Medicare Managed Care Manual

Chapter 20 - Plan Communications Guide

(Rev. 40, 11-14-03)

Appendix C - Record Layouts

Enrollment/Disenrollment Transaction

Field	Size	Position	Remarks
Claim Number	12	1 - 12	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)
Surname	12	13 - 24	Beneficiary Surname
First Name	7	25 - 31	Beneficiary Given Name
Middle Initial	1	32	Beneficiary Middle Initial
Sex	1	33	Beneficiary Sex Identification Code 1 = Male 2 = Female 0 = Unknown
Date of Birth	8	34 - 41	Beneficiary Birth Date; YYYYMMDD format
EGHP Flag	1	42	Y = EGHP member
PBP Identifier	3	43 – 45	Identification number of Plan Benefit Package
Filler	1	46	Spaces
Contract Number	5	47 - 51	Contract Number
Application Signature Date YYYYMMDD format	8	52 - 59	Date the applications was signed
Transaction Code	2	60 - 61	Beneficiary GHP Transaction Type Code 51 = Disenroll 60 = Employer Group Enroll* 61 = Enroll 71 = PBP Election
Disenrollment Reason	2	62 - 63	Disenrollment reason code
Effective Date YYYYMMDD format	8	64 - 71	Transaction Effective Date;
[Filler]	8	72 - 79	Spaces
Prior Commercial	1	80	Beneficiary GHP Prior Commercial Month Count 0 - 9, A - F = number of months a beneficiary was enrolled in Plan on a commercial basis prior to Plan's Medicare contract; otherwise, blank

Correction Transaction

Field	Size	Position	Remarks
Claim Number	12	1 - 12	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)
Surname	12	13 - 24	Beneficiary Surname
First Name	7	25 - 31	Beneficiary Given Name
Middle Initial	1	32	Beneficiary Middle Initial
Action Code	1	33	D = Institutional ON E = Medicaid ON F = Medicaid OFF G = Nursing Home Certifiable (NHC) ON
[Filler]	13	34 - 46	Spaces
Contract Number	5	47 - 51	GHP Contract Number
[Filler]	8	52 - 59	Spaces
Transaction Code	2	60 - 61	Beneficiary GHP Transaction Code; code is always 01
[Filler]	19	62 - 80	Spaces

Header Record for Enrollment/Disenrollment/Correction Data Files

Field	Size	Position	Remarks
Header Message	12	1 - 12	ZZZHEADERZZZ
[Filler]	21	13 - 33	
Payment Month	6	34 - 39	MMYYYY (Note that the date should be one month after the processing date, e.g., input 022002 for data submitted before the January 2002 cutoff date.)
[Filler]	41	40 - 80	

Transaction Reply - DATA FORMAT

	Field	Size	Position	Remarks
1.	Claim Number	12	1 - 12	Claimant Account Number
2.	Surname	12	13 - 24	Beneficiary Surname
3.	First Name	7	25 - 31	Beneficiary Given Name
4.	Middle Name	1	32 - 32	Beneficiary Middle Initial
5.	Sex Code	1	33 - 33	Beneficiary Sex Identification Code 0 = Unknown 1 = Male 2 = Female
6.	Date of Birth	8	34 - 41	YYYYMMDD Format
7.	Medicaid Indicator	1	42 - 42	1 = Medicaid 0 = No Medicaid
8.	Contract Number	5	43 - 47	Plan Contract Number
9.	State Code	2	48 - 49	Beneficiary Residence State Code
10.	County Code	3	50 - 52	Beneficiary Residence County Code
11.	Disability Indicator	1	53 - 53	1 = Disabled 0 = No Disability
12.	Hospice Indicator	1	54 - 54	1 = Hospice 0 = No Hospice
13.	Institutional/NHC Indicator	1	55 - 55	1 = Institutional 2 = NHC 0 = No Institutional
14.	ESRD Indicator	1	56 - 56	1 = End-Stage Renal Disease 0 = No End-Stage Renal Disease
15.	Transaction Reply Code	3	57 - 59	Transactions Reply Code
16.	Transaction Type Code	2	60 - 61	Transactions Type Code
17.	Entitlement Type Code	1	62 - 62	Beneficiary Entitlement Type Code
18.	Effective Date	8	63 - 70	YYYYMMDD Format; Present only when the Transaction Reply Code is one of the following: 11, 12, 16, 17, 21 – 23, 38, 52, 80, 82 – 84, 100, 109 and 112.
19.	WA Indicator	1	71 - 71	1 = Working Aged 0 = No Working Aged

20.	Plan Benefit Package ID	3	72 - 74	PBP number
21.	Filler	1	75	Spaces
22.	Transaction Date	8	76 - 83	YYYYMMDD Format; Present for all transaction reply codes.
23.	Filler	1	84 - 84	Space

24. Positions 85 - 96 are dependent upon the value of the TRANSACTION REPLY CODE. There are spaces for all codes except where indicated below.

a.	Disenrollment Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 14, 18, 84.
b.	Enrollment Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 83.
c.	Claim Number (new)	12	85 - 96	Present only when Transaction Reply Code is one of the following: 22, 25, 86.
d.	Date of Death	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 36, 90, 91, 92.
e.	Hospice Start Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 35, 71.
f.	Hospice End Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 72.
g.	ESRD Start Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 45, 73.
h.	ESRD End Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 74.
i.	Institutional/NHC Start Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 48, 75.
j.	Institutional/NHC End Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 49, 76.
k.	Medicaid Start Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 77.
l.	Medicaid End Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 78.
m.	Part A End Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 79.

n.	WA Start Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 66.
o.	WA End Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 67.
p.	Part A Reinstate Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 80.
q.	Part B End Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 81.
r.	Part B Reinstate Date	8	85 - 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 82.
s.	SCC	5	85 - 89	Beneficiary Residence State and County Code; Present only when Transaction Reply Code is the following: 85.
25.	District Office Code	3	97 - 99	Code of the originating district office; Present only when Transaction Type Code is 53.
26.	Part A AAPCC Pay Rate	7	100 - 107	Part A Demographic Payment Rate
27.	Part B AAPCC Pay Rate	7	108 - 115	Part B Demographic Payment Rate
28.	Source ID	5	116 - 120	Transaction Source Identifier
29.	Prior Plan Benefit Package ID	3	121 - 123	Prior PBP number; present only when transaction type code is 71.
30.	Filler	10	124 - 133	Spaces

RECORD LENGTH = 133 BLOCK SIZE = 23408

Monthly Membership Report DATA FORMAT

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	
6	First Initial	1	39-39	
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
	Demographic Health Status Indicators:			
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Working Aged	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional
18	NHC	1	65-65	Y = Nursing Home Certifiable

#	Field Name	Len	Pos	Description
19	Medicaid	1	66-66	Y = Medicaid Status
	Risk Adjuster Indicators:			
20	FILLER	1	67-67	SPACES
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon
*22	PIP-DCG	2	69-70	PIP-DCG Category - **Only on pre-2004 adjustments**
• *23	**Default Indicator**	**1**	**71-71**	Y = default RA factor in use • For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor.
• 24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
•	Fields 26 - 30 applicable to both Demographic and Risk Adjuster:			
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
• 28	Adjustment Reason Code	2	90-91	99 Always Spaces on Payment
29	Paymt/Adjustmt Start Date	8	92-99	YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	YYYYMMDD
31	Demographic Paymt/Adjustmt Rate A	9	108-116	-$$$$$.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	-$$$$$.99

#	Field Name	Len	Pos	Description
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	-$$$$$.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	-$$$$$.99
35	Blended Paymt/Adjustmt Rate A	9	144-152	-$$$$$.99
36	Blended Paymt/Adjustmt Rate B	9	153-161	-$$$$$.99
37	Total Paymt/Adjustmt	9	162-170	-$$$$$.99
	Additional Risk Adjuster Indicators:			
*38	FILLER	1	171-171	SPACES
39	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
40	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – **Only on pre-2004 adjustments**
• 41	FILLER	1	183-183	SPACES
42	FILLER	1	184-184	SPACES
43	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
44	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native

#	Field Name	Len	Pos	Description
*45	RA Factor Type Code	2	• 189-190	Type of factors in use (see Fields 24-25): C = Community CP = Community Post-Graft (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) EP = New Enrollee Post-Graft (ESRD) G = Graft (ESRD) I = Institutional IP = Institutional Post-Graft (ESRD)
*46	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
• *47	Previously Disabled Indicator	1	192-192	Y = Previously Disabled – **Only on post-2003 payments/adjustments**
*48	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
• *49	Future Flag Indicator	1	194-194	Y = Member eligible for new provision
• *50	FILLER	6	195-200	Spaces

Bonus Payment Report - Data File

Field	Size	Position	Remarks
Contract Number	5	1-5	Plan contract number
Run Date	8	6-13	YYYYMMDD; date the report was created
Payment Month	6	14-19	YYYYMM; the month payments are effective
Adjustment Reason Code	2	20-21	Reason for the adjustment; equal to spaces if a payment
Payment/Adjustment Start Month	6	22-27	YYYYMM
Payment/Adjustment End Month	6	28-33	YYYYMM
State and County Code	5	34-38	2-digit state code followed by 3-digit county code of residence
HIC	12	39-50	Beneficiary's claim number
Surname	7	51-57	First 7 letters of the last name
Initial	1	58-58	Initial of the first name
Sex	1	59-59	Gender; M=male. F=female
Date of Birth	8	60-67	YYYYMMDD
Bonus Percentage	5	68-72	Bonus payment percent; 5.000% or 3.000%
Total Blended Payment/Adjustment w/o Bonus	9	73-81	Total Payment/Adjustment without bonus
Bonus Part A Payment/Adjustment	8	82-89	Part A bonus payment/adjustment
Bonus Part B Payment/Adjustment	8	90-97	Part B bonus payment/adjustment
Total Bonus Payment/Adjustment	9	98-106	Total bonus payment/adjustment
Blended + Bonus Payment/Adjustment Part A	9	107-115	Part A payment/ adjustment with bonus
Blended + Bonus Payment/Adjustment	9	116-124	Part B payment/ adjustment with bonus Part B
Total Blended + Bonus Payment/Adjustment	9	125-133	Total payment/ adjustment with bonus

Monthly Summary Membership Report - Record Layout

Field	Size	Position	Remarks
Plan Identification Code	5	1 - 5	GHP contract number*
Run Date	8	6 - 13	YYYYMMDD format, the format of the plan's payment which reflects the payment adjustments listed in the report.*
Payment Date	6	14 - 19	YYYYMM format, the month for which the calculated beneficiary payments are effective.*
Adjustment Code	2	20 - 21	00 for P*
Reason for the Adjustment	10	22 - 31	Reason for the adjustment*
Number of Payments/Adjustments	7	32 - 38	Z7*
Number of Months	7	39 - 45	Z7*
Number of Members Part A	7	46 - 52	Z7*
Number of Months Part A	7	53 - 59	Z7*
Number of Members Part B	7	60 -66	Z7*
Number of Months Part B	7	67 - 73	Z7*
Part A Payment Dollars	13	74 - 86	Z13.2*
Part B Payment Dollars	13	87 - 99	Z13.2*
NET Payment Dollars	14	100 - 113	Z14.2*
Part A AAPCC	9	114 - 122	Z9.2, P
Part B AAPCC	9	123 - 131	Z9.2, P
Payment/Adjustment Character	1	130 - 130	P for Payment, A for adjustment

* Payment and Adjustment

ASUF (Age Sex Underwriting Factor) Record Layout

Demographic Factor Record:

	Field	Size	Position	Remarks
1.	ASUF Key	5	1-5	Value = "*****"
2.	ASUF Part	1	6	1 = PART A, 2 = PART B
3.	ASUF Age	2	7-8	01 = 85 & Over 02 = 80-84 03 = 75-79 04 = 70-74 05 = 65-69 06 = 60-64 07 = 55-59 08 = 45-54 09 = 35-44 10 = Under 35
4.	Entitlement	1	9-14	"PART A" or "PART B"
5.	Filler	5	15-19	Spaces
6.	Aged Disabled	8	20-27	"AGED" or "DISABLED"
7	Filler	8	28-35	Spaces
8.	Age Group	9	36-44	85 & Over 75-79 65-69 55-59 35-55 80-84 70-74 60-64 45-54 Under 35
9.	Filler	3	45-47	Spaces
10.	Male Instit	3	48-50	Institutional Factor for Males
11.	Filler	1	51	Spaces
12.	Male Medicaid	3	52-54	Non-institutional Medicaid Factor for Males
13.	Filler	1	55	Spaces
14.	Male Non-Medicaid	3	56-58	Non-institutional Non-Medicaid Factor for Males
15.	Filler	1	59	Spaces
16.	Male Working Aged	3	60-62	Working Aged Factor for Males
17.	Filler	1	63	Spaces
18.	Female Instit	3	64-66	Institutional Factor for Females
19.	Filler	1	67	Spaces
20.	Female Medicaid	3	68-70	Non-institutional Medicaid Factor for Females
21.	Filler	1	71	Spaces
22.	Female Non-Medicaid	3	72-74	Non-institutional Non-Medicaid Factor for Females
23.	Filler	1	75	Spaces
24.	Female Working Aged	3	76-78	Working Aged Factor for Females

AAPCC Dollar Amounts Record (Mainframe)

	Field	Size	Position	Remarks
1.	State Code	2	1-2	SSA State Code
2.	County Code	3	3-5	SSA County Code
3.	Filler	1	6	Spaces
4.	State	15	7-21	State Name
5.	County	20	22-41	County Name
6.	Part A Aged	6	42-47	Part A Aged Rate
7.	Part B Aged	6	48-53	Part B Aged Rate
8.	Part A Disable	6	54-59	Part A Disabled Rate
9.	Part B Disable	6	60-65	Part B Disabled Rate
10.	Part A ESRD	6	66-71	Part A End-Stage Renal Disease Rate
11.	Part B ESRD	6	72-77	Part B End-Stage Renal Disease Rate
12.	Filler	1	78	VALUE = *

AAPCC Dollar Amounts Record (PC)

Field	Size	Position	Remarks
State Code	2	1-2	SSA State Code
County Code	3	3-5	SSA County Code
Filler	1	6-6	Spaces
Quotes	1	7-7	Quotation Mark
State	2	8-9	State Name
Quotes	1	10-10	Quotation Mark
Filler	1	11-11	Spaces
Quotes	1	12-12	Quotation Mark
County	20	13-32	County Name
Quotes	1	33-33	Quotation Mark
Part A Aged	7	34-40	Part A Aged Rate
Filler	1	41-41	Spaces
PART B Aged	7	42-48	Part B Aged Rate
Filler	1	49-49	Spaces
Part A Disable	7	50-56	Part A Disabled Rate
Filler	1	57-57	Spaces
PART B Disable	7	58-64	Part B Disabled Rate
Filler	1	65-65	Spaces
Part A ESRD	7	66-72	Part A End Stage Renal Disease Rate
Filler	1	73-73	Spaces
Part B ESRD	7	74-80	Part B End Stage Renal Disease Rate

Working Aged Transaction

	Field	Size	Position	Remarks
1.	Record Type (mandatory)	4	1-4	Value = "HUSP"
2.	Filler	1	5-5	Space
3.	HIC Number (mandatory)	12	6-17	Beneficiary's HICN/RRB number
4.	Beneficiary's Surname (mandatory)	6	18-23	Last name of beneficiary
5.	Beneficiary's First Initial (mandatory)	1	24-24	Initial of beneficiary's first name
6.	Filler	1	25-25	Space
7.	Beneficiary's Date of Birth (mandatory)	6	26-31	Beneficiary's date of birth; format MMDDYY
8.	Beneficiary's Sex Code (mandatory)	1	32-32	Sex of beneficiary: 0 = Unknown 1 = Male 2 = Female
9.	Filler	5	33-37	Spaces
10.	Contract Number (mandatory)	5	38-42	Plan Contract Number (your Plan number - Hxxxx); Required for system generation of the Document Control Number
11.	Filler	14	43-56	Spaces
12.	Transaction Type (mandatory)	1	57-57	Identifies type of maintenance 0 = Add or change MSP data transaction 1 = Delete MSP data transaction
13.	Validity Indicator (mandatory)	1	58-58	Validity of MSP coverage Y = beneficiary has MSP coverage N = beneficiary does not have MSP coverage
14.	Filler	8	59-66	Spaces
15.	Insurer's Name (mandatory)	32	67-98	Primary Insurer's Name
16.	Insurer's Address-1 (mandatory)	32	99-130	Primary Insurer's Address Line 1
17.	Insurer's Address-2 (mandatory)	32	131-162	Primary Insurer's Address Line 2

18. Insurer's City (mandatory)	15	163-177	Primary Insurer's City
19. Insurer's State (mandatory)	2	178-179	Primary Insurer's State Code
20. Insurer's Zip Code (mandatory)	9	180-188	Primary Insurer's Zip Code
21. Policy Number	17	189-205	Primary Insurer's policy number of insured
22. MSP Effective Date (mandatory)	8	206-213	Effective date of MSP coverage; format MMDDYYYY
23. MSP Termination Date (mandatory)	8	214-221	Termination date of MSP coverage; format MMDDYYYY
24. Patient Relationship (mandatory)	2	222-223	Relationship of patient to insured 01 = Patient is insured 02 = Spouse
25. Subscriber First Name	9	224-232	First Name of Policyholder
26. Subscriber Last Name	16	233-248	Last Name of Policyholder
27. Employee ID Number	12	249-260	Employee ID Number; assigned by employer
28. Filler	1	261-261	Spaces
29. Employee Information Data	1	262-262	To whom the employment data applies P = Patient S = Spouse
30. Employer Name	24	263-286	Employer providing coverage
31. Employer's Address	18	287-304	Employer's Street Address
32. Employer's City	15	305-319	Employer's City
33. Employer's State	2	320-321	Employer's State Code
34. Employer's Zip Code	9	322-330	Employer's Zip Code
35. Insurance Group Number	20	331-350	Group number assigned by primary payer
36. Insurance Group	17	351-367	Name of group plan
37. Filler	8	368-375	Spaces
38. Date of Birth Century (mandatory)	2	376-377	Century in which the beneficiary was born; must be 18, 19, or 20
39. Filler	46	378-423	Spaces

Part B Claims Report (Record Type 5)

Field	Size	Position	Remarks
Contract Number	5	1	MCO Contract Number
Records Code	1	6	Record Type 5 – Home Health Agency
Can-Bic	12	7	HIC Number
Period From	8	19	Start Date - yyyymmdd
Period TO	8	27	End Date - yyyymmdd
HIMA-DOB	8	35	Date of Birth - yyyymmdd
PAT - Surname	6	43	First 6 positions of Benefiicaries surname
First Name	1	49	First letter of beneficiaries first name
Middle Initial	1	50	First letter of beneficiaries middle name
REIMB-AMT	11	51	Reimbursement amount for this claim
TOT-CHARGE	11	62	Total charges on the claim
RPT-DATE	6	73	Claims processed thru date - yyyymmdd
INTER-NUM	5	79	ID number of the contractor
PROV-NUM	6	84	Provider’s ID number.

PART B Claims Record (Record Type 6 and 7)

Field	Size	Position	Remarks
Contract Number	5	1	MCO Contract Number
Records Code	1	6	Record Type 5 – Home Health Agency
Can-Bic	12	7	HIC Number
Period From	8	19	Start Date - yyyymmdd
Period TO	8	27	End Date - yyyymmdd
HIMA-DOB	8	35	Date of Birth - yyyymmdd
PAT - Surname	6	43	First 6 positions of Benefiicaries surname
First Name	1	49	First letter of beneficiaries first name
Middle Initial	1	50	First letter of beneficiaries middle name
REIMB-AMT	11	51	Reimbursement amount for this claim
TOT-CHARGE	11	62	Total charges on the claim
RPT-DATE	6	73	Claims processed thru date - yyyymmdd
INTER-NUM	5	79	ID number of the contractor
PROV-NUM	10	84	Provider’s ID number.
Carrier-Control-No.	15	94	Control number assigned by Medicare carrier.
Total Provider Amt	11	109	Total provider payment amount for claim.
Patient Pmt. Amt.	11	120	Total bene payment amount for claim..
Amount Bene Paid	11	164	Amount paid by bene to provider
Total Submitted Chrge	11	175	Total submitted charge amount for the claim

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Appendix D - Enrollment Data Transmission Schedule

The following is a recommendation for the best time to transmit your data:

1. Monday through Friday **6:00 a.m. to 7:30 p.m.** ET
   Data **WILL** be received for monthly processing.

2. Monday through Friday **after 7:30 p.m.** ET
   Data **WILL NOT** be received for monthly processing until the next day.

3. Saturday, Sunday, and MCCOY down days
   Data **WILL NOT** be received for monthly processing.
   Refer to your annual GHP Plan Due Dates/MCCOY Down Schedule.

4. Enrollment Data Cutoff Day - **Data Due by 5:00 pm** ET.
   Plans can transmit enrollment data up to 5pm ET.
   Please refer to the GHP monthly schedule for each month's cutoff date.

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Appendix E - Explanation of Data Transmission Messages

Once your data has been received at the HDC, a job checks the data and copies it to a file for monthly processing. When this job is complete, you receive a message in your Transfer file where TOXX is your User ID:

'TOXX.@BGD5050.TRANSFER.DATA'

Instructions for viewing these messages are found in Section 2 of this manual.

1. If your data was accepted for monthly processing, the following message displays:

TRANSACTIONS RECEIVED
YYYYMMDD, HH:MM:SS

2. If the header record is missing or is not the first record in the file, or is not in the correct format, the following message displays:

PROCESSING STOPPED
HEADER RECORD IS MISSING OR INVALID
HEADER = [Value in header record]
DATE = [Date value in header record]
YYYYMMDD, HH:MM:SS

Your data will not be received for monthly processing. Verify your header record layout with the layout in Appendix C. Verify that the header record is the first record in your file and is not preceded by a blank line. Then retransmit your file.

3. If the date on the header record is greater than the current payment month, the following message displays:

DATA REJECTED
PROCESSING MONTH ON HEADER RECORD IS A FUTURE PROCESSING MONTH
RESUBMIT DURING CORRECT PROCESSING MONTH
PROCESSING MONTH = [Current Processing Month]
YYYYMMDD, HH:MM:SS

Your data will not be received for monthly processing. Verify that you have entered the correct date in the header record. For example, if you are transmitting data after the cutoff date in July and prior to the cutoff date in August, this data will be processed in August for the September payment. Your month should be "09" and the year should be the current year. Correct the header record date and retransmit.

4. If the date on the header record is for a prior payment month, the following message displays:

TRANSACTIONS RECEIVED
RETROACTIVE FOR: [Date from header record]
YYYYMMDD, HH:MM:SS

This data will not be processed for the current payment month. If the data should be processed retroactively, you must receive prior approval from DDS. Contact David P. Evans at 1-410-786-7613 to coordinate approval. If the date on the header record is incorrect and should be processed for the current payment month, correct the date and retransmit.

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Appendix F - MSP Maintenance Transaction Error Codes

MSP Maintenance Transaction edit rejects are denoted by a value of "SP" in the disposition field and the Reply Record. A trailer of "08" containing up to four error codes, will always follow. Listed below are the possible MSP Maintenance Transaction error codes with a description.

Error Codes	Description
SP11	Invalid MSP transaction record type (Mandatory) Non-blank, must be valid record type "HUSP," "HISP," or "HBSP"
SP12	Invalid HIC number (Mandatory) Non-blank, must be valid for Equatable conversion
SP13	Invalid beneficiary Surname (Mandatory) Non-blank, alphabetic
SP14	Invalid beneficiary first name initial (Mandatory) Non-blank, alphabetic
SP15	Invalid beneficiary date of birth (Mandatory) Non-blank, numeric
SP16	Invalid beneficiary Sex Code (Mandatory) Non-blank, must be "0," "1," or "2" 0 = unknown 1 = male 2 = female
SP17	Invalid contractor number (Mandatory) Non-blank, numeric, must be valid CMS assigned contractor number
SP18	Invalid document control number Mandatory for HUSP and HBSP Transactions only Blank for all others

Error Codes	Description
SP19	Invalid maintenance transaction type (Mandatory) Non-blank, must be either "0" or "1" 0 = Add/Change MSP Data transaction 1 = Delete MSP Data Transaction
SP20	Invalid Validity Indicator (Mandatory) Non-blank, must be "Y" or "N" Y = Beneficiary has MSP coverage N = Beneficiary does not have MSP coverage
SP21	Invalid MSP Code (Mandatory) Non-blank, A, B, C, D, E, F, G, H, I, or L.
SP22	Invalid Diagnosis Code 1 – 5 A through Z, 0 through 9, and spaces are valid
SP23	Invalid Remarks Code 1 – 3 01 - 12, 20 – 26, 30 - 44, 50 - 62, 70 - 72, and spaces are valid 01 = Beneficiary retired as of termination date 02 = Beneficiary's employer has less than 20 employees 03 = Beneficiary's employer has less than 100 employees 04 = Beneficiary is dually entitled to Medicare, based on ESRD and Age or ESRD and disability 05 = Beneficiary is not married 06 = The beneficiary is covered under the group health plan of a family member whose employer has less than 100 employees. 07 = Beneficiary's employer has less than 20 employees and is in a multiple or multi-employer plan which has elected the working aged exception 08 = Beneficiary's employer has less than 20 employees and is in a multiple or multi-employer plan which has NOT elected the working aged exception 09 = Beneficiary is self-employed. 10 = A family member of the beneficiary is self-employed. 20 = Spouse retired as of termination date. 21 = Spouse's employer has less than 20 employees. 22 = Spouse's employer has less than 100 employees. 23 = Spouse's employer has less than 100 employees but is in a qualifying multiple or multi-employer plan. 24 = Spouse's employer has less than 20 employees and is in a multiple or multi-employer plan which has elected the working aged exception

Error Codes	Description
	25 = Spouse's employer has less than 20 employees and is in a multiple or multi-employer plan which has NOT elected the working aged exception.
	26 = Beneficiary's spouse is self-employed.
	30 = Exhausted benefits under the plan.
	31 = Pre-existing condition exclusions exist.
	32 = Conditional payment criteria met.
	33 = Multiple primary payers, Medicare is tertiary payer.
	34 = Information has been collected indicating that there is not a parallel plan that covers medical services.
	35 = Information has been collected indicating that there is not a parallel plan that covers hospital services.
	36 = Denial sent by EGHP, claims paid meeting conditional payment criteria.
	37 = Beneficiary deceased.
	38 = Employer certification on file.
	39 = Health plan is in bankruptcy or insolvency proceedings.
	40 = The termination date is the beneficiary's retirement date.
	41 = The termination date is the spouse's retirement date.
	42 = Potential non-compliance case, beneficiary enrolled in supplemental plan.
	43 = GHP coverage is a legitimate supplemental plan.
	44 = Termination date equals transplant date.
	50 = Employment related accident.
	51 = Claim denied by workers comp.
	52 = Contested denial.
	53 = Workers compensation settlement funds exhausted.
	54 = Auto accident - no coverage
	55 = Not payable by black lung.
	56 = Other accident - no liability.
	57 = Slipped and fell at home.
	58 = Lawsuit filed - decision pending.
	59 = Lawsuit filed - settlement received.
	60 = Medical malpractice lawsuit filed.
	61 = Product liability lawsuit filed.
	62 = Request for waiver filed.
	70 = Data match correction sheet sent.
	71 = Data match record updated.
	72 = Vow of Poverty correction.
SPACES	

Error Codes	Description
SP24	Invalid Insurer type A through M and spaces are valid. A = Insurance or Indemnity B = HMO C = Preferred Provider Organization (PPO) D = Third Party Administrator arrangement under an administrative Service Only (ASO) contract without stop loss from any entity. E = Third Party Administrator arrangement with stop loss insurance issued from any entity. F = Self-Insured/Self-Administered. G = Collectively-Bargained Health and Welfare Fund. H = Multiple Employer Health Plan with at lease one employer who has more than 100 full and/or part time employees. I = Multiple Employer Health Plan with at least one employer who has more than 20 full and/or part time employees. J = Hospitalization Only Plan - A plan which covers only non-inpatient medical services. K = Medical Services Only Plan - A plan which covers only non-inpatient medical services.
SP24	M = Medicare Supplemental Plan, Medigap, Medicare Wraparound Plan or Medicare Carve Out Plan. SPACES = Unknown.
SP25	Invalid Insurer Name Spaces if not used, no low values or Insurer Name must be present if Validity Indicator = Y.
SP26	Invalid Insurer Address 1 and/or Address 2 Spaces if not used. If used, cannot be
SP27	Invalid Insurer City Spaces if not used, no low value, and not numeric.
SP28	Invalid Insurer State Spaces if not used, alphabetic, must match on valid state table.
SP29	Invalid Insurer Zip Code Cannot be low values. If present the first five positions must be numeric and the last four positions may be spaces. If foreign country “FC” state code the nine positions may be spaces if not used.

Error Codes	Description
SP30	Invalid Policy Number Spaces if not used, no low values.
SP31	Invalid MSP Effective Date (Mandatory) Non-blank, non-zero, numeric, number of days must correspond with the particular month. MSP Effective Date must be less than or equal to the current date.

OTHER EFFECTIVE DATE COVERAGE EDITS

Error Codes **Description**

If MSP code = A (Working Aged and Spousal Working Aged)
effective date must be the greater of:
X January 1, 1983 (830101)
X Calculated date bene turned 65 (first day of month)

If MSP code = B (ESRD)
effective date must be the greater of:
X October 1, 1981

If MSP code = D (no-fault)
effective date must be the greater of:
X December 1, 1980

If MSP code = E (Workers' Compensation)
effective date must be the greater of:
X July 1, 1966

If MSP Code = F (Federal/Public Health)
effective date must be greater of:
X July 1, 1966 (660701)

If MSP Code = H (Black Lung)
effective date must be greater of:
X July 1, 1973 (730701)

If MSP Code = I (Veterans' Administration)
effective date must be greater of:
July 1, 1966 (660701)

If MSP Code = G (Disabled) 43
effective date must be greater of:
X January 1, 1987 (870101)
X Prior to the 1st day of the month the beneficiary turns 65

If MSP Code = L (Liability)
effective date must be greater of:
X December 1, 1980

Error Codes	Description
SP32	Invalid MSP Termination date must be numeric, may be all zeroes if not used, if used, date must correspond with the particular month.

OTHER TERMINATION DATE COVERAGE EDITS

Error Codes	Description
	X If contractor number is that of the IRS/SSA datamatch project ("77777"), the term date may be equal to or greater than the effective date. X Cannot be greater than the current date plus 6 months, except for MSP code = B. X Cannot be greater then the first day the bene turned 65 if the MSP code is B or G.
SP33	Invalid Patient Relationship Numeric, must be zeroes. Values 01 through 19. 01 = Patient is Insured 02 = Spouse 03 = Natural Child, Insured has Financial Responsibility 04 = Natural Child, Insured does not have Financial responsibility 05 = Step Child 06 = Foster Child 07 = Ward of the Court 08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ Donor 12 = Cadaver Donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored Dependent 17 = Minor Dependent of a Minor Dependent 18 = Parent 19 = Grandparent
SP34	Invalid Subscriber First Name Spaces if not used, no low values.
SP35	Invalid Subscriber Last Name Spaces if not used, no low values.
SP36	Invalid Employee ID Number Spaces if not used, no low values.

Error Codes	Description
SP37	Invalid Sources Code A through W and spaces are valid. A = Claims Processing B = IRS/SSA/CMS Data Match C = First Claim Development D = IRS/SSA/CMS Data Match II E = Black Lung (DOL) F = Veterans (VA) G = Other Data Matches H = Workers' Compensation I = Notified by Beneficiary J = Notified by Provider K = Notified by Insurer L = Notified by Employer M = Notified by Attorney N = Notified by Group Health Plan /Primary Payer O = Initial Enrollment Questionnaire P = HMO Rate Cell Adjustment Q = Voluntary Insurer Reporting R = Office of Personnel Management Data Match S = Miscellaneous Reporting T = IRS/SSA/CMS Data Match III U = IRS/SSA/CMS Data Match IV V = IRS/SSA/CMS Data Match V W = IRS/SSA/CMS Data Match VI SPACES = Unknown
SP38	Invalid Employee Information Data Code Spaces if not used, alphabetic values P, S, M, F P = Patient S = Spouse M = Mother F = Father
SP39	Invalid Employer Name Spaces if not used, no low values.
SP40	Invalid Employer Address Spaces if not used.
SP41	Invalid Employer City Spaces if not used, no low values.

Error Codes	Description
SP42	Invalid Employer State Spaces if not used, alphabetic, must match on valid state table.
SP43	Invalid Employer Zip Code Spaces if not used, non-zero, must be within valid zip code range on zip code table. If foreign country "FC" state code the first five digits can be zeros and last four can be blanks.
SP44	Invalid Insurance Group Number Spaces if not used, no low values.
SP45	Invalid Insurance Group Name Spaces if not used, no low values.
SP46	Invalid Pre-paid Health Plan Date Numeric, number of days must correspond with the particular month and be in the range of 01 - 31.
SP47	Beneficiary MSP indicator not on for delete transaction.
SP48	MSP auxiliary record not found for delete data transaction.
SP49	MSP auxiliary occurrence not found for delete data transaction.
SP50	Invalid function for update or delete. Contractor number unauthorized.
SP51	MSP Auxiliary record has 17 occurrences and none can be replaced.
SP52	Invalid Patient Relationship Code which is mandatory for MSP Codes A, B and G when the Validity Indicator is "Y'. MSP Code — Patient Relationship Code A = Working Aged — 01 - Patient 02 - Spouse B = ESRD01 - Patient — 02 - Spouse 03 - Child 04 - Natural Child 05 - Step Child 18 - Parent G = Disabled — 01 - Patient 02 - Spouse 03 - Child

Error Codes	Description
	04 - Natural Child 05 - Step Child 18 - Parent
SP53	The maintenance transaction was for Working Aged EGHP and there is either an ESRD E6HP or Disability EGHP entry on file that has a termination date after the effective date on the incoming transaction or is not terminated, and the contract number on the maintenance transaction is not equal to "33333," "66666," "77777," or "88888."
SP54	MSP Code A, B or G has an Effective Date that is in conflict with the calculated age 65 date of the Beneficiary. For MSP Code A, the Effective Date must not be less than the date at age 65. For MSP Code G, the Effective Date must not be greater than the date at age 65.
SP55	MSP Effective Date is less than the earliest Beneficiary Part A or Part B Entitlement Date.
SP56	MSP Pre-paid Health Plan (PHP) Date must be = to or greater than MSP effective date or less than MSP Termination date.
SP57	Termination Date Greater than 6 months prior to date Added for Contractor other than 33333 or 77777.
SP58	Invalid Insurer type, MSP code, and validity indicator combination If MSP code is equal to "A" or "B" or "G" and validity indicator is equal to "Y" then insurer type must not be equal to spaces.
SP59	Invalid Insurer type, and validity indicator combination If validity indicator is equal to "N" then insurer type must be equal to spaces.
SP60	Other Insurer type for same period on file (Non "J" or "K") Insurer type on incoming maintenance record is equal to "J" or "K" and Insurer type on matching auxiliary record is not equal to "J" or "K". Note: Edit only applies to MSP codes - A - Working Aged B - ESRD EGHP G - Disability EGHP

Error Codes	Description
SP61	Other Insurer type for same period on file (“J” or “K”) Insurer type on incoming maintenance record is not equal to “J” or “K” and Insurer type on matching auxiliary record is equal to “J” or “K”. Note: Edit only applies to MSP codes - A - Working Aged B - ESRD EGHP G - Disability EGHP
SP62	Incoming termination date is less than the MSP effective date.
SP66	MSP effective date is greater than the effective date on matching occurrence on auxiliary file.
SP67	Incoming termination date is less than posted termination date for Provident.
SP69	Updating contractor number is not equal to the Header Contractor number. Data match and IEQ MSP TRANSACTION only.
SP70	IEQ MSP TRANSACTIONS must have a Source Code of “0.” Bypass SP70 for HICR HCSP maintenance transactions.
SP71	SOURCE CODE IS “O,” “P,” “Q,” “R,” or “S” for an existing record on the MSP auxiliary file, and the source code on the MSP transaction record are different.

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Appendix G - Adjustment Reason Codes

Adjustment reason codes identify the type of adjustment made for payment for a member. They are included for all adjustments contained on the Monthly Membership Report and the Bonus Payment Report. The following list contains the current codes.

Code	Description
01	Notification of Death
02	Retroactive Enrollment
03	Retroactive Disenrollment
04	Correction of Enrollment Date
05	Correction of Disenrollment Date
06	Correction of Part A Entitlement
07	Retroactive Hospice Status
08	Retroactive ESRD Status
09	Retroactive Institutional Status
10	Retroactive Medicaid Status
11	Retroactive SCC Change
12	Correction of Date of Death
13	Correction of Date of Birth
14	Correction of Sex
15	Retroactive Change in DCG Category
16	Graham Rudman
17	RTG Change
18	AAPC Rate Change
19	Correction of Part B Entitlement
20	Retroactive Working Aged Status
21	Retroactive NHC Status
22	Disenroll Due to Prior ESRD
23	Demo Factor Adjustment
24	Retroactive Change to Bonus Payment
25	Retro Risk Adj. Factor change / Recon
26	Retro Risk Adj. Factor change / Ongoing
27	Retroactive Congestive Heart Failure
28	BIPA606 Rate change
29	Hospice Rate Change

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Appendix H - CMS Central Office Contact Information

If you have any questions on **policy information** contained in this letter, please contact your CMS Central Office Health Insurance Specialist assigned to your regional area:

1. Boston:	Jacquline Buise	410.786.7607
2. New York:	Juan Lopez	410.786.7621
3. Philadelphia:	James Dorsey	410.786.1143
4. Atlanta:	Brenda Hicks	410.786.1159
5. Chicago:	Janice Bailey	410.786.7603
6. Dallas:	Joanne Weller	410.786.5111
7. Kansas City:	Gloria Webster	410.786.7655
8. Denver:	Luigi Distefano	410.786.7611
9. San Francisco:	Ed Howard OR	410.786.6368
	Jim Logan	410.786.7625
10. Seattle:	David Evans	410.786.0412

If you have any questions on **technical information** contained in this letter, please contact your CMS Central Office Computer Specialist assigned to your regional area:

Boston, New York, Philadelphia, Kansas City:	Sarah Brown at 410.786.6358
Atlanta, Chicago, Dallas:	Susan Hartmann at 410.786.6192
Denver, San Francisco, Seattle:	Sue Mathis at 410.786.6938

Data Processing Vendor

The company mentioned below is under contract with CMS and is authorized to take M+C organization records and send them to CMS. It provides instructions to the M+C organization about how to prepare reports for proper submission through their facilities to the CMS Data Center. M+C organizations are to negotiate directly with this contractor.

Systems Management Specialist
9171 Oso Avenue
Chatsworth, CA 91311
Contact: Medicare Account Representative

1-800-527-8737 ext. 79616

M+C organizations wishing to contract with this contractor are not required to purchase more than minimum services. Minimum services are limited to online eligibility look-up for their members' records and online entry of enrollments. The charge for the minimum services cannot exceed the rate agreed to by the contractor in their contract with CMS. M+C organizations may also contract for online submission of disenrollments and correction records and for access to their reports in GROUCH. M+C organizations needing more information should contact the above contractor directly.