FEHB Program Carrier Letter
All Community-Rated Carriers

U.S. Office of Personnel Manageme
Healthcare and Insurance

Letter No. 2012 - 15 **Date: May 25, 2012**

Fee-for-service [n/a] Experience-rated HMO [n/a] Community-rated HMO [14]

SUBJECT: Audit Requirements for Adjusted Community-Rating Plans

Some community-rated carriers participating in the Federal Employees Health Benefits Program (FEHBP) utilize an Adjusted Community Rating (ACR) methodology, which uses group-specific experience data to develop premium rates for the FEHBP and other fully-insured commercial groups. 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 the carriers must 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 only.

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 rates as large carriers and use an ACR methodology to develop the FEHBP rates for 2013 **must submit this data to the OIG when they submit the 2013 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 submit rates as large carriers are not required to submit this data at the time they submit the 2013 proposals. However, any carrier which submitted the data for its 2008, 2009, 2010, 2011, or 2012 proposals is required to submit the data for 2013. The systems should already be established to 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.

Medical Loss Ratio (MLR) Plans

Beginning in 2013 (2012 for Plans participating in the MLR Pilot Program), all carriers using an ACR or Community Rating by Class (CRC) rating methodology will also be required to submit FEHBP claims data used in their MLR calculation. Therefore, there will be two sets of claims data submissions required for ACR plans, one submission to support the experience period of the FEHBP rate development and one submission to support their MLR calculation (i.e., contract year). More information will be made available during next year's carrier letter.

Required Documentation

Please read and provide the requested documentation in the following section. This will ensure that all required and appropriate data is provided to the OIG. If the documents are not completed and returned then the claims submission will not be accepted.

- Required Claims Data Submission in an approved file format
  - Microsoft Access
  - Microsoft Excel
  - Other
- Completed Attachments 1 and 2 (Claim Fields) – updated
- Completed Attachment 3, Media Specification Form (for each file)
- Claim file layout
- Data Dictionary – if necessary

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 the field is not provided. Please include at the end of the listed fields any additional fields that you feel contain pertinent information **and 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.

All claims data should be submitted on CD, DVD, USB flash drive, or electronically transmitted to the OIG. The OIG prefers that carriers electronically transmit its claims data in **encrypted ASCII comma delimited** text files. **PLEASE DO NOT USE TAB DELIMITED TEXT FILES**. If you elect to send the information electronically, please inform the OIG, via the e-mail addresses noted below, when the file was sent and the file name. For plans that have not established an electronic transmission process, please contact the OIG technical representative (details below).

To meet recent security requirements, you must *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 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 emailed to Nekitra Tuell (Nekitra.Tuell@opm.gov). Please email the password 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. **Further, provide the names or headers of the fields in the claims tape provided to the OIG.** 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: 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: Date Format: YYYYMMDD	incurred

Please send the requested data and documentation to:

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

Questions regarding audit objectives or requirements should be directed to James L. Tuel, Jr., Chief, Community-Rated Audits Group on (724) 741-0713 or at jim.tuel@opm.gov. Technical questions regarding the claims database or requirements for data submission should be directed to Lewis Parker, Chief, Information Systems Audits Group, on (202) 606-4738 or at lewis.parker@opm.gov.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

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	Member First Name	First name of the member
5	Member Last Name	Last name of the member
6	Patient Identifier	Unique identifier of the patient within the Member Number.
7	Patient Date of Birth*	Patient age as of date of service or **complete (i.e., month, date, year)** date of birth. Date Format: YYYYMMDD
8	Patient First Name	First name of the patient
9	Patient Last Name	Last name of the patient
10	Patient Gender	F=Female; M=Male
11	Claim Number	The unique number assigned to this claim by the plan.
12	Claim/Charge Line #	The line number assigned to this charge. If the claim only has one charge line, the value will usually be 1.
13	Claim Type	Indicates the type of claim being reported (i.e. I = Inpatient Hospital, O = Outpatient Hospital, P = Physician, etc.)
14	First Date of Service *	The first billed date/incurred date of service for the charge. Date Format: YYYYMMDD
15	Last Date of Service*	The last date of service/discharge date for the charge. Date Format: YYYYMMDD
16	Number of Services/Days	The number of times the same service, etc. was rendered.
17	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.)
18	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.)
19	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.)
20	Diagnosis Code	The primary diagnosis for the charges on this line. Use ICD-9 or equivalent code.
20	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.
22	Procedure Modifier Code	Code that indicates additional information about the procedure (i.e. a specific body part, who performed the procedure, etc.)
23	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.
24	Performing Provider Name	Name of the Performing Provider (Last Name as a minimum).
25	Performing Provider Zip Code	Zip code of the provider who performed the service or rendered the care.
26	Performing Provider Specialty Code	Code that identifies the specialty of the Performing Provider.
27	Performing Provider Network Status	Code to indicate whether the performing provider is in the network (Y), out of the network (N)
28	Date Paid *	Date the plan paid the claim. Date Format: YYYYMMDD
29	Payee	Code to indicate the recipient of the insurance payment. P = Provider; S = Subscriber; T = 3rd party
30	Billed Charges Amount	Total amount charged by the performing provider for the service.
31	Allowed/Covered Amount	The amount of the billed charges that are covered by the plan.
32	Other Carrier Coverage Code	Code to indicate which, if any, other insurance has primary liability. Field is blank if this insurance is primary.
33	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.
34	Amount Paid by Other Insurance	Amount paid by another insurance for this service.
35	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.
36	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.
37	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

* Do not include the time in date fields

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	Member First Name	First name of the member
5	Member Last Name	Last name of the member
6	Patient Identifier	Unique identifier of the patient within the Member Number.
7	Patient First Name	First name of the patient
8	Patient Last Name	Last name of the patient
9	Patient Date of Birth*	Patient age as of date of service or complete date of birth. Date Format: YYYYMMDD
10	Patient Gender	F=Female; M=Male
11	Claim Number	The unique number assigned to each prescription by the plan.
12	Mail Order/Retail Claim Code	M=Mail Order; R=Retail Pharmacy in Network; O=Other
13	Prescription Number	Prescription number assigned by the pharmacy.
14	Date Filled*	Date the drug was dispensed by the pharmacy. Date Format: YYYYMMDD
15	NDC Number	National Drug Code (NDC) for the dispensed drug.
16	Drug Name	Name of the drug dispensed
17	Drug Strength	Drug strength (i.e., 500MG, 0.5%, etc.)
18	Unit of Measure	Indicates the dosage form of the drug dispensed “space” – Not specified ML – Milliliters GM – Grams EA - Each
19	Generic/Name Brand Code	Code to indicate if the drug dispensed is G = Generic or B = Name Brand.
20	Refill Number	The number of times this prescription has been refilled. Use zero for a new prescription.
21	Quantity Dispensed	Total quantity dispensed expressed in metric decimal units as submitted by the pharmacy.
22	Days Supply	The estimated number of days the prescription will last.
23	Pharmacy NABP Number	Unique ID number assigned by the National Association of Boards of Pharmacy (NABP) to the pharmacy that dispensed the prescription.
24	Pharmacy Name	Name of the pharmacy that dispensed the drug.
25	Pharmacy Zip Code	Zip code of the pharmacy location that dispensed the drug.
26	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.

27	Prescribing Physician Name	Name of the Prescribing Physician (Last Name as a minimum).
28	Date Paid *	Date the plan paid for the dispensed drug. Date Format: YYYYMMDD
29	Payee	Code to indicate the recipient of the insurance payment. P = Provider; S = Subscriber; T = 3rd party
30	Ingredient Cost	Cost of the ingredient that was dispensed
31	Amount Billed	Total amount of the submitted prescription.
32	Dispensing Fee	The dispensing fee submitted by the pharmacy.
33	Other Carrier Coverage Code	Code to indicate which, if any, other insurance has primary liability. Field is blank if this insurance is primary.
34	Other Carrier Amount Paid	Amount paid by another insurance for this service.
35	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.
36	Patient Liability Amount	The patient's out-of-pocket expense for the dispensed drug.
37	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

Please Complete and Return with each File

Plan Name:____

Plan Code:____

File Name:____
(Maximum 31 character name)

File Format:

___ Microsoft Access

___ Microsoft Excel

___ Other, describe: ____

Data Compression/Encryption:

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

___ Other, explain:____

Media Type & Recording Format:

___ CD

___ DVD

___ USB flash drive

___ Other, please describe:_____________________________________

Record Size:	**Record Count**:	**Amount Control Total:**
_____________	______________	_$____________________

Signature: ____________________________ **Phone:** _____________ **Date:** ________