – Paid Indicator (2)	Character	02	**(16, BL, C1, MA, MB, MU, NF, SP, SU, WC)** otherwise **Blanks** if this carrier paid as Primary. ► See **Attachment 4** for Code Value Definitions. Left justified.

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64	Other Carrier-Amount Paid (2)	Amount	PIC X, PIC S9(07)V99	Report the amount paid by a second other insurance carrier when applicable who paid prior to this carrier on this line item. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating with an amount.*
65	Other Insurance/Medicare Allowed Amount	Amount	PIC X, PIC S9(07)V99	Report the Other Carrier allowed amount or the Medicare priced amount for this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating with an amount.*
66	Pricing Method Code (1)	Character	01	**Values**: (4, 5, 6, B, D, E, F, G, I, K, L, M, N, U, V) ► See **Attachment 4** for Code Value Definitions. Left justified.
67	Pricing Method Code (2)	Character	01	**Values:** (4, 5, 6, B, D, E, F, G, I, K, L, M, N, U, V) ► See **Attachment 4** for Code Value Definitions. Left justified.

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68	Patient Liability Amount	Amount	PIC X, PIC S9(07)V99	The patient's out-of-pocket expense for this charge on this line. It is comprised of the remaining calendar year deductible amount, copayment amount and coinsurance amount, depending on the carrier's benefit structure for the service. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
69	Insurance Amount Paid	Amount	PIC X, PIC S9(07)V99	The amount paid to the payee by this insurance company for the service on this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
70	Claim - Total Billed Amount	Amount	PIC X, PIC S9(08)V99	Report the total billed amount for all line items for this claim. First position is the sign followed by 10 digits with an implied decimal

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				before the last 2 digits. **Ex**. -9999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
71	Claim - Total Covered Charges	Amount	PIC X, PIC S9(08)V99	Amount of the submitted charges for all line items for this claim that are covered by the carrier's contract. This amount should exclude charges billed for non-covered services. First position is the sign followed by 10 digits with an implied decimal before the last 2 digits. **Ex**. -9999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
72	Claim - Total Amount Paid	Amount	PIC X, PIC S9(08)V99	Amount of the submitted charges for all line items for this claim that are covered by the carrier's contract. This amount should exclude charges billed for non-covered services. First position is the sign followed by 10 digits with an implied decimal before the last 2 digits. **Ex**. -9999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if

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				the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
73	Coinsurance Amount	Amount	PIC X, PIC S9(07)V99	The amount coinsurance due from patient for this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
74	Copayment Amount	Amount	PIC X, PIC S9(07)V99	The copayment amount due from the patient for this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex.** -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*

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75	Deductible Amount	Amount	PIC X, PIC S9(07)V99	The deductible amount due from the patient for this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex. -** 999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
76	Total Amount Paid by all Sources	Amount	PIC X, PIC S9(07)V99	This field should be the sum of the carrier, other insurance and member amount paid fields for this line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*

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Attachment 2

US OPM, OFFICE OF THE INSPECTOR GENERAL, OFFICE OF AUDITS
MANDATORY PHARMACEUTICAL CLAIM FIELD REQUIREMENTS

Field #	Field Name	Field Format	Length	Field Description
1	Plan Code	Character	02	The two digit alphanumeric plan code assigned by the FEHB. (e.g. JP, CY, 63, etc.) Left justified.
2	Plan Name	Character	40	Plan Name – Brochure Name (Coventry Health Care of Kansas, Dean Health Plan, etc.)
3	Group Number	Character	15	Unique identifier for the group. Left justified.
4	Group Name	Character	40	Name of the group. Left justified.
5	Subscriber ID Number	Character	12	Unique identifier of the Subscriber. Please coordinate the medical and prescription drug files subscriber IDs. Left justified.
6	SSN-Patient	Character	09	SSN of Patient, left justified with appropriate leading zeros, no hyphens.
7	Subscriber First Name	Character	25	First name of the subscriber .Left justified.
8	Subscriber Middle Name	Character	25	Middle name of the subscriber. Left justified.
9	Subscriber Last Name	Character	25	Last name of the subscriber. Left justified.
10	Subscriber Name Suffix	Character	05	Name suffix that follows subscriber's last name. (e.g. Jr., Sr., III, IV, etc.) Left justified.
11	Patient Identifier	Character	02	Unique alphabetic code (A-Z) or sequential number to differentiate each person covered on this contract. Left justified
12	Patient First Name	Character	25	First name of the patient. Left justified.
13	Patient Middle Name	Character	25	Middle name of the patient. Left justified.
14	Patient Last Name	Character	25	Last name of the patient. Left justified.
15	Patient Suffix	Character	05	Name suffix that follows patient's last name. (e.g. Jr., Sr., III, IV, etc.) Left justified.
16	Patient ID Number	Character	12	Unique identifier of the patient. Please coordinate the medical and prescription drug files patient IDs (if applicable). Left justified.
17	Patient Date of Birth*	Date	08	Complete date of birth. **Date Format:** YYYYMMDD
18	Patient Gender	Character	01	**F**=Female; **M**=Male; else Blank = unknown. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*

* Do not include the time in the date fields

19	Claim Number	Character	20	The unique number assigned to each prescription by the carrier. Left justified.
20	Mail Order/Retail Claim Code	Character	01	**Values: M**=Mail Order; **R**=Retail Pharmacy in Network; **S**= Specialty; **O**=Other. Left justified.
21	Prescription Number	Character	20	Prescription number assigned by the pharmacy. Left justified.
22	Date Filled*	Date	08	Date the drug was dispensed by the pharmacy. **Date Format:** YYYYMMDD
23	Date Prescription Written	Date	08	Date the prescription was written as submitted pharmacy. **Date Format:** YYYYMMDD
24	Date Processed	Date	08	Date the drug was processed by the pharmacy**. Date Format:** YYYYMMDD
25	NDC Number	Character	15	National Drug Code (NDC) for the dispensed drug. Left justified.
26	Drug Name	Character	30	Name of the drug dispensed. Left justified.
27	Drug Strength	Character	10	Drug strength (i.e., 500MG, 0.5%, etc.). Left justified.
28	Unit of Measure	Character	02	Indicates the dosage form of the drug dispensed "space" – Not specified **ML** – Milliliters **GM** – Grams **EA** – Each Left justified.
29	Generic/Name Brand Code	Character	01	Code to indicate if the drug dispensed is **G** = Generic or **B** = Name Brand. Left justified.
30	Compound Indicator	Character	01	Indicates if the drug dispensed is a compound. Left justified. **0** = unknown **1** = Not a Compound **2** = Compound
31	Formulary Indicator	Character	01	Indicates if the drug dispensed is formulary. Left justified. **0** = unknown **1** = Not Formulary **2** = Formulary
32	Refill Number	Numeric	02	The number of times this prescription has been refilled. Use zero for a new prescription. Code identifying whether the prescription is an original (00) or by refill number (01-99). **00** - New **01-99** - Refill number Left justified.

* Do not include the time in the date fields

33	Quantity Dispensed	Numeric	6	Total quantity dispensed expressed in metric decimal units as submitted by the pharmacy. Left justified.
34	Days Supply	Numeric	03	The estimated number of days the prescription will last. Left justified.
35	Dispensing Status	Character	01	Indicates if the prescription was a partial fill or the completion of a partial fill. **Values:** **Blank** = not a partial fill **P**=partial fill **C**= completion of partial fill This data is submitted by the pharmacy. Note that if a partial fill is submitted by a pharmacy, this field must be submitted with a 'p' or 'c' value. Left justified.
36	Dispense As Written	Character	01	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed. **Values**: **Y**= Yes; **N**=No; else Blank = unknown. Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
37	Pharmacy NABP Number	Character	15	Unique ID number assigned by the National Association of Boards of Pharmacy (NABP) to the pharmacy that dispensed the prescription. Left justified.
38	Pharmacy NPI	Character	10	10 Digit Pharmacy NPI number as assigned by the Centers for Medicare and Medicaid Services. If Pharmacy not NPI field will = spaces. Left justified.
39	Pharmacy NCPDP	Character	10	Provide the pharmacy's NCPDP ID number. Left justified.
40	Pharmacy Name	Character	35	Name of the pharmacy that dispensed the drug. Left justified.
41	Pharmacy Zip Code	Character	09	Zip code of the pharmacy location that dispensed the drug. Left justified.
42	Prescribing Physician ID	Character	15	ID assigned to the prescribing physician for the drug dispensed. Left justified.
43	Prescriber ID Type	Character	05	Identifies the type of ID being submitted in the Prescriber ID field. **Values:** Blank=Not Specified Ø1=National Provider Identifier (NPI) Ø2=Medicare

* Do not include the time in the date fields

				Ø3=Medicaid Ø4=UPIN Ø5=NCPDP Provider ID Ø6=State License Ø7=Champus Ø8=Health Industry Number (HIN) Ø9=Federal Tax ID 10=Drug Enforcement Administration (DEA) 11=State Issued 12=Carrier Specific 99=Other Left justified. *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
44	Prescribing Physician NPI	Character	10	ID assigned to the prescribing physician for the drug dispensed. Provide the physician's National Provider ID (NPI). Left justified.
45	Prescribing Physician Name	Character	35	Name of the Prescribing Physician (Last Name as a minimum). Left justified.
46	Date Paid *	Date	08	Date the carrier paid for the dispensed drug. **Date Format:** YYYYMMDD
47	Payee	Character	02	Code to indicate the recipient of the insurance payment. **P** = Provider; **S** = Subscriber; **T** = 3rd party. Left justified.
48	Ingredient Cost	Amount	PIC X, PIC S9(07)V99	Cost of the ingredient that was dispensed. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex.** -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
49	Client Pricing Cost Basis	Character	02	Code indicating the method by which ingredient cost submitted is calculated based on client pricing. **Values:** Blank = Not Specified 01 = AWP 1P = Pre-settlement AWP 02 = ACQ 03 = Manufacturer Direct Pricing 04 = Federal upper limit 05 = Average Generic Pricing

* Do not include the time in the date fields

				06 = U&C 07 = Submitted Ingredient Cost 08 = State MAC 09 = Unit 10 = U&C or Copay *If "**blank**" is used, do not add the actual word "blank". Please leave the field empty.*
50	Amount Billed	Amount	PIC X, PIC S9(07)V99	Total amount of the submitted prescription. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
51	Allowed/Covered Amount	Amount	PIC X, PIC S9(07)V99	Report the covered charges less any savings for this line for this claim. Left justified. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. Ex. -999999999 with implied decimal before last 2 digits. Note: Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals.
52	Dispensing Fee	Amount	PIC X, PIC S9(07)V99	The dispensing fee submitted by the pharmacy. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
53	Other Carrier Coverage Code	Character	02	Code to indicate which, if any, other insurance has primary liability. Field is blank if this insurance is primary. Communicated by the pharmacy regarding other coverage. **Values:** Ø= Not Specified 1= No other coverage identified

* Do not include the time in the date fields

				2= Other coverage exists-payment collected 3=Other coverage exists-this claim not covered 4=Other coverage exists-payment not collected 5=Managed care plan denial 6=Other coverage denied-not a participating provider 7=Other coverage exists-not in effect at time of service 8=Claim is a billing for a copay Left justified.
54	Other Carrier Amount Paid	Amount	PIC X, PIC S9(07)V99	Amount paid by another insurance carrier for this service. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
55	Patient Liability Amount	Amount	PIC X, PIC S9(07)V99	The patient's out-of-pocket expense for the dispensed drug. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
56	Insurance Amount Paid	Amount	PIC X, PIC S9(07)V99	The amount paid to the payee by this carrier for dispensed drug. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits**. Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
57	Total Amount Paid by all Sources	Amount	PIC X, PIC S9(07)V99	This field should be the sum of the carrier, other insurance and member amount paid fields First position is the sign followed by 9 digits with an

* Do not include the time in the date fields

				implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
58	Sales Tax	Amount	PIC X, PIC S9(07)V99	The sale tax associated with this claim line. First position is the sign followed by 9 digits with an implied decimal before the last 2 digits. **Ex**. -999999999 with implied decimal before last 2 digits. **Note:** Only add the sign if the value is negative. If the value is positive, there is no need for a sign, hold the first position with a space. Additionally, places need to be held by digits not spaces in the totals. Left justified. *Please populate with zeros instead of blanks if not populating an amount.*
59	Patient Relationship Code	Character	02	Code to define/identify the relationship of the patient to the subscriber/contract holder. Please provide code set for this field. Left justified.

* Do not include the time in the date fields

Attachment 3

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

Please Complete and Return with each File

Insurance Company or Health Plan Name: _____

Plan Code(s):_____

File Name: _____
(maximum 31 character name)

File Format:

___ **Fixed Width Flat File (Text)**
(Not Excel or Access)

Data Compression/Encryption:

___ WinZip, encryption and compression, Version 9.0 (or higher)

___ Other, explain _____

Media Type & Recording Format:

___ SFTP (All Groups)

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

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

Print Name: _____

Attachment 4

US OPM, OFFICE OF THE INSPECTOR GENERAL, OFFICE OF AUDITS
MANDATORY MEDICAL & PHARMACY CLAIM CODE SETS

Claim Disposition Status Code – (See Field # 24)

1	**Original Claim**
2	**Adjustment of Original, Adjusted or Split Billed Claim**
3	**Extension to original facility claim (split bill)**
4	**Denied Claim**

Service Unit Code (HIPAA codes) – (See Field # 28)

DA	**Days**
DH	**Miles (Ambulance)**
MA	**Modalities (Therapeutic Agents)**
MJ	**Minutes (Anesthesia, etc.)**
MO	**Month (DME Certification Loop)**
UN	**Units (Default Value)**
VS	**Visits**
WK	**Week (DME Certification Loop)**
YR	**Year (DME Certification Loop)**
blank	**Unknown –** *(Do not add the actual word "blank". Please leave the field empty).*

Patient Discharge Status Code (UB-04 codes) – (See Field # 45)

00	**Unknown or not applicable (not an inpatient facility claim)**
01	**Discharged/Transferred to Home or self-care (routine discharge)**
02	**Discharged/Transferred to another short term general hospital for inpatient care**
03	**Discharged/Transferred to SNF (Skilled Nursing Facility)**
04	**Discharged/Transferred to ICF (Intermediate Care Facility)**
05	**Discharged/Transferred to another type of facility (e.g. Cancer Hospital, Children's Hospital) or referred for outpatient services to another facility**
06	**Discharged/Transferred to Home under care of Home Health Service**
07	**Left against medical advice or discontinued care**
08	**Discharged/Transferred to Home under care of Home IV Service [deleted 10/1/2005]**
09	**Admitted as an inpatient to this hospital (more than 3 days after related outpatient services or admission is unrelated to outpatient services)**
20	**Died**
21	**Discharged/Transferred to Court/Law Enforcement [added 10/1/2009]**
30	**Still a patient or expected to return for Outpatient Services**
40	**Died at home (Hospice claims only)**
41	**Died in a medical facility (Hospice claims only)**
42	**Died at unknown location (Hospice claims only)**
43	**Discharged/Transferred to Federal Health Care Facility (e.g. DOD, VA) [added 10/1/2003]**
50	**Discharged/Transferred to Hospice care- Home**
51	**Discharged/Transferred to Hospice care - Medical Facility**

61 **Discharged/Transferred to Hospital-based Medicare approved Swing Bed [added 10/1/2001]**
62 **Discharged/Transferred to Inpatient Rehabilitation Facility or Hospital Rehabilitation Unit [added 10/1/2001]**
63 **Discharged/Transferred to LTC (Long Term Care) Hospital [added 10/1/2001]**
64 **Discharged/Transferred to Nursing Facility - Medicaid Certified [added 10/1/2002]**
65 **Discharged/Transferred to Psychiatric Hospital or Hospital Psychiatric Unit [added 10/1/2003]**
66 **Discharged/Transferred to CAH (Critical Access Hospital) [effective 1/1/2006]**
70 **Discharged/Transferred to another type of health care institution not defined elsewhere in the code list [effective 4/1/2008]**
71 **Discharged/Transferred for Outpatient Services - another Facility [10/1/2001 - 9/30/2003 only]**
72 **Discharged/Transferred for Outpatient Services - this Facility [10/1/2001 - 9/30/2003 only]**

Debarred Provider - Payment Reason Code– (See Field # 54)

C **OPM has approved payment. Member is receiving continuing care.**
D **Denied [no payment, after 15 day grace period]**
G **Claim is within 15 day grace period.**
M **OPM has approved payment. Member resides in a Medically Underserved Area.**
U **Claim was paid, unknown reason.**
X **OPM has approved payment. Other/unspecified reason.**
blank **not applicable - not a debarred provider** *(Do not add the actual word "blank". Please leave the field empty).*

Medicare Payment Disposition Code – (See Field # 59)

A **Medicare Part A or Medicare Prepaid/Advantage Plan payment**
B **Medicare Part B or Medicare Prepaid/Advantage Plan payment**
C **Medicare Part A and Part B payments [ended 12/31/2005]**
C **Medicare Part D Prescription Drug Coverage payment [effective 1/1/2006]**
D **all charges applied to Medicare Part B Deductible, no Medicare payment**
E **Medicare Part A Benefit Period is Exhausted, no Medicare payment**
F **Not a Medicare Part A or Part B or Medicare Prepaid/Advantage Plan Benefit, no Medicare payment**
G **all charges applied to Medicare Part A Deductible, no Medicare payment**
H **Provider is not covered by the Medicare Prepaid/Advantage Plan, no Medicare payment**
J **Medicare Part A or Part B multi-line pricing; Medicare payment is indicated on another charge line**
K **No Medicare Part A benefit available, Medicare Part B provided payment**
N **Not enrolled in the Part of Medicare that would cover this service, no Medicare payment**
P **Speculative Medicare**
U **Medicare Part A and/or Part B payment (Unable to distinguish)**
X **Medicare Part A and/or Part B priced the claim but the carrier is unable to determine why there was no Medicare payment.**

blank **not enrolled in Medicare** *(Do not add the actual word "blank". Please leave the field empty).*

Carrier - Paid Indicator (HIPAA codes) – (See Fields #60, 62)

16 **Medicare Fee-for-Service/Advantage Plan**
BL **Other BlueCross BlueShield**
C1 **Other Commercial Care**
MA **Traditional Medicare (Part A)**
MB **Traditional Medicare (Part B)**
MU **Traditional Medicare (Unable to determine whether Part A and/or Part B)**
NF **No Fault Insurance**
SP **Speculative**
SU **Subrogation**
WC **Workers Compensation**
blank **this carrier paid as primary**-*(Do not add the actual word "blank". Please leave the field empty).*

.

Pricing Method– (See Fields #60, 66)

4 **Percentage of Technical Amount Paid - applied after appropriate savings have been deducted from the Total Covered Charges, but prior to the application of any deductible and/or coinsurance.**
5 **Dental Fee Schedule Allowance (Rate X the Number of Services)**
6 **Maximum Allowable Charge (MAC) - deductible and/or coinsurance applied to the MAC Amount.**
B **Percentage of FEP Allowable Charges - applied after appropriate savings have been deducted from the Total Covered Charges, but prior to the application of any deductible and/or coinsurance.**
D **Percentage of Total Covered Charges - applied directly to the Total Covered charges prior to the application of appropriate savings, deductible and/or coinsurance.**
E **Per Diem (Rate X the Number of Days) - deductible and/or coinsurance applied to the lesser of the Per Diem Amount or the Total Covered Charges. Applies only to inpatient claims.**
F **Medical Fee Schedule Allowance (Rate X the Number of Services)**
G **Diagnostic Related Group (DRG) Price Amount - deductible and/or coinsurance applied to the lesser of the DRG Amount or the Total Covered Charges. Applies only to inpatient claims.**
I **Encounter/Capitated Service - the service reported on this charge is considered encounter data as it is covered by a set fee paid to the provider regardless of whether or not services are rendered. No disbursement will occur as a result of this charge.**
K **Per Diem (Rate X the Number of Days) plus any deductible and/or coinsurance - Deductible and/or coinsurance is calculated on the Per Diem allowance to determine the amount the provider agreed to accept as payment in full. Applies only to inpatient claims.**
L **Percentage of Total Charges All Services - applied directly to the Total Charges All Services prior to the application of appropriate savings, deductible and/or coinsurance.**

M **Percentage of Negotiated Allowance - applied after the primary pricing method has been used to reduce the Total Covered Charges, but prior to the application of any other savings, deductible and/or coinsurance amounts.**

N **Percentage of Amount Paid Special Formula - the Pricing Percentage is applied after any non-covered amount, deductible and/or coinsurance has been deducted from the Billed Charges.**

U **Unspecified - the specific pricing method is not available.**

V **Priced by Vendor - such as PPO Provider Networks, etc. This should be used if it was priced by a vendor and do not know what method the Vendor used.**