Statewide Planning and Research Cooperative System (SPARCS) Overview of Data Submission System

# Overview of SPARCS
Data Submission History

Background

- SPARCS has been in existence for over 35 years. It was establshed by statute in 1979. New York was the first state to collect this type of data.

- This all payer data set consists of pre-adjudicated claim data including: patient characteristics, diagnoses, services, and related charges for hospital discharges, ambulatory surgery, emergency department, and expanded outpatient data.

- Health care facilities submit SPARCS data necessary to meet New York State purposes.

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Submission System Overview

- NYSDOH has a contract with Optum Government Solutions, Inc. (Optum) for data submission processing.
- Optum's solution components include:
  - 24x7 Submission and Processing Window
  - OTVM (Optum Transaction Validation Manager)
    - Translation Engine
    - Rules Engine for Performing Edits
  - Standardized Response Transactions
- Edits will closely align with industry norms for claim submission editing
- Response transactions will include X12 standard transactions
- Files can include both inpatient and outpatient transactions. Individual claims will be classified as inpatient/outpatient using the Facility Type Code.

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SPARCS File Submission Process

SPARCS Submission Process
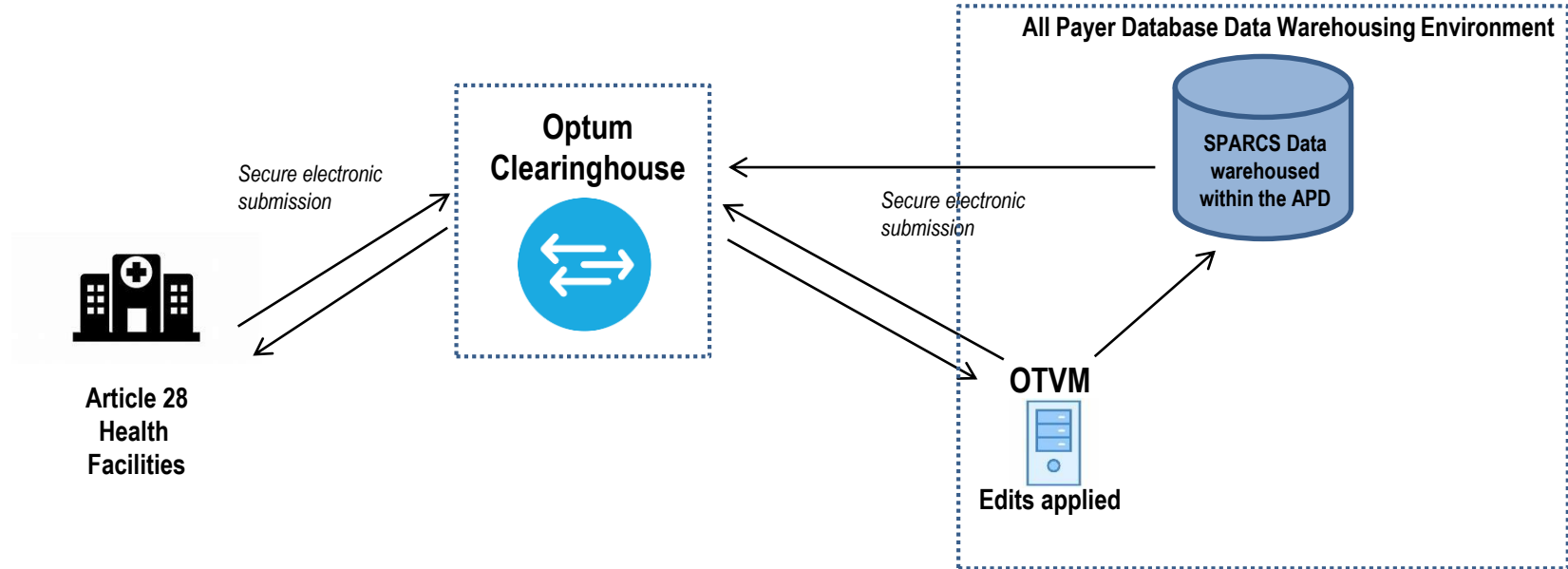
Upload and Retrieval Automation (SFTP Availability)

- SFTP is an available option for facilities that need to automate the file upload and retrieval process or need file size greater than 5 mg.

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Help Desk Support

- With the processing of data submissions now being handled by Optum, they will also be handling the Help Desk for technical submission support.

- Facilities will contact Optum's Help desk for processing issues.

- NYSDOH will remain involved in communications and providing assistance:
  - Working with Optum to identify problem areas in the submission process.
  - Handling Data Compliance and Statements of Deficiency (SOD).
  - Quality of data issues.

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Help Desk Support

- Help Desk Ticket Process

    - Each support issue will be assigned a help desk ticket that will be tracked updated and reported until the issue is resolved and resolution is communicated to the submitter.
    - Each ticket is assigned to a technician who is accountable to resolve the issue.
    - If the issue involves extensive research and/or IT development, the Technician will contact the submitter and provide continual updates until the issue is resolved.
    - At the start of each business day, an internal operational meeting is conducted by the clearinghouse team to review the status of all outstanding issues.

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Help Desk Support (cont.)

Hours of Operation

- The OptumInsight Support Desk is staffed 8:00 am – 7:00 pm EST, Monday through Friday.

Contact Information

- Telephone: IEDI Number (800-225-8951)
- Support Fax: IEDI Number (800-225-8951)
- Clearinghouse Enrollment Fax: 877-630-2064

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SPARCS Response Files

Response Files

- Multiple response file formats are available:

  - Machine readable standard X12 response transactions.
    - TA1 – File Acknowledgement
    - 999 – Transaction Set Acknowledgement
    - 277CA – Claim Acknowledgement
  - Duplicate Edit and Adjustment/Void Rejection Error File
  - Rejected Claim Records in X12 837R Format

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Response Files – TA1 and 999

TA1 – Interchange Acknowledgement
- Validates that the first 106 characters are compliant with the ISA segment layout
- Failure results in file rejection

999 – File Acknowledgement
- Validate the X12 syntax
- Validate Implementation Guide (TR3) rules
- Failure results in rejection of the transaction set as defined by the ST/SE

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Implementation Guide Rules

- Enforce X12 syntax
  - Loops and segments are structured properly and in the right order
  - All required data elements are present
  - Applicable situational rules are enforced
  - Implementation Guide codes are valid

SITUATIONAL	SBR09	1032	Claim Filing Indicator Code	O 1	ID	1/2
			Code identifying type of claim			

SITUATIONAL RULE: *Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.*

CODE	DEFINITION
09	Self-pay
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)

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Response Files – 277CA Claim Acknowledgement

- All errors encountered and identified will be reported.
- The 277CA provides an indication of whether individual claims were accepted for further processing or rejected for facility correction.
- Error reporting will be at the claim level.
- STC12 is used to provide a human readable description of the reason for the rejection.
- When the source of the rejection is based on line level data, the STC12 description will include the affected procedure code.

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Response Files
277CA (cont.)

Example

STC12

HL*4*3*PT~
NM1*QC*1*smith*john****MI*123456789~
TRN*2*1234506153101~
STC*A7:486*20170717*U*471********H51000 The Procedure Code '12345' is not a valid CPT or HCPCS Code for this Date of Service.~
STC*A7:486*20170717*U*471********H51000 The Procedure Code '54321' is not a valid CPT or HCPCS Code for this Date of Service.~
STC*A7:486*20170717*U*471********H51000 The Procedure Code '1212Z' is not a valid CPT or HCPCS Code for this Date of Service.~
REF*BLT*131~
DTP*472*RD8*20160815-20160815~

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Response Files
Duplicate Edit and Adjustment/ Void Rejection Error File

- Duplicate editing and Adjustment/Void processing will be performed as part of the downstream processing after the 277CA has been created.
- A comma delimited (CSV) file containing data elements necessary to identify the rejected transaction will be produced.
- Files will only be created when errors are encountered.
- Data elements include:
  - Patient Control Number (CLM01)
  - Statement From and Thru Dates (DTP03 when DTP01 = 434)
  - File Processed Date
  - Error Description

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Response Files
Rejected Claim Records in X12 837R Format

- This is the current "Error File" that is available for download.

- It will contain all rejected transactions in 837R format.

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Companion Guide

Companion Guide

- 837 Claim: Health Data Reporting (X225A2 837R)
    - Developed to align, to the extent possible, with the HIPAA 837I (X223A2)
    - Collects demographic information (e.g., race/ethnicity)
    - NTE Segment used to collect Source of Payment Typology and Cardiac data elements
    - A review of over 900 files demonstrates 44% of current submissions will reject because they are not in the X225A2 837R format.
        - To find out if your files fall into this category, ask your EDI/IT team to check the value reported in ST03. That value must be '005010X225A2'.
- The SPARCS Website Data Submission page can be found on the "New Process" page at https://www.health.ny.gov/statistics/sparcs/submission/. On this page you can find documentation to support implementation.

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Transaction Set, Submitter and Receiver Loops

Transaction Set
- ST - Transaction Set Header
  - ST03 - Implementation Convention Reference must be "005010X225A2"

Submitter (1000A SUBMITTER NAME)
- PER - Submitter EDI Contact Information
  - Contact Information (Phone, Fax, or Email) for the Submitter is required

Receiver (1000B RECEIVER NAME)
- NM1 - Receiver Name
  - Receiver Name and Receiver Primary Identifier are required
  - Required value for both fields is "SPARCS"

Provider Loops

- Service Provider Name (2010AA)

- Attending Provider Name (2310A)

- Operating Physician Name (2310B / 2420A)

- Other Operating Physician Name (2310C / 2420B)

- Rendering Provider Name (2310D)

- Referring Provider Name (2310F)

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Provider Information

The following rules apply to all Provider Loops:

- NM1 Provider Name
    - Last Name/Organization Name is required
    - First Name, Middle Initial, and Suffix are required when available.
    - National Provider Identifier (NPI) is required for all providers

- REF Secondary Provider Identification
    - NYS License Number is no longer required

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Service Provider

- NM1 Service Provider Name
    - The qualifier for service provider (NM101) must be "SJ".
    - "85" is not a valid qualifier for 5010 transactions.

- REF Service Provider Secondary Identification
    - The Permanent Facility Identifier (PFI) will continue to be required

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Subscriber/Patient

The following rules apply to both the Subscriber and Patient Loops:

- NM1 Subscriber/Patient Name
    - Last Name is required
    - First Name, Middle Initial, and Suffix are required when available
    - Primary Member Identifier is required

- N3 Subscriber/Patient Address
    - The address segments are required. If the patient is homeless with no address, use the facility address. The indication of homelessness is to be conveyed using Condition Code "17".

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Subscriber/Patient (Cont.)

- N4 Subscriber/Patient City, State, ZIP Code
    - The City, State and Postal Code are required when appropriate.
    - State and Postal Code must be valid values.
    - Location Identifier – County must be reported using Federal Information Processing Standards (FIPS) County Codes.

- DMG Subscriber/Patient Demographic Information
    - Race and Ethnicity codes are required. This will require a minimum of one race code and one ethnicity code.
    - Marital Status is required

- REF Subscriber/Patient Secondary Identification
    - Social Security Number is required when available
    - Unique Person Identifier (UPID) is no longer required

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Subscriber/Patient (Cont.)

- Subscriber Information
  - SBR Subscriber Information
    - Subscriber Group Number is required if available.
    - Subscriber Group Name is required if available and the group number is not reported.
    - Claim Filing Indicator Code may contain any valid code. Relational edits with Payer ID, Policy Number, NPI, and Payment Typology will no longer be enforced.
  - NM1 Subscriber Name
    - Subscriber Name will allow both person and non-person qualifiers. When a non-person qualifier is reported, Organization Name is required and First, Middle and Suffix are not used.

- PAT Patient Information
  - Individual Relationship Code (Patient Relationship to Subscriber) is required.

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Payer Information

- NM1 Payer Name
    - Payer Organization Name is required.
    - Payer Identifier Code is required. Payer specific instructions are being eliminated.

- REF Payer Additional Identifier
    - No longer required. Payer specific instructions are being eliminated.

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Claim Information

- Submission Limits
  - Discharge dates more than 10 years old will no longer be accepted.

- CLM   Claim Information
  - Total Claim Charge Amount of zero is allowed.
  - Facility Type Code is no longer limited. All valid values are allowed.

- DTP   Discharge Hour
  - Discharge Hour is required for Inpatient only.

- DTP   Statement Dates
  - Statement From Date can precede the Admission Date.

- DTP   Admission Date/Hour
  - Admission Date and Hour are required for Inpatient only.

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Claim Information (Cont.)

- AMT   Payer Estimated Amount Due
  - Estimated Claim Due Amount is not required.

- AMT   Patient Estimated Amount Due
  - Patient Responsibility Amount is not required.

- REF   Mother's Medical Record Number for Newborns
  - Mother's Medical Record Number is required when the age of the patient is 28 days or less and the Admission Type Code is "4 – Newborn".

Claim Note (NTE)

The following data elements are being removed:

- Expected Principal Reimbursement
- Expected Reimbursement Other 1
- Expected Reimbursement Other 2
- Method of Anesthesia
- Exempt Unit Indicator
- Procedure Time

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Claim Note (NTE)

- The NTE segment will be in a delimited format using the "[" as the delimiter.

- The NTE segment format is being modified to:

Data Element	Required/ Situational	Format	Max Length
Source of Payment Typology I	Required	AN	5
Source of Payment Typology II	Situational	AN	5
Source of Payment Typology III	Situational	AN	5
Heart Rate	Situational	AN	3
Blood Pressure Systolic	Situational	AN	3
Blood Pressure Diastolic	Situational	AN	3
Previous Patient Control Number (CLM01)	Situational	AN	38

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Adjustment/Void Processing

Identifying Transaction to be Adjusted/Voided

- If the "Previous Patient Control Number" is submitted in the NTE segment:
    - Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
    - Previous Patient Control Number (NTE)

- If the "Previous Patient Control Number" is not submitted in the NTE segment:
    - Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
    - Patient Control Number (Loop 2300 – CLM01)

- If no match is found, the transaction will be rejected.

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Diagnosis Information

- Present on Admission Indicator
  - Required for Principal Diagnosis, Other Diagnoses and External Cause of Injury diagnoses
  - "1" is not a valid value

- Patient's Reason For Visit
  - Patient Reason For Visit is required for outpatient visits

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Health Care Information

- All Valid Values may be reported for:
  - Occurrence Code
  - Value Code
  - Condition Code
  - Occurrence Span Code

- Occurrence Information
  - Associated Dates may be outside of the Statement Dates when appropriate

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Procedure Information

- Principal Procedure Date and Procedure Date edits rejecting procedures more than 3 days prior to the admission date have been removed.

Service Line Information

- Service Line Revenue Code
  - Current edits using Non-Covered Charges have been removed
  - All valid values can be reported
- Procedure Modifiers 3 and 4 can now be reported
- Line Item Charge Amount
  - All restrictions have been removed
  - Zero is a valid amount
- Service Unit Count is required
- Line Item Denied Charge or Non-Covered Charge Amount current restrictions have been removed

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Reference Documentation Sources

X12 Health Care Service: Data Reporting Implementation Guide
- 5010 837-R Health Care Service: Data Reporting
- Guide ID: X225
- http://store.x12.org/store/healthcare-5010-original-guides

Official UB-04 Data Specifications Manual
- National Uniform Billing Committee (NUBC) / American Hospital Association
- http://www.nubc.org/

Contact Information

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