

**Medicare Part C Plan Reporting Requirements
Technical Specifications Document**

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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).

This document provides a description of the measures, reporting timeframes and deadlines, and specific data elements for each measure. The 2009 Part C Reporting Requirements 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 2010 Technical Specifications do not add to the data collection requirement.

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.

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.
- C. Reminder: Red underlined passages indicate updates, and/or new information.

GENERAL INFORMATION

Organizations for which these specifications apply will be required to collect these data beginning on January 1, 2010. 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. A subset of measures included in these technical specifications is subject to retrospective data validation in 2011.

The following data elements in the measures listed in this document are considered proprietary, and CMS considers these as 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)

***Under FOIA Plans may need to independently provide justification for protecting these data if a FOIA request is submitted.**

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 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.

Suspended from Reporting: Do not report these measures for data collected in 2010.

*Measurement #10 Agent Compensation Structure and;
Measurement #11 Agent Training and Testing are suspended indefinitely*

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.

Organizations failing to submit data at all, or on time and organizations submitting accurate data will receive compliance notices from CMS.

Correction of Previously Submitted Data / Resubmission Requests

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.
- Resubmission requests can only be submitted after a reporting deadline has passed.
- Once a reporting deadline has passed, organizations that need to correct data must submit a formal request to resubmit via HPMS Plan reporting module.
- CMS reserves the right to establish deadlines after which no further corrections may be submitted.

Detailed instructions will be provided in the HPMS Plan Reporting Module User Guide. Organizations should not submit resubmission requests until they have data available to submit. Resubmission requests 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. Data corrections may be submitted until one year from the required submission date.

Due Date Extension Requests

Generally speaking, CMS does not grant extensions to reporting deadlines, as these have been established and published well in advance. It is our expectation that organizations do their best with the information provided in the most current version of the Technical Specifications to prepare the data to be submitted in a timely fashion. Any assumptions that organizations may make in order to submit data timely should be fully documented and defensible under audit.

Periodic Updates to the Technical Specifications

Given the volume of questions CMS expects to receive in the initial year of implementation of the Part C Reporting Requirements, periodic updates will be issued. CMS expects to issue updates in advance of the first due date for each of the reporting sections that contains responses to industry questions on those reporting sections in particular. The clarifying information provided in these updates neither adds to nor changes any of the previously approved measures. By providing additional information beyond the baseline requirements, we hope to receive a more consistent dataset across all Part C plans.

Email Address for Questions

CMS has established the following email address for the purpose of collecting all questions regarding the Part C Technical Specifications: PartCplanreporting@cms.hhs.gov. Plans should be aware that immediate responses to individual questions may not be possible given the volume

of email this box receives. Plans should look for answers to their questions in the next update to the Part C Reporting Requirements Technical Specifications.

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	2/year PBP	<u>1/1 - 12/31</u>	<u>2/28 of following year</u>

	groups), Employer/Union Direct Contract			
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 <u>Validation</u> <u>unnecessary—using</u> <u>for monitoring only</u>
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 <u>Validation</u> <u>unnecessary—using</u> <u>for monitoring only</u>

Agent Compensation Structure		<u>Suspended For Data Collected in 2010</u>		
Agent Training and Testing		<u>Suspended for data collected in 2010</u>		
12. Plan Oversight of Agents	CCP, PFFS, 1876, Cost, Demo, MSA (includes all 800 series plans)	4/Year Contract	<u>1/1 – 12/31</u>	<u>2/28 of the following year</u>
13. SNPs Care Management	SNPs (includes all 800 series plans)	1/Year PBP	1/1-12/31	5/31 of following year

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 and is reported at the Plan Benefit Package (PBP) level.

A table representation of the data elements to be collected under this reporting requirement is provided in Appendix 1.

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 by employer group members reflects these richer benefits and the results of 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.

CMS intends that plan sponsors use the benefit structure captured in the bids for the contract year period to report this measure.

The expenditures reported under the OP Facility – Emergency services category include those performed in conjunction with an emergency room visit. If an enrollee is admitted directly from the ER to an inpatient hospital setting, then any costs from that admission forward are to be included in the Inpatient Facility services category.

If information on ‘Admits’ and ‘Days’ is available, use ‘Days’ for the reporting requirement.

For Data Elements 1.9 and 1.10, data are normally derived from claims data and the Plan Benefit Package.

For Data Elements 1.83 – 1.90, the Other Medicare Part B services category is to include all Part B services excluded from the other benefit categories.

All plan revenues and medical expenses are to be represented in the report. This includes revenues and costs for beneficiaries with ESRD status.

Claims run out date: If a plan sponsor submits bids in late May/early June, and they include data for claims paid through 03/31; the cut-off date for this report would be 06/30/10 for the 8/31/11 due date.

The premiums collected field is to represent the earned premium revenues from all sources including members, employer/union groups, and State Medicaid agencies.

Cost Sharing: Enter the cost sharing that would be required for covered services using original Medicare requirements. This amount can be estimated using the actuarial equivalent factors published in the bid pricing tool. Note that the amounts for non-covered services can only be \$0 since those service type categories are by definition not covered by original Medicare.

Services purchased under a capitation agreement with a subcontractor: CMS assumes that the subcontractor will provide costs for each of the defined benefits.

For non-covered services, there can be a wide range of benefits, and the utilization should be determined based on the specific requirements of the service. For example, if the only health & education benefit is a specific wellness seminar, then the utilization counts will reflect the number of members that attended the seminar.

Column D/Utilizers: The calculation of the number of services used must be consistent with the utilization type. Thus, for the utilization type “Day” or “D”, it is appropriate to treat each day of home health as one unit of service regardless of how many services were provided for the day. However, if the utilization type is “Visits” or “V” then the utilization count is to reflect the number of unique visits.

Column H/Total Member Cost Sharing: Column H should reflect the cost sharing liability of the member as specified in the Plan Benefit Package (PBP).

CMS will not be providing an electronic version (e.g., MS Excel, .csv, XML) of the applicable CPT, ICD-9-CM Procedure, ICD-9-CM Diagnosis and MS-DRG codes for reporting purposes.

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.

Identify the number of procedures by using CPT codes, ICD-9-CM procedures, ICD-9 CM diagnosis and MS-DRGs provided in Appendix 4. The expectation is that all four types of indicators need to be used singularly or in a combination, keeping in mind that steps must be taken to avoid duplicate reporting when different code types are used on different claim forms. That is, one or any combination of these codes can be used if it “casts a wider net.” and therefore is more likely to capture the procedure. If a diagnosis is necessary to define a procedure, for example prostate cancer surgery, use the ICD-9-CM diagnosis code also. This would exclude reporting of a prostatectomy for benign prostatic hyperplasia (BPH).

The counts represented in each data element under this measure need not be mutually exclusive. If an enrollee received two or more of the same procedure (e.g., CABGs at different times during the reporting year) the plan should report only one CABG, because enrollees receiving procedures during the reporting period, not procedures per se, are being reported.

Plans should report procedures at the contract level.

For contracts with fewer than 1,000 members, plans are still required to report all the procedures.

Plans should report the count of members per contract and not the detail of each member.

Plans do not have to calculate a denominator, since only numbers will be reported and not rates. Report only the number of enrollees receiving the specific procedures (that occurred during the reporting period) that fall into each of the categories with no exclusions unless specific exclusions are listed.

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 in accordance with NCQA's timetable for data submission. If an organization reports these measures in HEDIS, it is not required to report it again under these requirements. (This includes PFFS contracts that voluntarily report HEDIS data.)

CMS recognizes that the codes in Appendix 4 do not align exactly to those in the HEDIS Technical Specifications; organizations may still forgo reporting the starred measures if the related HEDIS measure is reported. CMS does not anticipate the HEDIS requirements will change to align with CMS Part C reporting. Organizations do not have to submit any overlapping HEDIS procedures for the Part C reporting requirements if they have not yet started HEDIS reporting, provided that they will be submitting HEDIS reporting for the same CY as the Part C reporting requirements.

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.

Percutaneous Transluminal Coronary [PTCA], or Balloon Angioplasty with Coronary artery bypass graft (CABG) surgery, is indicated by codes in the following range: 36.10 through 36.17 and 36.19.

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 5 for the codes to identify Serious Reportable Adverse Events. Some of the SRAEs do not have codes, but the events are so egregious and rare that the hospitals should be able to report them to the plans. Plans should use both primary and secondary diagnosis and procedure code fields to identify the event.

Organizations are required to report on these events and are also required to differentiate among the three possibilities listed: surgery on wrong body part, surgery on wrong patient, and wrong surgical procedures on a patient. These are serious events that could require some plan follow-up with the hospitals involved.

For purposes of the Part C reporting requirements, plans should be reporting SRAE data consistent with the current CMS hospital reporting requirements. In most, if not all cases, plans will be receiving the SRAE data from hospitals; therefore, this should not ordinarily present a problem with reporting requirements.

An event should be reported in the period of time in which it is confirmed to have occurred. We acknowledge that this may generate the need for correction of previously submitted data. If an SRAE event is alleged to have occurred in a previous reporting period but you do not receive a credible report until a later reporting period, you report the event in the later reporting period. In other words report them via HPMS as you become aware of confirmed SRAE events.

An SRAE report should be pulled by date of service, and any re-run done as close as possible to the reporting date.

Plans should report the count of members per contract and not the detail of each member

Plans should report the number of surgeries occurring in just acute inpatient hospitalizations.

A single episode cannot count in more than one category.

For determining an ASA category #1 patient, CMS recommends follow-up with the hospital to obtain this documentation.

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 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 these provider adequacy measures are distinct from the information on health services delivery (HSD) that is required to be provided as part of the 2011 Medicare Advantage Application. The above data elements are defined differently from the HSD elements, they are designed to address different questions, and they are required to be submitted at the contract (rather than county) level by all MAOs subject to the Part C reporting requirements.

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

The NCQA definitions for specialists and/or facilities are not necessarily the same as those listed here.

For Data Elements 4.1 - 4.36: If the plan does not recognize, for example, Obstetricians (OBs) as Primary Care Physicians (PCP), then for entry into HPMS plans should still code OBs as PCPs for the purposes of this reporting.

MAOS should report their providers under all corresponding categories, regardless of whether or not they have dual specialties or are considered a PCP and a specialist.

Service is considered on-going if the provider provides continuous service in a plan's service area, even if the provider moves within the service area.

If a provider moves one office out of the service area but a second office remains, it is considered continuous service. If the provider moves out of the service area entirely (i.e., all offices move out or no offices remain), then it is not considered continuous.

If a provider continually sees plan beneficiaries at the start of the reporting period and at the end of the period while remaining in the service area, this is considered continuous. For the next reporting period, the new service area would be the reference location.

Newly added providers are providers who are new to the network and/or are new to a specialty.

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 Expedited Grievances
5.7	Number of Grievances for Other

B. Notes

This measure requires direct data entry into HPMS.

Chapter 13 of the Medicare Managed Care Manual provides the definition of a grievance and provides several examples of grievances. (See the Medicare Managed Care Manual, Ch. 13, Sections 10.1 and 20.2.)

Counting Multiple Grievances Filed by the Same Beneficiary:

If a beneficiary files a grievance and then files a grievance again on the same issue, **prior** to the Plan's decision or the deadline for decision notification (whichever is earlier), then that should only be counted as one grievance.

If a beneficiary files a grievance and then files a subsequent grievance on the same issue **after** the Plan's decision or deadline for decision notification (whichever is earlier), then that counts as a separate grievance.

If a beneficiary files a grievance about two different issues, then they are counted as separate grievances.

A grievance that relates to a marketing issue, for example, and that is addressed under the plan's grievance process as defined in Chapter 13, should be reported as a Marketing Grievance (Element 5.3) for purposes of this effort.

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.

For MA-PDs, plans should report a grievance as either a Part C or Part D grievance, depending on the process the plan used to investigate/resolve the grievance. 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, cases should be reported as Part C grievances.

In some instances, grievances reportable under this section will overlap with CTM cases, but plans should only report grievances that are filed directly with the plan.

The list of grievance categories is intended to be "all inclusive." Plans should collapse additional categories they track, that are not specifically listed in Data Elements 5.1 – 5.6, into the "other" category (Data Element 5.7).

Only completed grievances (plan has notified enrollee of its decision) during the reporting period should be included. Grievances should be reported in the period in which they were completed, regardless of when the grievance was filed.

Grievances on all services covered under plan benefits should be reported, even if they are not services that would otherwise be covered under Fee for Service Medicare.

Grievances should be included regardless of who filed the grievance. If a plan handles an event or incident as a grievance, regardless of whether the grievance was filed late (i.e., more than 60 calendar days after the event), then the plan should categorize and report the issue as a grievance for this effort.

If one grievance contains multiple issues, plans need to report each issue as a separate data element.

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

A. Notes

This measure requires direct data entry into HPMS.

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. With regard to categorizing UM determinations, whether pre-service, post-service, or concurrent, the point at which the review is done (e.g., concurrent review) is irrelevant for Part C data reporting requirement purposes.

For this effort, plans must report those decisions that are consistent with the definition of “organization determination” under 42 C.F.R. §422.566(b). Thus, CMS expects plans to include all pre-service contract and non-contract denial data and payment denials that result in zero payment being made to non-contract providers, including information from delegated entities. This includes, but is not limited to some determinations made on UM and claims payment. The term “some” in the preceding sentence is intended to clarify that CMS is not requesting all claims data, but expects plans to include payment denials that result in zero payment being made to non-contract providers.)

CMS expects plans to count initial requests for coverage as organization determinations. Plans are not to count the continuation of authorization as separate, favorable organization determinations.

Plans should not combine fully favorable pre-service determinations and fully favorable claims determinations. In asking plans to include claims data from non-contract providers for this effort, CMS’ intent was to avoid duplication (i.e. if the predeterminations are decided and the claims are paid in the same quarter, this would duplicate the entries).

With respect to “reconsiderations,” plans must report reviews of partially favorable and adverse organization determinations.

Where there is no member liability, there is no appealable issue to report.

Organization types listed in the table at the beginning of this section are required to report on these data; e.g., PFFS non-contract plans are not exempt from reporting adverse and partial claims data.

Plans should not report dismissals or withdrawals. Plans should not report duplicate claims/edits for this effort as they do not fit the definition of an organization determination; plans would treat such cases as dismissals or withdrawals.

The totals for each “type” of organization determination (i.e., pre-service and claims) should be reported for each element; e.g., the total number of adverse non-contract claims decisions + the total number of adverse contract and non-contract pre-service decisions should be combined for the Element 6.3 total.

Organization determination and appeals data from delegated entities should be included in this reporting requirement.

A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) should not be counted as an organization determination for Part C Reporting purposes. A plan's review of an individual's request to continue Medicare-covered services (e.g., if a beneficiary misses the QIO review deadline) should be counted as a reconsideration for this effort.

QIO reviews do not count as a reconsideration for the purposes of this reporting requirement. Plans are required to collect only plan-level data for this effort.

If a reconsideration is forwarded to Maximus, health plans will either report the case as a partially favorable decision (Element 6.5) or as an adverse decision (Element 6.6) depending on the organization's determination of the case prior to it being forwarded.

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.

The term "dismissals" is defined as when an independent review entity (IRE) under contract with CMS to review a plan's adverse reconsiderations may dismiss a case forwarded by the plan if the case lacks required information or otherwise does not meet CMS requirements for a valid reconsideration request. For example, if an individual files for reconsideration as a member's representative, but the plan does not receive documentation supporting representation of the member within the required timeframe, the plan must forward the case to the IRE with a request for dismissal. Also, if an enrollee requests a pre-service reconsideration, but the plan learns the enrollee obtained the service before the plan completes its reconsideration determination, the plan should forward the pre-service reconsideration request to the IRE for dismissal since the provision of the service is moot. (See the Medicare Managed Care Manual, Ch. 13, Sections 60.1.1, 60.1.4 and 70.7.5.)

If a non-contracted provider who signed a waiver of liability submits a reconsideration request under the beneficiary reconsideration process set forth at 42 C.F.R. Part 422, Subpart M, then a plan should report this reconsideration in the same manner it would report a member-filed reconsideration.

The term "withdrawals" is defined as the situation where the party who files a request for reconsideration may withdraw the request at any time before a decision is mailed by writing to the Medicare health plan. If the health plan receives such a request, they are to withdraw the original request. (See the Medicare Managed Care Manual, Ch. 13, Section 70.4)

The term "appeal" is defined in Chapter 13 of the Medicare Managed Care Manual, Section 10.1.

Organization Determinations / Reconsiderations should be included regardless of who filed the request.

In some instances, organization determinations and reconsiderations reportable under this section will overlap with CTM cases, but plans should only report organization determinations and reconsiderations that are filed directly with the plan.

The Industry Collaboration Effort (ICE) Monthly Timeliness Report (MTR) is not part of Medicare's Part C Reporting Requirements. Thus, there may be differences between the data required for the Part C Reporting Requirements and the ICE MTR or other data collection requirements.

Plans should report services that are either Medicare-covered only or are both Medicare- and Medicaid-covered. That is, if the service is covered under Medicare, it should be captured as described under CMS reporting requirements. Plans should not report services that are only covered under Medicaid.

When arriving at the parts of the star ratings based on Independent Review Entity (IRE) findings, CMS will in these cases, base the ratings on member appeals.

CMS expects plans to count initial requests for coverage as organization determinations. Plans are not to count the continuation of authorization as separate, favorable organization determinations.

For this effort, plans are not to distinguish between member/provider filed organization determinations/reconsiderations in their reporting.

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	<u>1/1 - 12/31</u> <u>Note: Semi-annual Reporting is suspended.</u>	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 6 to this document.

All employer groups who have an arrangement in place with the Part C Organization for any portion of the reporting period should be included in the file upload, regardless of enrollment. For employer groups maintaining multiple addresses with your organization, please report the address from which the employer manages the human resources/health benefits.

Federal Tax ID is a required field in the file upload. Organizations should work with their employer groups to collect this information directly. Alternatively, there are several commercially available lookup services that may be used to locate this number.

Data Element 7.7 refers to the type of contract your organization holds with the employer group that binds you to offer benefits to their retirees.

Data Element 7.8, Employer Plan Year Start Date, is the month and year when the Employer Group Plan Sponsor started health benefits with your organization. The month reported should be the month in which the Employer's benefit year begins.

For Data Element 7.9, the enrollment to be reported should be as of the last day of the reporting period and should include all enrollments from the particular employer group into the specific PBP noted. (If an employer group canceled mid-way through the reporting period, they would still appear on the listing but would show zero enrollments.)

The employer organization type is based on *how* plan sponsors file their taxes.

If there is one large group and several smaller groups, CMS would accept the larger group under the single Tax Identification Number and the very first start date.

For organizations that provide coverage to private market employer groups and which are subject to Mandatory Insurer Reporting (MIR) of Medicare Secondary Payer data, CMS permits these organizations to use the employer address and tax ID information submitted via the MIR to also satisfy CMS' Part C reporting and validation requirements. However, this does not imply that if the organization has already submitted this information to CMS for some other purpose, they do not have to resubmit it to us again for the purposes of the Part C reporting requirements.

8. PFFS Plan Enrollment Verification Calls –Validation of this measure is not required because these data will be initially used only for monitoring

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.

Plans should tie the reported elements to enrollment effective dates. That is, for example, report for 2010 all those calls and follow-up letters linked to 2010 effective enrollments--including those done in late 2009 for 2010 enrollments. Any enrollment requests received in 2010 (for 2011 effective dates) and calls/letters associated with them would be reported in the 2011 reporting period--not in the 2010 reporting period. Otherwise, the reported elements for this measure would not connect for AEP enrollments.

9. PFFS Provider Payment Dispute Resolution Process –Validation of this measure is not required because these data will be initially used only for monitoring

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.

This reporting requirement seeks to capture only provider payment disputes which include any decisions where there is a dispute that the payment amount made by the MA PFFS Plan to deemed providers is less than the payment amount that would have been paid under the MA PFFS Plan's terms and conditions, or the amount paid to non-contracted providers is less than would have been paid under original Medicare (including balance billing).

10. Agent Compensation Structure---SUSPENDED: Do not report this measure for data collected in 2010

11. Agent Training and Testing---SUSPENDED: Do not report this measure for data collected in 2010

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	<u>1/1-12/31</u> <u>Note: Quarterly reporting is suspended</u>	<u>2/28 of following year</u>

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 on behalf of the sponsor, either by being a direct employee or by contractual arrangement, regardless of whether the agent is actively selling during the reporting period.

If a contract does not have any licensed agents, it is appropriate to report all zeros for each element in this reporting requirement.

"Complaints" refer to both complaints from the HPMS Complaint Tracking Module (CTM) and to other complaints made directly to the MAO or Cost contractor.

If a complaint is reported to your organization that cannot be tied to a particular contract, the complaint should be reported under all contracts that the agent is licensed to sell.

A complaint could result in “disciplinary 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 disciplinary action along this continuum would be reportable. A short term revocation (e.g., 1-2 days) is among those which CMS will require reporting. Note that disciplinary action refers to action taken by the MA plan.

For Data Element 12.2, the number of agent investigations that were completed during the reporting period should be reported, regardless of when the complaint that caused the investigation was received.

42 CFR 422.2272(d) and 42 CFR 423.2272(d) require that MA organizations (MAOs) and PDP sponsors report to the State in which the MAO or PDP sponsor appoints the agent/broker the termination of such agent/broker, including the reasons for such termination if State law so requires. 42 CFR 422.2274(e) and 42 CFR 423.2274(e) requires that MA organizations and sponsors comply with State requests for information about the performance of a licensed agent/broker as part of State investigations into that agent/brokers’ conduct (with CMS establishing a Memorandum of Understanding (MOU) to share compliance and oversight information with States). Beyond this required reporting, there are no additional regulatory requirements for the reporting of complaints. Therefore, it is possible that an organization or sponsor could report a “0” for this data element.

Data Element 12.4 is intended to include only those complaints originating with the MAO that are then reported to the State.

Please report all terminations under element 12.5. Element 12.4 should include all complaints, including any that were related to a termination reported under element 1.5.

For Data Element 12.6, “Agent assisted enrollments” is defined to mean a count of any enrollment effective during the reporting period that a beneficiary used the services of a licensed

agent to complete the enrollment process. Examples of this include, but are not limited to: enrollments completed through a call center staffed by licensed agents, in person sales appointments, or public sales meetings where a licensed agent collects the forms.

Agent assisted enrollments include both individual and group enrollments in which a licensed agent (employee or independent) assisted in completing the enrollment process and for which that agent is compensated.

The count of agent assisted enrollments should be enrollments that are as a direct result of the participation of the group of agents reported in Data Element 12.1.

Cases should be reported when they are opened.

Plans should report the number of complaints received during a given reporting period.

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.

For Data Elements 13.3 and 13.4 CMS requires only **completed** assessments.

Capturing the completion of initial and annual health risk assessment will be variable among MAOs offering SNPs. MAOs are required to use a standardized health risk assessment tool that may be paper-based or electronic, and may be self-developed or commercially available. The tool must assess medical, psychosocial, functional, and cognitive needs, but CMS has not identified a standard tool that all SNPs must use. The results of the health risk assessments must be used to develop and update the required care plan for each beneficiary. MAOs are required to maintain documentation of health risk assessment. Examples of this documentation include, but are not limited to, electronic or paper copies of the completed health risk assessment tool, evidence of communication (facsimile, e-mail, letter, etc.) with providers for verification of care (reports from specialists, copies of medical records, copies of medical histories, etc.), the OASIS

assessment tool for beneficiaries receiving home care, or the MDS assessment tool for beneficiaries in long-term care facilities. The information will not be captured by designated CPT or ICD-9 Procedure codes.

Appendices

Appendix 1: Table Summarizing Benefit Utilization Measure

Contract number	1
PBPs	2
Organization Name	
Reporting period	

		(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)
Medical Expenses														
Service Category		Utilization				Plan Experience			Allowed cost		Cost sharing		Net	
		# of Enrollees with Benefit	Utilizers	Utilization Type	Total Utilization	Total Plan reimb.	Total Member cost sharing	Allowed cost (g + h)	Total Medicare covered	Supplemental benefits (i - j)	Medicare actuarial equivalent	Supplemental benefits (l - h)	supplemental benefits (k + m)	
a.	Inpatient Facility	3	4	5	6	7	8		9		10			
b.	Skilled Nursing Facility	11	12	13	14	15	16		17		18			
c.	Home Health	19	20	21	22	23	24		25		26			
d.	Ambulance	27	28	29	30	31	32		33		34			
e.	DME/Prosthetics/Supplies	35	36	37	38	39	40		41		42			
f.	OP Facility - Emergency	43	44	45	46	47	48		49		50			
g.	OP Facility - Surgery	51	52	53	54	55	56		57		58			
h.	OP Facility - Other	59	60	61	62	63	64		65		66			
i.	Professional	67	68	69	70	71	72		73		74			
j.	Part B Rx	75	76	77	78	79	80		81		82			
k.	Other Medicare Part B	83	84	85	86	87	88		89		90			
l.	Transportation (Non-Covered)	91	92	93	94	95	96							
m.	Dental (Non-Covered)	97	98	99	100	101	102							
n.	Vision (Non-Covered)	103	104	105	106	107	108							
o.	Hearing (Non-Covered)	109	110	111	112	113	114							
p.	Health & Education (Non-Covd)	115	116	117	118	119	120							
q.	Other Non-Covered	121	122	123	124	125	126							
r.	Total Medical Expenses	127	128			129	130		131		132			

Supplemental data	
Total Enrollees	133
Member months	134
Premiums collected	135
CMS revenue collected	136
CMS Rebates for A & B	137
Reserve for outstanding claims	138

Notes

- Form to be completed at the PBP level for all plans.
- Data to be entered by Plans are shaded in blue.
- Data calculated by CMS are shaded in yellow.
- Utilization types: A - Admits; D - Days; BP - Benefit period; V - visits; P - procedures; T - Trips; S - Scripts; O - other; U - Data is unavailable
- Medicare actuarial equivalent cost sharing to be developed using actuarial equivalent factors contained in MA bid pricing tool.
- Premiums collected include payments from plan enrollees, employer/union groups, State Medicaid agencies, and other third parties.
- Optional supplemental benefits, revenues, and member months are to be excluded.

Appendix 2: Instructions for Completing the Benefit Utilization Table

The table in Appendix 1 may not represent the final format of the HPMS upload, although all the data elements will be the same. CMS will provide a data entry template to facilitate the creation of the upload file at a later date. Appendix 2 and 3 provide additional instructions for completing the Benefit Utilization table reflected in Appendix

General instructions:

- Complete one form representing all membership in the specified contract/PBP number.
- Optional supplemental benefits, revenues, and member months are to be excluded.
- Complete the header information:
 - Enter your contract number.
 - List the PBP under that contract number that had any enrollment during the reporting period.
 - Enter your organization name.
- Review the service category types in rows a-r in Column B. Reference the BPT service mappings provided in Appendix 3 to determine the correlation between the service categories in the BPT and the service categories appearing in this chart.
- Complete each column for each service category type (rows a-r):
 - **Column C – Number of enrollees with benefit:** Enter the number of enrollees who had access to the service under their plan benefit package during the reporting period. (An enrollee is defined as an individual enrolled under the contract for a minimum of one month.)
 - **Column D – Utilizers:** Enter the number of unique plan enrollees who used the service.
 - **Column E – Utilization type:** From the drop down box, select the appropriate code to identify how you capture utilization data. Choices include: A - Admits; D - Days; BP - Benefit period; V - visits; P - procedures; T - Trips; S - Scripts; O - other; U - unavailable.
 - **Column F – Total Utilization:** Enter the total number of services used by plan enrollees during the period (this is not a dollar amount).
 - **Column G – Total Plan Reimbursement:** Enter the reimbursement amount from the plan to providers for services used during the period.
 - **Column H – Total Member Cost Sharing:** Enter the total cost sharing paid by members directly to providers for services used during the period. Attach a brief narrative explaining your approach for deriving this information.

- **Column I – Allowed Cost:** *This will be calculated automatically.* Allowed cost is defined as the sum of columns G & H, which represents the total payments made by plans and enrollees to providers.
- **Column J – Total Medicare Covered (Allowed Cost):** Enter the total payments made to providers for services covered under original Medicare. Note – The amount entered in this column is a subset of column I; that is, the portion of Allowed Costs that would be covered services under original Medicare. Further note that the amounts in this column for Rows L through Q can only be \$0 since those service type categories are by definition not covered by original Medicare. Attach a brief narrative explaining your approach for deriving this information.
- **Column K – Supplemental Benefits (Allowed Cost):** *This will be calculated automatically and does not require Sponsor input.* Supplemental benefits (allowed cost) is defined as payments made to providers for services not covered under original Medicare (this will be calculated by the spreadsheet as Column I minus Column J). Note that this is the portion of allowed costs (Column I) that are not reported by you in Column J to be for Medicare covered services.
- **Column L – Medicare Actuarial Equivalent (Cost Sharing):** Enter the cost sharing that would be required for covered services using original Medicare requirements. This amount can be estimated using the actuarial equivalent factors published in the 2010 bid pricing tool. Note that the amounts in this column for Rows L through Q can only be \$0 since those service type categories are by definition not covered by original Medicare. Attach a brief narrative explaining your approach for deriving this information.
- **Column M – Supplemental Benefits (Cost Sharing):** *This will be calculated automatically and does not require Sponsor input.* Supplemental benefits (cost sharing) are defined as extra benefits provided in the form of cost sharing reductions (this will be calculated by the spreadsheet as Column L minus Column H).
- **Column N – Net Supplemental Benefits:** *This will be calculated automatically and does not require Sponsor input.* Net supplemental benefits is defined as supplemental allowed benefits (Column K) plus supplemental cost sharing benefits (Column M).
- Complete the Supplemental Data box:
 - Enter the total number of enrollees under the contract during the reporting period. (An enrollee is defined as an individual enrolled under the contract for a minimum of one month.)
 - Enter the number of member months during the reporting period.
 - Enter the dollar figure representing premiums collected over the course of the entire reporting period. Premiums collected include payments from plan enrollees, employer/union groups, State Medicaid agencies, and other third parties.
 - Enter the dollar figure representing CMS revenue collected under the contract over the course of the entire reporting period.
 - Enter the dollar figure representing CMS rebates for Parts A & B services collected under the contract over the course of the entire reporting period.

- Enter the dollar figure representing reserves for outstanding claims from the reporting period. This figure should represent claims that have not been submitted to your organization as well as claims that have been received, but not yet processed.
- The exhibit is to reflect revenues earned during the calendar year and medical expenses incurred during the calendar year. Thus, for the 2010 exhibit the CMS revenues are to reflect payments made by CMS in 2010 and 2011 with start dates in 2010. Consistent with this principle, the CMS revenues are to include the final 2010 risk adjustment settlement, which is expected to be paid in August 2011.

Appendix 3: Mapping of MA PBP Categories to Benefit Utilization Categories

The following chart illustrates the mapping of PBP categories to the service categories

PBP line #	PBP Service Category	Corresponding MA Medical Utilization and Expenditure Experience Category
1a	Inpatient Hospital - Acute	a1. Inpatient Facility: Acute
1b	Inpatient Hospital - Psychiatric	a2. Inpatient Facility: Mental Health
2	Skilled Nursing Services	b. Skilled Nursing Facility
3	Rehab. Services (CORF)	h5. Outpatient Facility - Other: Other
4a	Emergency Care/Post Stabilization Care	f. Outpatient Facility - Emergency
4b	Urgently Needed Care/Urgent Care Centers	f. Outpatient Facility - Emergency
5	Partial Hospitalization	h3. OP Facility - Other: Observation; or h5. OP Facility - Other: Other
6	Home Health Services	c. Home Health
7a	Primary Care Physician Services	i1. Professional: PCP
7b	Chiropractic Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7c	Independent Occupational Therapy Services	i4. Professional: Therapy (PT/OT/ST)
7d	Physician Specialist Services Except Psych (excl Radiology)	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7d	Physician Specialist Services Except Psych (Radiology)	i5. Professional: Radiology
7e	Mental Health Specialty Services - Non-Physician	i3. Professional: Mental Health
7f	Podiatry Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7g	Other Health Care Professional Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7h	Psychiatric Services	i3. Professional: Mental Health
7i	Physical/Speech Therapy	i4. Professional: Therapy (PT/OT/ST)
8a	OP Clinical/Diagnostic /Therapy Radiological Lab Services	h1. OP Facility - Other: Lab
8b	Outpatient X-Ray	h2. OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g. OP Facility - Surgery; or h. OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center Services	g. OP Facility - Surgery
9c	Outpatient Substance Abuse Services	h5. OP Facility - Other: Other
9d	Cardiac Rehabilitation Services	h5. OP Facility - Other: Other
10a	Ambulance	d. Ambulance
10b	Transportation	l. Transportation (Non-covered)
11a	Durable Medical Equipment	e1. DME/Prosthetics/Supplies: DME
11b	Prosthetics/Medical Supplies	e2. DME/Prosthetics/Supplies: Prosthetics/Supplies
11c	Diabetes Monitoring Supplies	e2. DME/Prosthetics/Supplies: Prosthetics/Supplies
12	Renal Dialysis	h4. OP Facility - Other: Renal Dialysis
13a	Blood	k. Other Medicare Part B
13b	Acupuncture	r. Other Non-covered
14a	Health Education/Wellness Programs	q. Health & Education (Non-covered) or k. Other Medicare Part B
14b	Immunizations	i1. Professional: PCP
14c	Routine Physical Exams	i1. Professional: PCP
14d	Pap Smears and Pelvic Exams Screening	i1. Professional: PCP; i2. Professional: Specialist excl MH; or i6. Professional: Other
14e	Prostate Cancer Screening	
14f	Colorectal Screening	
14g	Bone Mass Measurement	

14h	Mammography Screening	
14i	Diabetes Monitoring	
15	Outpatient Drugs and Biologicals/Prescription Drug	j. Part B Rx
16a	Dental: Preventative Services	m. Dental (Non-covered)
16b	Dental: Comprehensive Services	m. Dental (Non-covered)
17a	Eye Exams	n1. Vision (Non-covered): Professional
17b	Eye Wear	n2. Vision (Non-covered): Hardware
18a	Hearing Exams	o1. Hearing (Non-covered): Professional
18b	Hearing Aids	o2. Hearing (Non-covered): Hardware
19	POS	p. POS

Appendix 4: 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	201.00-201.28 201.40-201.78 201.90-201.98 203.00-203.11 203.80-203.81	009

			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, 32525, 32540,32503,	32.20, 32.22, 32.23 -32.26 32.28, 32.29, 32.30, 32.39, 32.41, 32.49, 32.50, 32.59 32.9	162.2 - 162.5 162.8, 162.9 197.0	163-168

	32504			
Excision of Large Intestine	44141,44143-44147, 44140,44150 44160, 44204- 44208,4421044211,442 12,44213	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

¹ 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 5: 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	Two codes are required to identify these events--one code to identify the site of the pressure ulcer (707.00-707.07, 707.09) and then the code to identify the stage of the pressure ulcer (707.20-707.25). The diagnosis codes for stage III and IV Pressure Ulcers are as follows: 707.23 Pressure ulcer, stage III

	707.24 Pressure ulcer, stage IV
Falls and Trauma: -Fractures -Dislocations -Intracranial Injuries -Crushing Injuries -Burns	Codes within these ranges on the CC/MCC list: 800-829 (Fractures) 830-839 (Dislocations) 850-854 (Intracranial Injuries) 925-929 (Crushing Injuries) 940-949 (Burns) 991-994 (Other & Unspecified Effects of External Causes)
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	<i>Principal Diagnosis</i> – 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 6: 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	20	Provide the federal tax ID of the Employer Group Plan Sponsor. (Note: This is a numeric field only.)	<numeric>
Employer_Street_Address	CHAR Required	150	Provide the street address of the Employer Group Plan Sponsor headquarters.	1212 North Luther Street
Employer_City	CHAR	75	Provide the city in	Wichita

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
_Address	Required		which the Employer Group Plan Sponsor headquarters is located.	
Employer_State_Address	CHAR Required	2	Provide the state abbreviation in which the Employer Group Plan Sponsor headquarters is located. (Note: The system shall validate the state abbreviation is appropriate.)	MO
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	062008

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
			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.)	
Employer Enrollment	NUM Required	7	Provide the current (or anticipated) enrollment for the Employer Group Plan Sponsor. (Note: This is a numeric field only. Do not include commas.)	9999999