Medicare Part C Plan Reporting Requirements
Technical Specifications Document

Version: January 15, 2009

Prepared by:
Centers for Medicare & Medicaid Services
Center for Drug and Health Plan Choice

Table of Contents

BACKGROUND AND INTRODUCTION

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42CFR §422.516 (a). Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements are also found in the Final Rule entitled "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-F), and in the interim final rule (CMS 4138-IFC).

The 2009 Part C Reporting Requirements document provides a description of the measures, reporting timeframes and deadlines, and specific data elements for each measure. The document has completed OMB review and approval in compliance with the Paperwork Reduction Act of 1995, and its OMB control number is 0938-1054.

The technical specifications contained in this document should be used to develop a common understanding of the data, to assist organizations in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to CMS, and to reduce the need for organizations to correct and resubmit data. These technical specifications are identical in content to the 2009 Part C Reporting Requirements document as referenced in the prior paragraph, and do not alter or add to the data collection described therein. This document provides a simplified, user-friendly guide to the information that received OMB clearance.

Each Part C Reporting Requirement section of this document has the following information presented in a standardized way for ease of use:

A. Data element definitions - details for each data element reported to CMS,

B. Notes - additional clarifications to a reporting section derived from the responses to comments received under the OMB clearance process.

GENERAL INFORMATION

All measures included in these technical specifications are subject to audit in 2010. Organizations for which these specifications apply will be required to collect these data beginning on January 1, 2009. Reporting will vary depending on the plan type and measure. Some measures will be reported annually, while others will be reported quarterly or semi-annually.

The following data elements in the measures listed in this document are considered proprietary and, therefore, are not subject to public disclosure under provisions of the Freedom of Information Act (FOIA):

- Per service costs in the benefit utilization measure (Benefit Utilization)
- Employer DBA and Legal Name, Employer Address, Employer Tax

Identification Numbers (Employer Group Sponsors)
- Total agent compensation related to sales (Agent Compensation Structure)

In order to provide Part C sponsors guidance on the actual process of entering reporting requirements data into the Health Plan Management System, a separate the HPMS Plan Reporting Module User Guide will be released at a later date.

Exclusions from Reporting

National PACE plans and 1833 cost plans are excluded from reporting all Part C Reporting Requirements measures.

Timely Submission of Data

Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline. CMS expects that data are accurate on the date they are submitted. Data submitted after the given reporting period deadline shall be considered late, and may not be incorporated within CMS data analyses and reporting. Only data that reflect a good faith effort by an organization to provide accurate responses to Part C reporting requirements will count as data submitted in a timely manner. It is unacceptable for organizations to submit "placeholder" data (e.g., submitting the value "0" in reporting fields in HPMS) for the sole purpose of meeting a reporting deadline.

Correction of Previously Submitted Data

CMS expects organizations to promptly correct all previously submitted data if it is later determined that the data were erroneous. Corrections of previously submitted data are appropriate if they are due to an error made at the date of the original submission. Organizations are not required to update previously submitted data as a result of subsequent information received by the organization after the reporting deadline for the section at issue. Once a reporting deadline has passed, organizations that need to correct data must submit a formal request to resubmit. Data corrections may be submitted until one year from the required submission date. Organizations needing to submit corrected data should request a resubmission in the HPMS Plan Reporting Module. Detailed instructions will be provided in the HPMS Plan Reporting Module User Guide.

Due Date Extension Requests

Organizations may request due date extensions if complete and accurate data cannot be produced by the reporting section deadline. Organizations should not submit due date extension requests until they have data available to submit; even if this means the original due date is missed. Due date extensions may be granted to allow seven calendar days from the date the request is reviewed by CMS for the organization to submit data via

HPMS. Failure to resubmit after requesting a resubmission is considered overdue. Organizations requiring a due date extension should request a resubmission in the HPMS Plan Reporting Module. Detailed instructions will be provided in the HPMS Plan Reporting Module User Guide.

REPORTING REQUIREMENTS SUMMARY

The following summary table provides an overview of the parameters around each of the Part C reporting requirements measures. This information is also presented for each measure in the more detailed measure descriptions which follow in this document.

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
1. Benefit Utilization	CCP, PFFS, Demo, MSA (includes all 800 series plans), Employer/Union Direct Contract	1/year PBP	1/1-12/31	8/31 of the following year.
2. Procedure Frequency	CCP, PFFS, Demo, MSA (includes all 800 series plans), Employer/Union Direct Contract	1/year Contract	1/1-12/31	5/31 of following year
3. Serious Reportable Adverse Events	CCP, PFFS, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	1/year Contract	1/1-12/31	5/31 of following year
4. Provider Network Adequacy	CCP, 1876 Cost, Demo (includes all 800 series plans)	1/year Contract	1/1 - 12/31	2/28 of following year
5. Grievances	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	4/Year PBP	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year
6. Organization Determinations/ Reconsiderations	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

7. Employer Group Plan Sponsors	CCP, PFFS, 1876 Cost, Demo, MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contract	2/year PBP	1/1 - 6/30 7/1- 12/31	8/31 2/28 of following year
8. PFFS Plan Enrollment Verification Calls	PFFS (800-series plans should NOT report)	1/year PBP	1/1- 12/31	2/28 of following year
9. PFFS Provider Payment Dispute Resolution Process	PFFS (includes all 800 series plans), Employer/Union Direct Contract	1/year PBP	1/1- 12/31	2/28 of following year
10. Agent Compensation Structure	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans)	1/year Contract	1/1- 12/31	2/28 of following year
11. Agent Training and Testing	CCP, PFFS, 1876 Cost, Demo, MSA (800-series plans should NOT report)	1/year Contract	1/1- 12/31	2/28 of following year
12. Plan Oversight of Agents	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans)	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1- 12/31	5/31 8/31 11/30 2/28 of following year
13. SNPS Care Management	SNPs (includes all 800 series plans)	1/Year PBP	1/1- 12/31	5/31 of following year

Note: For #4, Employer/Union Direct Contracts are not included since they currently only offer PFFS plans. If, at a later date, PFFS plans are required to report on this measure and/or Direct Contracts are allowed to offer other kinds of MA plans, they should be required to report on this measure as well.

MEASURES

1. Benefit Utilization

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
1. Benefit Utilization	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	1/year PBP	1/1-12/31	8/31 of the following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Benefit Utilization Measure
1.1	CMS issued contract number
1.2	Plan Benefit Package (PBP) ID
1.3	Number of member months for enrollees who had access to the Inpatient Facility service under their plan benefit package during the reporting period
1.4	Unique number of plan enrollees who used the Inpatient Facility service
1.5	Appropriate code to identify how you capture utilization data for Inpatient Facility services
1.6	Total number of Inpatient Facility services used by plan enrollees during the period
1.7	Reimbursement amount from the plan to providers for Inpatient Facility services used during the period.

1.8	Total cost sharing paid by members directly to providers for Inpatient Facility services used during the period
1.9	Total payments made to providers for Inpatient Facility services covered under original Medicare
1.10	Cost sharing that would be required for covered Inpatient Facility services using original Medicare requirements
1.11	Number of member months for enrollees who had access to the Skilled Nursing Facility service under their plan benefit package during the reporting period
1.12	Unique number of plan enrollees who used the Skilled Nursing Facility service
1.13	Appropriate code to identify how you capture utilization data for Skilled Nursing Facility services
1.14	Total number of Skilled Nursing Facility services used by plan enrollees during the period
1.15	Reimbursement amount from the plan to providers for Skilled Nursing Facility services used during the period
1.16	Total cost sharing paid by members directly to providers for Skilled Nursing Facility services used during the period
1.17	Total payments made to providers for Skilled Nursing Facility services covered under original Medicare
1.18	Cost sharing that would be required for covered Skilled Nursing Facility services using original Medicare requirements
1.19	Number of member months for enrollees who had access to the Home Health service under their plan benefit package during the reporting period
1.20	Unique number of plan enrollees who used the Home Health service
1.21	Code to identify how you capture utilization data for Home Health services
1.22	Total number of Home Health services used by plan enrollees during the period
1.23	Reimbursement amount from the plan to providers for Home Health services used during the period
1.24	Total cost sharing paid by members directly to providers for Home Health services used during the period
1.25	Total payments made to providers for Home Health services covered under original Medicare
1.26	Cost sharing that would be required for covered Home Health services using original Medicare requirements
1.27	Number of member months for enrollees who had access to the Ambulance service under their plan benefit package during the reporting period
1.28	Unique number of plan enrollees who used the Ambulance service
1.29	Code to identify how you capture utilization data for Ambulance services
1.30	Total number of Ambulance services used by plan enrollees during the

	period
1.31	Reimbursement amount from the plan to providers for Ambulance services used during the period
1.32	Total cost sharing paid by members directly to providers for Ambulance services used during the period
1.33	Total payments made to providers for Ambulance services covered under original Medicare
1.34	Cost sharing that would be required for covered Ambulance services using original Medicare requirements
1.35	Number of member months for enrollees who had access to the DME/Prosthetics/Supplies service under their plan benefit package during the reporting period
1.36	Unique number of plan enrollees who used the DME/Prosthetics/Supplies service
1.37	Appropriate code to identify how you capture utilization data for DME/Prosthetics/Supplies services
1.28	Total number of DME/Prosthetics/Supplies services used by plan enrollees during the period
1.39	Reimbursement amount from the plan to providers for DME/Prosthetics/Supplies services used during the period
1.40	Total cost sharing paid by members directly to providers for DME/Prosthetics/Supplies services used during the period
1.41	Total payments made to providers for DME/Prosthetics/Supplies services covered under original Medicare
1.42	Cost sharing that would be required for covered DME/Prosthetics/Supplies services using original Medicare requirements
1.43	Number of member months for enrollees who had access to the OP Facility – Emergency service under their plan benefit package during the reporting period
1.44	Unique number of plan enrollees who used the OP Facility – Emergency service
1.45	Appropriate code to identify how you capture utilization data for OP Facility – Emergency services
1.46	Total number of OP Facility – Emergency services used by plan enrollees during the period
1.47	Reimbursement amount from the plan to providers for OP Facility – Emergency services used during the period
1.48	Total cost sharing paid by members directly to providers for OP Facility – Emergency services used during the period
1.49	Total payments made to providers for OP Facility – Emergency services covered under original Medicare
1.50	Cost sharing that would be required for covered OP Facility – Emergency services using original Medicare requirements
1.51	Number of member months for enrollees who had access to the OP Facility – Surgery service under their plan benefit package during the

	reporting period
1.52	Unique number of plan enrollees who used the OP Facility – Surgery service
1.53	Appropriate code to identify how you capture utilization data for OP Facility – Surgery services
1.54	Total number of OP Facility – Surgery services used by plan enrollees during the period
1.55	Reimbursement amount from the plan to providers for OP Facility – Surgery services used during the period
1.56	Total cost sharing paid by members directly to providers for OP Facility – Surgery services used during the period
1.57	Total payments made to providers for OP Facility – Surgery services covered under original Medicare
1.58	Cost sharing that would be required for covered OP Facility – Surgery services using original Medicare requirements
1.59	Number of member months for enrollees who had access to the OP Facility – Other service under their plan benefit package during the reporting period
1.60	Unique number of plan enrollees who used the OP Facility – Other service
1.61	Code to identify how you capture utilization data for OP Facility – Other services
1.62	Total number of OP Facility – Other services used by plan enrollees during the period
1.63	Reimbursement amount from the plan to providers for OP Facility – Other services used during the period
1.64	Total cost sharing paid by members directly to providers for OP Facility – Other services used during the period
1.65	Total payments made to providers for OP Facility – Other services covered under original Medicare
1.66	Cost sharing that would be required for covered OP Facility – Other services using original Medicare requirements
1.67	Number of member months for enrollees who had access to the Professional service under their plan benefit package during the reporting period
1.68	Unique number of plan enrollees who used the Professional service
1.69	Code to identify how you capture utilization data for Professional services
1.70	Total number of Professional services used by plan enrollees during the period
1.71	Reimbursement amount from the plan to providers for Professional services used during the period
1.72	Total cost sharing paid by members directly to providers for Professional services used during the period
1.73	Total payments made to providers for Professional services covered under original Medicare

1.74	Cost sharing that would be required for covered Professional services using original Medicare requirements
1.75	Number of member months for enrollees who had access to the Part B Rx service under their plan benefit package during the reporting period
1.76	Unique number of plan enrollees who used the Part B Rx service
1.77	Code to identify how you capture utilization data for Part B Rx services
1.78	Total number of Part B Rx services used by plan enrollees during the period
1.79	Reimbursement amount from the plan to providers for Part B Rx services used during the period
1.80	Total cost sharing paid by members directly to providers for Part B Rx services used during the period
1.81	Total payments made to providers for Part B Rx services covered under original Medicare
1.82	Cost sharing that would be required for covered Part B Rx services using original Medicare requirements
1.83	Number of member months for enrollees who had access to the Other Medicare Part B service under their plan benefit package during the reporting period
1.84	Unique number of plan enrollees who used the Other Medicare Part B service
1.85	Code to identify how you capture utilization data for Other Medicare Part B services
1.86	Total number of Other Medicare Part B services used by plan enrollees during the period
1.87	Reimbursement amount from the plan to providers for Other Medicare Part B services used during the period
1.88	Total cost sharing paid by members directly to providers for Other Medicare Part B services used during the period
1.89	Total payments made to providers for Other Medicare Part B services covered under original Medicare
1.90	Cost sharing that would be required for covered Other Medicare Part B services using original Medicare requirements
1.91	Number of member months for enrollees who had access to the Transportation service under their plan benefit package during the reporting period
1.92	Unique number of plan enrollees who used the Transportation service
1.93	Code to identify how you capture utilization data for Transportation services
1.94	Total number of Transportation services used by plan enrollees during the period
1.95	Reimbursement amount from the plan to providers for Transportation services used during the period
1.96	Total cost sharing paid by members directly to providers for Transportation services used during the period

1.97	Number of member months for enrollees who had access to the Dental service under their plan benefit package during the reporting period
1.98	Unique number of plan enrollees who used the Dental service
1.99	Code to identify how you capture utilization data for Dental services
1.100	Total number of Dental services used by plan enrollees during the period
1.101	Reimbursement amount from the plan to providers for Dental services used during the period
1.102	Total cost sharing paid by members directly to providers for Dental services used during the period
1.103	Number of member months for enrollees who had access to the Vision service under their plan benefit package during the reporting period
1.104	Unique number of plan enrollees who used the Vision service
1.105	Code to identify how you capture utilization data for Vision services
1.106	Total number of Vision services used by plan enrollees during the period
1.107	Reimbursement amount from the plan to providers for Vision services used during the period
1.108	Total cost sharing paid by members directly to providers for Vision services used during the period
1.109	Number of member months for enrollees who had access to the Hearing service under their plan benefit package
1.110	Unique number of plan enrollees who used the Hearing service
1.111	Code to identify how you capture utilization data for Hearing services
1.112	Total number of Hearing services used by plan enrollees during the period
1.113	Reimbursement amount from the plan to providers for Hearing services used during the period
1.114	Total cost sharing paid by members directly to providers for Hearing services used during the period
1.115	Number of member months for enrollees who had access to the Health & Education service under their plan benefit package during the reporting period
1.116	Unique number of plan enrollees who used the Health & Education service
1.117	Code to identify how you capture utilization data for Health & Education services
1.118	Total number of Health & Education services used by plan enrollees during the period
1.119	Reimbursement amount from the plan to providers for Health & Education services used during the period
1.120	Total cost sharing paid by members directly to providers for Health & Education services used during the period
1.121	Number of member months for enrollees who had access to the Other (Non-Covered) service under their plan benefit package during the reporting period

1.122	Unique number of plan enrollees who used the Other (Non-Covered) service
1.123	Code to identify how you capture utilization data for Other (Non-Covered) services
1.124	Total number of Other (Non-Covered) services used by plan enrollees during the period
1.125	Reimbursement amount from the plan to providers for Other (Non-Covered) services used during the period
1.126	Total cost sharing paid by members directly to providers for Other (Non-Covered) services used during the period
1.127	Number of member months for enrollees who had access to the Medical services under their plan benefit package during the reporting period
1.128	Unique number of plan enrollees who used the Medical services
1.129	Reimbursement amount from the plan to providers for Medical services used during the period
1.130	Total cost sharing paid by members directly to providers for Medical services used during the period
1.131	Total payments made to providers for Medical services covered under original Medicare
1.132	Cost sharing that would be required for covered Medical services using original Medicare requirements
1.133	Total number of enrollees under the plan during the reporting period
1.134	Number of member months during the reporting period
1.135	Dollar figure representing premiums collected over the course of the entire reporting period for this plan
1.136	Dollar figure representing CMS revenue collected under the plan over the course of the entire reporting period inclusive of rebates applied to A/B services
1.137	Dollar figure representing CMS rebates for A and B Services under the plan over the course of the entire reporting period
1.138	Dollar figure representing reserves for outstanding claims from the reporting period

B. Notes

This measure is an HPMS upload. CMS will provide a data entry template to facilitate the creation of the upload file at a later date.

Data on specific services apply to plan benefits paid for with federal funding, state funding, group sponsor funding and member premiums. These data collections are for MA contracts in the individual market and for employer group offerings. It is the responsibility of an MA organization to verify the data received from providers for non-Medicare covered items such as dental services, vision care, and wellness programs.

Only rebates applied to A/B services and additional non-prescription drug benefits are to be included in reporting of rebates. All rebates are to be included except for those designated to reducing Part B and Part D premiums.

When completing this table, "Plan Experience" shall include all plan benefits furnished, regardless of their representation in the approved bid. Additionally, "Plan Experience" shall include experience for all enrollees, including those in ESRD status. "Plan Experience" shall exclude that experience for optional supplemental benefits.

Since this element is reported at the PBP level, we expect that for 800-series PBPs, the experience reported may be a blend of several EGWP arrangements.

Analysis of "800-series" bids will be conducted separately from the individual market plans because employers often purchase benefits beyond Medicare covered services, and in excess of the benefits included in their bids. The utilization of employer group members reflects these richer benefits and the induced impacts of more generous cost sharing.

The core analysis of this reporting measure will be a comparison of total plan revenues to plan expenses by category (benefit, non-benefit expense, and margin). This analysis will not be biased by the source of revenue; be it CMS bid-based payment, CMS rebate, member premium, or group contribution.

2. Procedure Frequency

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
2. Procedure Frequency	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type. NOTE: ORGANIZATIONS THAT CURRENTLY REPORT HEDIS MEASURES ARE NOT REQUIRED TO REPORT A SUBSET OF THE ELEMENTS UNDER THIS MEASURE.	1/year Contract	1/1-12/31	5/31 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Procedure Frequency Measure
2.1*	Number of Enrollees receiving Cardiac Catheterization
2.2	Number of Enrollees receiving Open coronary angioplasty
2.3	Number of Enrollees receiving PTCA or Coronary Atherectomy with CABG
2.4	Number of Enrollees receiving PTCA or Coronary Atherectomy

	with insertion of drug-eluting coronary artery stent (s)
2.5	Number of Enrollees receiving PTCA or Coronary Atherectomy with insertion of non-drug-eluting coronary artery stent (s)
2.6	Number of Enrollees receiving PTCA or Coronary Atherectomy without insertion of Coronary Artery Stent
2.7*	Number of Enrollees receiving Total Hip Replacement
2.8*	Number of Enrollees receiving Total Knee Replacement
2.9	Number of Enrollees receiving Bone Marrow Transplant
2.10	Number of Enrollees receiving Heart Transplant
2.11	Number of Enrollees receiving Heart/Lung Transplant
2.12	Number of Enrollees receiving Kidney Transplant
2.13	Number of Enrollees receiving Liver Transplant
2.14	Number of Enrollees receiving Lung Transplant
2.15	Number of Enrollees receiving Pancreas Transplant
2.16	Number of Enrollees receiving Pancreas/Kidney Transplant
2.17*	Number of Enrollees receiving CABG
2.18	Number of Enrollees receiving Gastric Bypass
2.19	Number of Enrollees receiving Excision or Destruction of Lesion or Tissue of Lung (with cancer diagnosis as specified)
2.20*	Number of Enrollees receiving Excision of Large Intestine (with cancer diagnosis as specified)
2.21*	Number of Enrollees receiving Mastectomy (with cancer diagnosis as specified)
2.22*	Number of Enrollees receiving Lumpectomy (with cancer diagnosis as specified)
2.23*	Number of Enrollees receiving Prostatectomy (with cancer diagnosis as specified)

B. Notes

This measure requires direct data entry into HPMS.

The starred measures in the table above are also collected through HEDIS reporting. Organizations currently submitting HEDIS data will continue to submit those elements through HEDIS. If an organization reports these measures in HEDIS, it is not required to report it again under these requirements. (This includes PFFS contracts who voluntarily report HEDIS data.)

The codes listed in Appendix 1 should be used to identify the procedures.

The counts represented in each data element under this measure need not be mutually exclusive.

CMS will consider the data submitted in light of contract enrollment when determining an analysis plan. We understand that HEDIS reporting is not required on the overlapping elements for contracts with less than 1,000 enrollees.

3. Serious Reportable Adverse Events (SRAEs)

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
3. Serious Reportable Adverse Events	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	1/year Contract	1/1-12/31	5/31 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Serious Reportable Adverse Events Measure (includes SRAEs and HACs)
3.1	Number of total surgeries
3.2	Number of surgeries on wrong body part
3.3	Number of surgeries on wrong patient
3.4	Number of wrong surgical procedures on a patient
3.5	Number of surgeries with post-operative death in normal health patient
3.6	Number of surgeries with foreign object left in patient after surgery
3.7	Number of Air Embolism events
3.8	Number of Blood Incompatibility events
3.9	Number of Stage III & IV Pressure Ulcers
3.10	Number of fractures
3.11	Number of dislocations
3.12	Number of intracranial injuries
3.13	Number of crushing injuries
3.14	Number of burns
3.15	Number of Vascular Catheter-Associated Infections

3.16	Number of Catheter-Associated UTIs
3.17	Number of Manifestations of Poor Glycemic Control
3.18	Number of SSI (Mediastinitis) after CABG
3.19	Number of SSI after certain Orthopedic Procedures
3.20	Number of SSI following Bariatric Surgery for Obesity
3.21	Number of DVT and pulmonary embolism following certain orthopedic procedures

B. Notes

This measure requires direct data entry into HPMS.

See Appendix 2 for the codes to identify Serious Reportable Adverse Events.

4. Provider Network Adequacy

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
4. Provider Network Adequacy	01 – Local CCP 05 - Demo 06 – 1876 Cost 11 – Regional CCP 15 – RFB Local CCP Organizations should include all 800 series plans.	1/year Contract	1/1 - 12/31	2/28 of following year

A. The data elements to be reported under this measure are:

Element Numbers	Data Elements for Provider Network Adequacy Measure
4.1 – 4.6	Number of PCPs in network on first day of reporting period by PCP type - General Medicine (4.1), Family Medicine (4.2), Internal Medicine (4.3), Obstetricians (4.4), Pediatricians (4.5), State Licensed Nurse Practitioners (4.6)
4.7 – 4.12	Number of PCPs in network continuously through reporting period by PCP type - General Medicine (4.7), Family Medicine (4.8), Internal Medicine (4.9), Obstetricians (4.10), Pediatricians (4.11), State Licensed Nurse Practitioners (4.12)
4.13 – 4.18	Number of PCPs added to network during reporting period by PCP type - General Medicine (4.13), Family Medicine (4.14), Internal Medicine (4.15), Obstetricians (4.16), Pediatricians (4.17), State Licensed Nurse Practitioners (4.18)
4.19 – 4.24	Number of PCPs accepting new patients at start of reporting period by PCP type - General Medicine (4.19), Family Medicine (4.20), Internal Medicine (4.21), Obstetricians (4.22), Pediatricians (4.23), State Licensed Nurse Practitioners (4.24)
4.25 – 4.30	Number of PCPs accepting new patients at end of reporting period by PCP type - General Medicine (4.25), Family Medicine (4.26), Internal Medicine (4.27), Obstetricians (4.28), Pediatricians (4.29), State Licensed Nurse Practitioners (4.30)
4.31 – 4.36	Number of PCPs in network on last day of reporting period by PCP type - General Medicine (4.31), Family Medicine (4.32), Internal Medicine (4.33), Obstetricians (4.34), Pediatricians (4.35), State Licensed Nurse Practitioners (4.36)

4.37 – 4.46	Number of specialists/facilities in network on first day of reporting period by specialist/facility type – Hospitals (4.37), Home Health Agencies (4.38), Cardiologist (4.39), Oncologist (4.40), Pulmonologist (4.41), Endocrinologist (4.42), Skilled Nursing Facilities (4.43), Rheumatologist (4.44), Ophthalmologist (4.45), Urologist (4.46)
4.47 – 4.56	Number of specialists in network continuously through reporting period by specialist/facility type– Hospitals (4.47), Home Health Agencies (4.48), Cardiologist (4.49), Oncologist (4.50), Pulmonologist (4.51), Endocrinologist (4.52), Skilled Nursing Facilities (4.53), Rheumatologist (4.54), Ophthalmologist (4.55), Urologist (4.56)
4.57 – 4.66	Number of specialists added during reporting period by specialist/facility type - Hospitals (4.57), Home Health Agencies (4.58), Cardiologist (4.59), Oncologist (4.60), Pulmonologist (4.61), Endocrinologist (4.62), Skilled Nursing Facilities (4.63), Rheumatologist (4.64), Ophthalmologist (4.65), Urologist (4.66)
4.67 – 4.76	Number of specialists accepting new patients at start of reporting period by specialist/facility type- Hospitals (4.67), Home Health Agencies (4.68), Cardiologist (4.69), Oncologist (4.70), Pulmonologist (4.71), Endocrinologist (4.72), Skilled Nursing Facilities (4.73), Rheumatologist (4.74), Ophthalmologist (4.75), Urologist (4.76)
4.77 – 4.86	Number of specialists accepting new patients at end of reporting period by specialist/facility type - Hospitals (4.77), Home Health Agencies (4.78), Cardiologist (4.79), Oncologist (4.80), Pulmonologist (4.81), Endocrinologist (4.82), Skilled Nursing Facilities (4.83), Rheumatologist (4.84), Ophthalmologist (4.85), Urologist (4.86)
4.87 – 4.96	Number of specialists in network on last day of reporting period by specialist/facility type- Hospitals (4.87), Home Health Agencies (4.88), Cardiologist (4.89), Oncologist (4.90), Pulmonologist (4.91), Endocrinologist (4.92), Skilled Nursing Facilities (4.93), Rheumatologist (4.94), Ophthalmologist (4.95), Urologist (4.96)

B. Notes

This measure requires direct data entry into HPMS.

Note that NCQA accreditation is independent of these reporting requirements and does not exempt an MAO from reporting these data.

5. Grievances

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
5. Grievances	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	4/Year PBP	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Grievances Measure
5.1	Number of Grievances for Fraud and Abuse
5.2	Number of Grievances for Enrollment/Disenrollment Access/Benefit package
5.3	Number of Grievances for Marketing
5.4	Number of Grievances for Confidentiality/Privacy
5.5	Number of Grievances for Quality of Care
5.6	Number of Grievances related to Expedited Requests
5.7	Number of Grievances for Other

B. Notes

This measure requires direct data entry into HPMS.

Note that this list is intended to be "all inclusive." Plans should collapse additional categories they track but are not specifically listed into the "other" category.

Expedited Grievances refers to grievances that are expedited if (1) the complaint involves an MAO's decision to invoke an extension in an organization determination or reconsideration or (2) the complaint involves an MAO's refusal to grant a request for an expedited organization determination or reconsideration.

Plans should report a grievance as either Part C or Part D, as a result of their process to investigate/resolve the grievance. This is the current policy for the Parts C and D Complaints Tracking Module (CTM). For most complaints or grievances, a Plan will be able to determine which is more applicable. For the minority of cases where a clear distinction is not available for a MA-PD, complaints should be reported as Part C complaints.

Only completed grievances (plan has notified enrollee of its decision) during the reporting period should be included.

6. Organization Determinations/Reconsiderations

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
6. Organization Determinations/ Reconsiderations	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Number of Organization Determinations – Fully Favorable
6.2	Number of Organization Determinations – Partially Favorable
6.3	Number of Organization Determinations – Adverse
6.4	Number of Reconsiderations – Fully Favorable
6.5	Number of Reconsiderations – Partially Favorable
6.6	Number of Reconsiderations – Adverse

B. Notes

This measure requires direct data entry into HPMS.

The term “Adverse” means Fully Unfavorable, but does not include Dismissals or Withdrawals. A partially favorable determination/reconsideration refers to a denial with a “part” that has been approved.

Note that the collection period for reconsiderations and organization determinations includes those cases where final decisions were made during the reporting period, regardless of when the case was initially received.

7. Employer Group Plan Sponsors

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
7. Employer Group Plan Sponsors	01 – Local CCP 02 - MSA 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS Organizations should include all 800 series plans and any individual plans sold to employer groups. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	2/year PBP	1/1 - 6/30 7/1- 12/31	8/31 2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Employer Group Plan Sponsors
7.1	Employer Legal Name
7.2	Employer DBA Name
7.3	Employer Federal Tax ID
7.4	Employer Address
7.5	Type of Group Sponsor (employer, union, trustees of a fund)
7.6	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
7.7	Type of Contract (insured, ASO, other)
7.8	Employer Plan Year Start Date
7.9	Current Enrollment

B. Notes

This measure is an HPMS upload. The full record layout for this upload is available as Appendix 3 to this document.

8. PFFS Plan Enrollment Verification Calls

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
8. PFFS Plan Enrollment Verification Calls	03 – RFB PFFS 04 – PFFS 800-series plans should NOT report	1/year PBP	1/1-12/31	2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for PFFS Plan Enrollment Verification Calls
8.1	Number of times the plan reached the prospective enrollee with the first call of up to three required attempts in reporting period
8.2	Number of follow-up educational letters sent in reporting period
8.3	Number of enrollments in reporting period

B. Notes

This measure requires direct data entry into HPMS.

Note that this does not apply to group PFFS coverage. Also, this measure only pertains to calls made to individual enrollees.

9. PFFS Provider Payment Dispute Resolution Process

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
9. PFFS Provider Payment Dispute Resolution Process	03 – RFB PFFS 04 - PFFS 14 – ED-PFFS	1/year PBP	1/1-12/31	2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for PFFS Provider Payment Dispute Resolution Process
9.1	Number of provider payment denials overturned in favor of provider upon appeal
9.2	Number of provider payment appeals
9.3	Number of provider payment appeals resolved in greater than 60 days

B. Notes

This measure requires direct data entry into HPMS.

This element must be reported by all PFFS plans, regardless of if they have a network attached.

10. Agent Compensation Structure

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
10. Agent Compensation Structure	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 15 – RFB Local CCP Organizations should include all 800 series plans.	1/year Contract	1/1-12/31	2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Agent Compensation Structure
10.2	Number of licensed independent agents for reporting period and who made a Part C or Part D or Cost plan sale.
10.3	Number of beneficiaries making an enrollment change in reporting period for which a licensed independent agent was involved.
10.4	Number of beneficiaries retained in reporting period for which a licensed independent agent was involved.
10.5	Total licensed independent agent compensation (related to volume of sales) for beneficiaries making a plan change in reporting period for which an agent was involved.
10.6	Number of licensed independent agents who received compensation for retained enrollees
10.7	Total licensed independent agent compensation (related to volume of sales) for beneficiaries retained from previous reporting period for which an agent was involved.

B. Notes

This measure requires direct data entry into HPMS.

Compensation data shall only be reported on licensed independent agents, not employed agents.

“Compensation” shall only include incentive compensation related to sales.

“Volume of sales” is defined as the number of sales generated by an agent within a specified period.

A beneficiary who is “retained” is one who remains in the same plan after initial enrollment or is enrolled by an agent or broker in a different plan of “like plan type.” A “like plan type” refers to PDP, MA, MA-PD, or cost plan. Refer to the interim final regulation with comments (CMS 4138-IFC2) addressing agent/broker compensation that was published on November 10, 2008.

11. Agent Training and Testing

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
11. Agent Training and Testing	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 15 – RFB Local CCP (800-series plans should NOT report)	1/year Contract	1/1-12/31	2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Agent Training and Testing
11.1	Total Number of agents in contract year
11.2	Number of agents in contract year that completed training successfully
11.3	Number of agents in contract year with a passing score of 85% or above on first testing
11.4	Average score of agents in contract year with a passing score of 85% or above on first testing
11.5	Number of agents taking second test
11.6	Number of agents in contract year with a passing score of 85% or above on second testing
11.7	Average score of agents in contract year with a passing score of 85% or above on second testing.
11.8	Number of agents in contract year taking test 3 or more times

B. Notes

This measure requires direct data entry into HPMS.

CMS does not require training or testing data from employer/union group plans.

The Agent Training and Testing measure category is for both salaried and contracted agents. It does not include sales support staff; rather it only applies to the agents themselves.

12. Plan Oversight of Agents

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
12. Plan Oversight of Agents	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 15 – RFB Local CCP includes all 800 series plans	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for Agent Oversight
12.1	Total Number of agents
12.2	Number of agents investigated based on complaints
12.3	Number of agents receiving disciplinary actions based on complaints
12.4	Number of complaints reported to State by MAO or Cost contractor
12.5	Number of agents whose selling privileges were revoked by the plan based on conduct or discipline
12.6	Number of agent-assisted enrollments

B. Notes

This measure requires direct data entry into HPMS.

The “number of agents” includes only agents who are licensed to sell and do sell on behalf of the sponsor, either by being a direct employee or by contractual arrangement.

Note that disciplinary action refers to action taken by the MA plan.

"Complaints" refer to both complaints from the HPMS Complaint Tracking Module (CTM) and to other complaints made directly to the MAO or Cost contractor. A complaint could result in action along a broad continuum, from manager-coaching, documented verbal warning, re-training, a documented corrective action plan, suspension, or termination of employment or contract. Any action along this continuum

would be reportable. A short term revocation (e.g., 1-2 days) is among those which CMS will require reporting.

13. Special Needs Plans (SNPs) Care Management

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
13. SNPS Care Management	SNP PBPs under the following types: 01 – Local CCP 05 - Demo 11 – Regional CCP 15 – RFB Local CCP Organizations should include all 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	5/31 of following year

A. The data elements to be reported under this measure are:

Element Number	Data Elements for SNPs Care Management
13.1	Number of new enrollees
13.2	Number of enrollees eligible for an annual reassessment
13.3	Number of initial assessments performed on new enrollees during reporting period
13.4	Number of annual reassessments performed on enrollees eligible for a reassessment

B. Notes

This measure requires direct data entry into HPMS.

APPENDICES

Appendix 1: Codes to Identify Procedures

Procedure Description	CPT	ICD-9-CM Procedure	ICD-9-CM Diagnosis (applicable for cancer surgeries)	MS-DRG[i]
Cardiac Catheterization	93501, 93510, 93511, 93514, 93524, 93526-93529, 93529,93530, 93531,93532, 93533,93539-93545	37.21-37.23, 88.52-88.58	n/a	216-218 222-225 233-234 286-287 (Diagnostic)
Open coronary angioplasty	35452	36.03		228, 229, 230
Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy with Coronary Artery Bypass Surgery (CABG)	35472, 35481, 35491, 92982, 92984 With 33510-33514, 33516-33519, 33521-33523, 33533-33536	00.66 and a code from the following range: 36.10-36.17, 36.19.		231-232
PTCA or Coronary Atherectomy with insertion of drug-eluting coronary artery stent (s)	35472, 35481, 35491, 92982, 92984 With 92980, 92981, 92995, 92996 (doesn't differentiate stent type)	00.66 or 36.09 and 36.07		246-247
PTCA or Coronary Atherectomy with insertion of non-drug-eluting coronary artery stent (s)	35472, 35481, 35491, 92982, 92984 With 92980, 92981, 92995, 92996 (doesn't differentiate stent type)	00.66 or 36.09 and 36.06		248-249
PTCA or Coronary Atherectomy without insertion of Coronary Artery Stent	35472, 35481, 35491, 92982, 92984 With no stent	00.66, 36.09		250-251
Total Hip Replacement	27130, 27132, 27134,27137, 27138	00.70, 81.51, 81.53	n/a	461-462, 466-470
Total Knee Replacement	27446, 27447, 27486, 27487	00.80, 81.54, 81.55	n/a	461-462, 466-470
Bone Marrow Transplant	38240-38241,38242	41.00 - 41.09	201.00-201.28 201.40-201.78 201.90-201.98 203.00-203.11	009

			203.80-203.81 204.00-204.91 205.00-205.31 205.80-205.91 206.00-206.21 206.80-206.91 207.00-207.21 207.80-207.81 208.00-208.21 208.80-208.91 238.4 238.71 238.73 – 238.76 238.79 277.39 284.01, 284.09 284.1, 284.2 284.81, 284.89 284.9	
Heart Transplant	33945	37.51	n/a	001,002
Heart/Lung Transplant	33935	33.6	n/a	001, 002
Kidney Transplant	50360,50365, 50380,50300- 50320,50547, 50340,50370, 50380	55.69	189.0, 189.1 198.0	652
Liver transplant	47135,47136	50.51, 50.59	155.0, 155.2 197.7	005, 006
Lung Transplant	32850-32854	33.50,33.51, 33.52	162.2 - 162.5 162.8, 162.9 197.0	007
Pancreas Transplant	48160,48550, 48554,48556	52.80-52.86	157.0 – 157.4 157.8, 157.9	010
Pancreas/Kidney Transplant	Pancreas transplant: 48160,48550, 48554,48556 Kidney transplant: 50360,50365, 50380,50300- 50320,50547, 50340,50370	Pancreas transplant: 52.80-52.86 Kidney transplant: 55.69	157.0 – 157.4 157.8, 157.9 189.0, 189.1 198.0	008
Coronary Artery Bypass Graft (CABG)	33510-33514, 33516-33519, 33521-33523, 33533-33536	36.10-36.17, 36.19	n/a	231-236
Gastric Bypass	43846,43845, 43842, 43848,43770-43774,43659	44.31, 44.38, 44.39	n/a	619-621
Excision or Destruction of Lesion or Tissue of Lung	32440, 32442, 32445,32480, 32482,32484, 32486, 32488, 32491, 32500, 32501, 32520, 32522,	32.20, 32.22, 32.23 -32.26 32.28, 32.29, 32.30, 32.39, 32.41, 32.49,	162.2 - 162.5 162.8, 162.9 197.0	163-168

	32525, 32540,32503, 32504	32.50, 32.59 32.9		
Excision of Large Intestine	44141,44143-44147, 44140,44150 44160, 44204-44208,4421044211,44212,44213	45.71-45.76 45.79, 45.8	153.0-153.9 197.5	374-376
Mastectomy	19180, 19182, 19200, 19220, 19240, 19300, 19301-19307	85.41-85.48	174.0-174.6, 174.8, 174.9 175.0, 175.9 198.81	582-583
Lumpectomy	19120, 19125, 19126, 19160, 19162, 19301, 19302	85.20, 85.21	174.0-174.6, 174.8, 174.9 175.0, 175.9 198.81	584-585
Prostatectomy	52601, 52612, 52614, 52620, 52630, 52640 52647, 52648, 52649,55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866	60.21, 60.29, 60.3, 60.4, 60.5, 60.61, 60.62, 60.69	185, 198.82	665-667 707-708 713-714

[i] Refer to Table 5, List of Medicare Severity-Diagnosis Related Groups, found in Final rule with comments, 42 CFR Parts 411, 412, 413, and 489 [CMS–1533–FC] RIN 0938–AO70 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, Centers for Medicare and Medicaid Services (CMS), HHS *Federal Register*/Vol. 72, No. 162/Wednesday, August 22, 2007.

Appendix 2: Codes to Identify Serious Reportable Adverse Events

Table 2: Serious Adverse Reportable Events Codes [ii]

Event Description	**CPT**	**ICD-9-CM Procedure**	**ICD-9-CM Diagnosis**	**MS-DRG**
Surgery on Wrong Body Part	n/a	n/a	E876.5 (not specific to this event)	n/a
Surgery on Wrong Patient	n/a	n/a	E876.5 (not specific to this event)	n/a
Wrong Surgical Procedures on a Patient	n/a	n/a	E876.5 (not specific to this event)	n/a
Surgery with Post-Operative Death in Normal Health Patient	ASA category 1 (a normal healthy patient).			

[ii] Refer to pages 47206—47213 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Federal Register / Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations.

Tables 3 and 4 below lists the codes for identifying HAC data.

Table 3: Hospital Acquired Conditions (HAC) from 2008 IPPS Final Rule [iii]

Selected HAC	**CC/MCC (ICD-9-CM Codes)**
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Stage III & IV Pressure Ulcers	Codes within these ranges on the CC/MCC list: 800-829, 830-839, 850-854, 925-929, 940-949, 991-994
Falls and Trauma: -Fractures -Dislocations -Intracranial Injuries -Crushing Injuries -Burns	Codes within these ranges on the CC/MCC list: CC/MCC list: 800-829 830-839 850-854 925-929

	940-949 991-994
Vascular Catheter-Associated Infection	999.31 (CC)
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC) 590.81 (CC), 595.0 (CC) 597.0 (CC), 599.0 (CC)

[iii] Refer to pages 47200—47220 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Federal Register / Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations.

Table 4: Hospital Acquired Conditions from 2009 IPPS Rule [iv]

Selected HAC	**CC/MCC (ICD-9-CM Codes)**
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.83, 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis* – 278.01 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

[iv] Based on CMS-approved document (p. 240) submitted to the Office of the Federal Register (OFR) for publication. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. Upon publication in the Federal Register, all regulations can be found at http://www.gpoaccess.gov/fr/ and at http://www.cms.hhs.gov/QuarterlyProviderUpdates/. The document published in the Federal Register is the official CMS-approved document.

Appendix 3: Employer Group Plan Sponsor Upload File Format

Required File Format = ASCII File - Tab Delimited
Do not include a header record
Filename extension should be ".TXT"
There can be multiple records per plan.

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Contract_Number	CHAR Required	5 Exactly	Provide the CMS issued contract number being offered to the Employer Group Plan Sponsor. (Note: The system shall validate the contract number is valid.)	H1234
Plan_ID	NUM Required	3 Exactly	Provide the ID (with leading zeros as appropriate) of the Plan Benefit Package (PBP) being offered to the Employer Group Plan Sponsor. (Note: This is a numeric field only. The system shall validate the plan ID is valid.)	801 or 001
Employer_Legal_Name	CHAR Required	150	Provide the legal name of the Employer Group Plan Sponsor.	United Parcel Service
Employer_DBA_Name	CHAR Optional	150	If applicable provide the doing business as (DBA) name of the Employer Group Plan Sponsor.	United Parcel Service Employees Association
Employer_Federal_Tax_ID	NUM Required	8	Provide the federal tax ID of the Employer Group Plan Sponsor. (Note: This is a numeric field only.)	22384919
Employer_Street_Address	CHAR Required	150	Provide the street address of the Employer Group Plan Sponsor headquarters.	1212 North Luther Street
Employer_City_Address	CHAR Required	75	Provide the city in which the Employer Group Plan Sponsor headquarters is located.	Wichita
Employer_S	CHAR	2	Provide the state	MO

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
tate_Address	Required		abbreviation in which the Employer Group Plan Sponsor headquarters is located. (Note: The system shall validate the state abbreviation is appropriate.)	
Employer_Zip_Address	NUM Required	10	Provide the Employer Group Plan Sponsor headquarters' zip code. (Note: This is a numeric field only.)	22203
Employer_Sponsor_Type	NUM Required	1	Indicate the Employer Group Plan Sponsor Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 3.)	1=Employer 2=Union 3=Trustees of a Fund
Employer_Organization_Type	NUM Required	1	Indicate the Employer Group Plan Organization Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 7.)	1=State Government 2=Local Government 3=Publicly Traded Corp. 4=Privately Held Corp. 5=Non-Profit 6=Church Group 7=Other
Employer_Contract_Type	NUM Required	1	Indicate the Employer Group Plan Contract Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 3.)	1=Insured 2=ASO 3=Other
Employer_Start_Date	NUM Required	6	Provide the month and year when the Employer Group Plan Sponsor started (or will start). The format is MMYYYY, so the sample is intended to depict June 2008 (062008). (Note: This is a numeric field only. The system shall validate that the month is a value of 01 to 12.)	062008
Employer_Enrollment	NUM Required	7	Provide the current (or anticipated) enrollment for	9999999

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
			the Employer Group Plan Sponsor. (Note: This is a numeric field only. Do not include commas.)	