

ODJFS Specifications for Reporting Payment Information on Encounter Data

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Office of Ohio Health Plans
Bureau of Managed Health Care**

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Introduction

Encounter data that is submitted to the Ohio Department of Jobs and Family Services (ODJFS) on or after January 1, 2006 must include payment information. The edits for encounter data will be based on submission date. The UB-92 Electronic Media Claims Version-4 Flat File Format (UB-92), Electronic Media Claims National Standard Format Version 1.03 (NSF), and the National Council for Prescription Drug Programs Telecommunication Standard Format Version 3 Release 2 Format (NCPDP) have been updated to reflect payment information reporting requirements.

UB-92 Specifications

Claims Not Paid by Diagnosis Related Groups (DRGs)

Table 1 specifies the fields used to report payment-related information for UB-92 claims that are not paid by DRG.

Header Level

- Header records for non-DRG paid claims will contain either: 1) the total amount paid for the claim (“0000000000” is only valid for header paid amount for claims in which all line items contain an immunization code, see Appendix B for complete list of immunization codes); or 2) “999999999” which indicates that the entire claim was part of a capitated arrangement.
- The total amount paid for the claim must be the sum of the line item paid amounts for the claim, including those claims that are partially capitated (some of the line items have capitation indicators).
- The date that the claim was paid must be reported at the header level.

Detail Level

- Line items will contain either: 1) the paid amount for the line item (may be “0000000000”); or 2) “999999999” which indicates that the line item was part of a capitated arrangement.
- Bundled payments, with the exception of diagnosis related group (DRG) payments, will be reported on a single line item and all other line items included in the bundled payment will be reported on the claim with a payment amount of “0000000000”. These bundled payments include ambulatory surgery group (ASG) payments.
- Room and board revenue center codes with their corresponding paid amounts/capitation indicators must be reported on record 50.
- There may be paid amounts, “0000000000”, and “999999999” on separate detail line items for a single claim.

Claims Paid by Diagnosis Related Groups (DRGs)

Table 1 of Appendix A specifies the fields used to report payment-related information for UB-92 claims that are paid by DRG.

Header Level

- The DRG code will be reported at the header level.
- Header records for claims paid by DRG will contain the total amount paid for the claim.
- The date that the claim was paid must be reported at the header level.

Detail Level

- The payment amounts for all line items for claims paid by DRG will contain “0000000000”.

NSF Specifications

Table 2 of Appendix A specifies the fields used to report payment-related information for NSF claims.

Header Level

- Header records will contain either: 1) the total amount paid for the claim (“0000000000” is only valid for header paid amount for claims in which all line items contain an immunization code, see Appendix B for complete list of immunization codes); or 2) “9999999999” which indicates that the entire claim was part of a capitated arrangement.
- The total amount paid for the claim must be the sum of the line item paid amounts for the claim, including those claims that are partially capitated (some of the line items have capitation indicators).

Detail Level

- Line items will contain either: 1) the paid amount for the line item (may be “0000000000”); or 2) “9999999999” which indicates that the line item was part of a capitated arrangement.
- Bundled payments, will be reported on a single line item and all other line items included in the bundled payment will be reported on the claim with a payment amount of “0000000000”. These bundled payments include ambulatory surgery group (ASG) payments.
- There may be paid amounts, “0000000000”, and “9999999999” on separate detail line items for a single claim.

NCPDP Specifications

Table 3 of Appendix A specifies the fields used to report payment-related information for NCPDP claims.

- Records will contain either: 1) the total amount paid for the claim (“000000” is not valid for pharmaceutical paid amount); or 2) “999999” which indicates that the entire claim was part of a capitated arrangement.
- The payment amount reported on the claim must be the total payment for prescription.
- Paid amounts should be rounded to the nearest dollar with the exception of payment amounts less than \$1, the amount on the claim will be “000001”.

ODJFS Edits

ODJFS will reject claims per the following specifications:

UB-92

Claims Not Paid by Diagnosis Related Groups (DRGs)

- There must be a dollar amount (may be “0000000000”) or a capitation indicator of “9999999999” for each line item.
- The total payment on the header record cannot contain “0000000000” except if a claim’s line item(s) contain only immunization codes (see Appendix B for complete list of immunization codes).
- The total payment on the header record must sum to the total payments of the line items for the claim for claims that are not capitated or partially capitated.
- The header record must contain a capitation indicator of “9999999999” if all of the line items for the claim contain a capitation indicator.
- A payment date must be reported at the header level that is on or after the last date of service on the claim.

Claims Paid by Diagnosis Related Groups (DRGs)

- If a DRG code is reported, there must be a payment amount at the header level.
- If a DRG code is reported, the line item payment fields must contain “000000000000”.
- If a DRG code is reported at the header level, the code must be a valid code.
- A payment date must be reported at the header level that is on or after the last date of service on the claim.

NSF

- There must be a dollar amount (may be “0000000000”) or a capitation indicator of “9999999999” for each line item.
- The total payment on the header record cannot contain “0000000000” except if a claim’s line item(s) contain only immunization codes (see Appendix B for complete list of immunization codes).
- The total payment on the header record must sum to the total payments of the line items for the claim for claims that are not capitated or partially capitated.
- The header record must contain a capitation indicator of “9999999999” if all of the line items for the claim contain a capitation indicator.
- A payment date must be reported at the header level that is on or after the last date of service on the claim.

NCPDP

- ODJFS will reject NCPDP claims if there is not either: a payment amount (“000000”) is not a valid for pharmaceutical paid amount); or a capitation indicator of “999999” in the payment field.
- A payment date must be reported for each record in the “Date Prescription Written” field that is on or after the date the prescription was filled on the claim.

Additional Submission Requirements and Guidelines

- Adjustments should not be submitted as adjustments. If adjustments are made, the entire claim will be resubmitted and will overlay the previous claim with the corrected payment information.
- The only claims which may be submitted with “0000000000” as a total payment in the header record are immunization claims. Free immunizations may be submitted as either stand alone claims or included in a claim in which other services are included.
- Submit all services which were: 1) paid either retrospectively through fee-for-service payment arrangements or prospectively through capitated arrangements by the managed care plan; and 2) immunization services regardless of payments made by the MCP.
- Charge-back arrangements will not be captured through encounter data. Given that charge backs are part of capitated arrangements, these line items will have a capitation indicator and will not include any payment amount.
- Capitated payment arrangement will be captured at the aggregate-level and through the annual cost reports by category of service, as is currently done.

Appendix A Fields for Reporting Payment Information

Table 1: UB-92 Fields for Reporting Payment Information

	VAR	REC TYPE	FIELD #	FIELD LENGTH	TYPE	POSITION FROM	POSITION THRU	FORMAT
INSTITUTIONAL CLAIM								
HEADER								
	PAYMENTS-RECEIVED	20	23	10	n	153	162	XXXXXXXXvXX*
	PAID DATE	40	19	6	n	124	129	MMDDYY
	DRG CODE	40	34	3	n	190	192	XXX
LINE ITEM								
	ACCOMODATIONS TOTAL CHARGES	50	7	10	N	42	51	XXXXXXXXvXX*
	INPATIENT ANCILLARY TOTAL CHARGES	60	9	10	n	45	54	XXXXXXXXvXX*
	OUTPATIENT TOTAL CHARGES	61	10	10	n	51	60	XXXXXXXXvXX*

Table 2: NSF Fields for Reporting Payment Information

	VAR	REC TYPE	FIELD #	FIELD LENGTH	TYPE	POSITION FROM	POSITION THRU	FORMAT
MEDICAL CLAIM								
HEADER								
	TOTAL PAYMENTS	CAO	06.0	10	n	55	64	XXXXXXXXvXX*
	PAID DATE	CAO	32.0	8	n	264	271	CCYYMMDD
LINE ITEM								
	LINE CHARGES	FAO	13.0	10	n	71	80	XXXXXXXXvXX*

Table 3: NCPDP Fields for Reporting Payment Information

	VAR	FIELD TYPE	FIELD #	FORMAT
PHARMACY CLAIM				
	USUAL & CUSTOMARY CHARGE	n	426	XXXXXX
	DATE PRESCRIPTION WRITTEN	n	414	CCYYMMDD

*v indicates an implied decimal point.

Appendix B Immunization Codes

Immunization	CPT Codes	ICD-9-CM Codes
DTP/DTaP	90698, 90700, 90701, 90702, 90703, 90719, 90720, 90721, 90723	V02.4, 032, 033, 037, 99.36, 99.37, 99.38, 99.39
IPV/OPV	90698, 90712, 90713, 90723	V12.02, 045, 99.41
MMR	<p>90704 (Mumps vaccine) with 90708 (Measles & rubella vaccine)</p> <p>90705 (Measles vaccine) with 90709 (Rubella & mumps vaccine)</p> <p>90706 (Rubella vaccine) with 90704 (Mumps vaccine) and 90705 (Measles vaccine)</p> <p>90707 (Measles, mumps, & rubella vaccine)</p> <p>90710 (Measles, mumps, rubella, & varicella vaccine)</p>	056, 072, 99.45, 99.46, 99.47, 99.48
HiB	90645, 90646, 90647, 90648, 90698, 90720, 90721, 90737, 90748	041.5, 038.41, 320.0, 482.2,
Hepatitis B	90723, 90740, 90744, , 90746, 90747, 90748	V02.61, 070.2, 070.3,
VZV	90710, 90716	052, 053