STATE OF NEW YORK
DEPARTMENT OF HEALTH
800 North Pearl Street, Room 231 Albany, New York 12204

Richard Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

October 1, 2008

Dear SPARCS Coordinator:

Re: Changes to SPARCS Reporting Requirements for 2009

In order for the NYS Department of Health to continue to make significant improvements to the SPARCS data, it is necessary to modify how payer information is reported to SPARCS.

Our current payer data element is inadequate in assessing the various types of payer and insurance mechanisms. In order to make the payer information more reflective of the existing insurance structures and programs, we will replace our data elements with a new payment typology developed by the Public Health Data Standards Consortium (PHDSC). This means that SPARCS will be adding three new payer data element to SPARCS in 2009 called the "Source of Payment Typology (I, II, III)" and replacing the existing data elements that were derived by Department of Health in 1983 called "Expected Principal Reimbursement". These data elements are needed by the Department of Health for rate setting purposes. In addition, the new payer typology keeps SPARCS in line with the national billing defined data elements and electronic version of the bill format, the ASC X12-837. The "Source of Payment Typology" data element is supported in the future version of the ASC X12-837 format.

Your facility is expected to completely transition to the new data elements by **December 31, 2009**. A successful transition will be exhibited by having one successful production file pass the edits for these new data elements for all records by December 31, 2009. During 2009, the current data elements for Expected Principal Reimbursement must be submitted; these data elements will be removed from SPARCS starting in 2010.

The SPARCS system will be able to accept these new data elements on July 1, 2009. You should begin sending in files with these new data elements as soon as possible after that date.

The details for this change are listed on the following pages. Enclosed you will find the Data Specifications Page and Appendix List that is needed for the new data elements. Please forward these on to the appropriate personnel within your facility or vendors for them to make the required changes and modifications to your system(s).

Thank you again for helping to improve the SPARCS data system.

Sincerely,

Laura K. Dellehunt

Laura K. Dellehunt
Director, SPARCS Administrative Unit
Bureau of Biometrics and Health Statistics

Enclosures

STATEWIDE PLANNING AND RESEARCH COOPERATIVE SYSTEM
2009 CHANGES - FINAL FORMAT

2300 NTE SEGMENT DEFINITION IN THE X12-837 FORMAT
4050 Reporting* or 4010(A1) Institutional

Inpatient NTE

Description	Position	Length	Format
Expected Principal Reimbursement	1 - 2	2	AN
Expected Reimbursement Other 1	3 - 4	2	AN
Expected Reimbursement Other 2	5 - 6	2	AN
Method of Anesthesia	7 - 8	2	AN
Exempt Unit Indicator	9 - 11	3	AN
Patient's Race *	12 - 13	2	AN
Patient's Ethnicity *	14 - 14	1	AN
Heart Rate on Arrival	15 - 17	3	AN
Blood Pressure on Arrival- Systolic	18 - 20	3	AN
Blood Pressure on Arrival- Diastolic	21 - 23	3	AN
Source of Payment Typology I (Primary)	**24 - 28**	**5**	**AN**
Source of Payment Typology II (Secondary)	**29 - 33**	**5**	**AN**
Source of Payment Typology III **(**Tertiary)	**34 - 38**	**5**	**AN**

Outpatient NTE

Description	Position	Length	Format
Expected Principal Reimbursement	1 - 2	2	AN
Method of Anesthesia	3 - 4	2	AN
Patient's Race *	5 - 6	2	AN
Patient's Ethnicity *	7 - 7	1	AN
Heart Rate Heart Rate on Arrival	8 - 10	3	AN
Blood Pressure on Arrival- Systolic	11 - 13	3	AN
Blood Pressure on Arrival- Diastolic	14 - 16	3	AN
Procedure Time	17 - 19	3	AN
Source of Payment Typology I (Primary)	**20 - 24**	**5**	**AN**
Source of Payment Typology II (Secondary)	**25 - 29**	**5**	**AN**
Source of Payment Typology III (Tertiary)	**30 - 34**	**5**	**AN**

* = When using the 4050 Reporting version the Patient Race and Patient Ethnicity are reported in the DMG Segment. Please see the data dictionary and addendums for complete details.

SOURCE OF PAYMENT TYPOLOGY I, II, III

Data Element Name:	Source of Payment Typology I Source of Payment Typology II Source of Payment Typology III					
Format-Length:	AN - 5				**Required For:**	IP, AS, ED
X12 Loop	**X12 Seg**	**Seg. Ele. (Ref)**	**Composite**	**Element ID**	**Code**	**Description**
2300	NTE	01	n/a	363	UPI	
		02	n/a	352	n/a	
Effective Date:	1/1/09				**Revision Date:**	

NOTE: These data elements are SPARCS extensions; they are not defined in the X12-837 ANSI 4050 reporting guide. For mapping guidelines refer to the SPARCS Inpatient and Outpatient 837 Addenda.

Definition:

The Source of Payment Typology identifies the payer expected to pay the bill.

Source of Payment Typology I is used for the MAJOR payer of the patient's bill.
Source of Payment Typology II is used for the secondary payer of the patient's bill, if applicable.
Source of Payment Typology III is used for the third payer of the patient's bill, if applicable.

The Source of Payment Typology is a hierarchical code list. It provides a range of codes from broad categories to related sub-categories that are more specific. Users should report the expected payer using the greatest level of detail without sacrificing accuracy of the information.

Specific attention should be given to types of payment using Managed Care Plans (MCPs). MCPs operate multiple products (HMO and PPO). Medicare (federal) and Medicaid (state) fund different HMO programs/products within the Managed Care Plans companies. In order to determine the appropriate funding, the MCP should advise on the state or federal funding to determine accurately the source of payment.

Codes and Values:

1. Must be a valid code in accordance with the Expected Reimbursement Codes in Appendix P.
2. Source of Payment Typology I must be entered
3. If Source of Payment Typology II or Source of Payment Typology III are not applicable, they must contain zeroes.

Inpatient Example:

Ex: Patient has Medicaid HMO:

*NTE**__UPI__**17 20ALR012072125080__211 0000000000__ ~*

Ex: Dual Eligible Patient:

*NTE**__UPI__**0304 20ALR012072125080__121 22 00000__ ~*

Outpatient Example:

Ex: Patient has Family Health Plus:

*NTE**__UPI__**1720012072125080230__2111 0000000000__~*

Ex: Patient has Medicaid HMO:

*NTE**__UPI__**1720012072125080230__211 0000000000__~*

Ex: Patient's race and ethnicity not reported in NTE section. Patient has Child Health Plus:

*NTE**__UPI__**1720 07212508023__23 0000000000__~*

Edit Applications:

1. Must be a valid entry.
2. Medicaid payers must be reported with a minimum of two digits from the typology.
3. Must be located in appropriate position in the NTE segment. See the appropriate Inpatient and Outpatient 837 Addenda.

Frequently Asked Questions on Source of Payment Typology

1. **Q: Who developed the Source of Payment Typology?**

   A: The Source of Payment Typology was developed by the Payer Subcommittee of the Standards Data Committee of the Public Health Data Standards Consortium (PHDSC). The PHDSC represents all 50 states from a public health / regulatory perspective. It was developed over the course of four years.

2. **Q: Is this a nationally recognized data element?**

   A: Yes. For those coding data under the HIPAA standards, the Payer Typology is referenced as an external code list in the ANSI X12 standards as a data element in the Subscriber Information Segment in the Subscriber and the Patient loops. Because this change was made after the October 2003 version of the ANSI X12 was approved and published, this modification will be supported in post 5010 (October 2003) version of the Health Services Data Reporting Guide. It has been adopted by the National Uniform Billing Committee.

3. **Q: Are other States using this?**

   A: Yes. Georgia started in 2007. Oregon began in June, 2008. New York will start in 2009.

4. **Q: Who is maintaining this code set?**

   A: The Source of Payment Typology will be maintained by the PHDSC. Any changes to the typology will be made annually in October.

5. **Q: Has PHDSC developed definitions for these values / code set?**

   A: Yes. The PHDSC has created a 20 page "User's Guide" for reporting. The link is: http://phdsc.org/about/committees/pdfs/SourceofPaymentTypologyUsersGuideOct2007.pdf

   The PHDSC website is**:** http://phdsc.org/standards/payment-typology-source.asp

6. **Q: When will SPARCS require this data element?**

   A: Start sending in as early as July 1, 2009. Required production submission by December 31, 2009.

7. **Q: Will SPARCS require a different X12-837 version for this data element?**

   A: No. At this time, the data element will be placed in the NTE segment and SPARCS will continue to accept the "4050 Reporting" and the "4010A(1) Institutional" versions. The future version that accepts the Source of Payment Typology data element is the 5010 Reporting version. SPARCS hopes to change to this version in the future.

8. **Q: What will be replaced with this data element?**

A: The following data elements will be removed in 2010:

Expected Principal Reimbursement
Expected Reimbursement Other 1 and
Expected Reimbursement Other 2

9. Q: Will the "Source of Payment Code" data element (aka Claim Filing Indicator) still be required?

A: Yes. This data element will be required in 2009 and 2010. Thus, in 2009 you will be reporting in essence, three types of payer data elements (the old NY payer fields called "Expected Principal Reimbursement", the X12-837 field "Source of Payment Code" and the new NY--adopted nationally depending on version of X12-837-- payer field). In the 5050 version of the X12-837 the standards committee will allow both to be reported. When SPARCS moves to another version X12-837 we will consider removing the "Source of Payment Code" data element so that you will only be reporting one type of payer data element to NYS (the new Source of Payment Typology).

10. Q: Will there be a cross walk to the other payer types?

A: Yes. The PHDSC has developed a crosswalk with the "Source of Payment/Claim Filing Indicator". NYS will provide a crosswalk with the Expected Principal Reimbursement payer type.

11. Q: Will there be any edits on this data element?

A: Yes. Only the values defined in the Source of Payment Typology will be accepted. The Medicaid and Medicare values must have a minimum of two digits when reporting.

In addition, the Payer ID for managed care plans will have a "cross-edit" to the Source of Payment Typology. With assistance from the NYS Department of Health, Office of Managed Care, this information will be checked. For example, the managed care plan "Capital District Physician Health Plan (CDPHP)" (NAIC #95491 in the Payer ID data field) is only licensed to have the following products/Source of Payment Typology's:

Example: Capital District Physician Health Plan (CDPHP)" NAIC #95491
'11' = Medicare Managed Care
'211' = Medicaid Managed Care
'2111' = Family Health Plus
'2112' = Healthy New York
'23' = Child Health Plus
'51' = Managed Care (Private)

Only these values will be accepted if the Payer ID is for CDPHP. A list of the NYS managed care plans and their corresponding Source of Payment Typology codes will be posted on the SPARCS website.

Appendix P - Public Health Data Standards Consortium
Source of Payment Typology
Version 3.0 - October 2007
with NYS Additions September 2008

Code	Description
1	**MEDICARE**
11	**Medicare (Managed Care)**
111	Medicare HMO
112	Medicare PPO
113	Medicare POS
119	Medicare Managed Care Other
12	**Medicare (Non-managed Care)**
121	Medicare FFS
122	Medicare Drug Benefit
123	Medicare Medical Savings Account (MSA)
129	Medicare Non-managed Care Other
19	**Medicare Other**
	MEDICAID
21	**Medicaid (Managed Care)**
211	Medicaid HMO
2111	**Family Health Plus** **(NYS ADDITION)**
2112	**Healthy New York** **(NYS ADDITION)**
	Medicaid PPO
213	Medicaid PCCM (Primary Care Case Management)
219	Medicaid Managed Care Other
22	**Medicaid (Non-managed Care Plan)** **(use this for Fee-for-Service)**
23	**Medicaid/SCHIP** **(use this for CHILD HEALTH PLUS)**
24	**Medicaid Applicant**
25	**Medicaid - Out of State**
29	**Medicaid Other**
3	**OTHER GOVERNMENT (Federal/State/Local)**
	(excluding Department of Corrections)
31	**Department of Defense**
311	TRICARE (CHAMPUS)
3111	TRICARE Prime--HMO
3112	TRICARE Extra--PPO
3113	TRICARE Standard - Fee For Service
3114	TRICARE For Life--Medicare Supplement
3115	TRICARE Reserve Select

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Code	Description
3116	Uniformed Services Family Health Plan (USFHP) -- HMO
3119	Department of Defense - (other)
312	Military Treatment Facility
3121	Enrolled Prime--HMO
3122	Non-enrolled Space Available
3123	TRICARE For Life (TFL)
313	Dental --Stand Alone
32	**Department of Veterans Affairs**
321	Veteran care--Care provided to Veterans
3211	Direct Care--Care provided in VA facilities
3212	Indirect Care--Care provided outside VA facilities
32121	Fee Basis
32122	Foreign Fee/Foreign Medical Program(FMP)
32123	Contract Nursing Home/Community Nursing Home
32124	State Veterans Home
32125	Sharing Agreements
32126	Other Federal Agency
322	Non-veteran care
3221	Civilian Health and Medical Program for the VA (CHAMPVA)
3222	Spina Bifida Health Care Program (SB)
3223	Children of Women Vietnam Veterans (CWVV)
3229	Other non-veteran care
33	**Indian Health Service or Tribe**
331	Indian Health Service - Regular
332	Indian Health Service - Contract
333	Indian Health Service - Managed Care
334	Indian Tribe - Sponsored Coverage
34	**HRSA Program**
341	Title V (MCH Block Grant)
342	Migrant Health Program
343	Ryan White Act
349	Other
35	**Black Lung**
36	**State Government**
361	State SCHIP program (codes for individual states)
362	Specific state programs (list/ local code)

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Code	Description
369	State, not otherwise specified (other state)
37	**Local Government**
371	Local - Managed care
3711	HMO
3712	PPO
3713	POS
372	FFS/Indemnity
379	Local, not otherwise specified (other local, county)
38	**Other Government (Federal, State, Local not specified)**
381	Federal, State, Local not specified managed care
3811	Federal, State, Local not specified - HMO
3812	Federal, State, Local not specified - PPO
3813	Federal, State, Local not specified - POS
3819	Federal, State, Local not specified - not specified managed care
382	Federal, State, Local not specified - FFS
389	Federal, State, Local not specified - Other
39	**Other Federal**
4	**DEPARTMENTS OF CORRECTIONS**
41	**Corrections Federal**
42	**Corrections State**
43	**Corrections Local**
44	**Corrections Unknown Level**
5	**PRIVATE HEALTH INSURANCE**
51	**Managed Care (Private)**
511	Commercial Managed Care - HMO
512	Commercial Managed Care - PPO
513	Commercial Managed Care - POS
514	Exclusive Provider Organization
515	Gatekeeper PPO (GPPO)
519	Managed Care, Other (non HMO)
52	**Private Health Insurance - Indemnity**
521	Commercial Indemnity
522	Self-insured (ERISA) Administrative Services Only (ASO) plan
523	Medicare supplemental policy (as second payer)
529	Private health insurance—other commercial Indemnity

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Code	Description
53	**Managed Care (private) or private health insurance (indemnity), not otherwise specified**
54	**Organized Delivery System**
55	**Small Employer Purchasing Group**
59	**Other Private Insurance**
6	**BLUE CROSS/BLUE SHIELD**
61	**BC Managed Care**
611	BC Managed Care - HMO
612	BC Managed Care - PPO
613	BC Managed Care - POS
619	BC Managed Care - Other
62	**BC Indemnity**
63	**BC (Indemnity or Managed Care) - Out of State**
64	**BC (Indemnity or Managed Care) - Unspecified**
69	**BC (Indemnity or Managed Care) - Other**
7	**MANAGED CARE, UNSPECIFIED** (to be used only if one can't distinguish public from private)
71	**HMO**
72	**PPO**
73	**POS**
79	**Other Managed Care, Unknown if public or private**
8	**NO PAYMENT from an Organization/Agency/Program/Private Payer Listed**
81	**Self-pay**
82	**No Charge**
821	Charity
822	Professional Courtesy
823	Research/Clinical Trial
83	**Refusal to Pay/Bad Debt**
84	**Hill Burton Free Care**
85	**Research/Donor**
89	**No Payment, Other**
9	**MISCELLANEOUS/OTHER**
91	**Foreign National**
92	**Other (Non-government)**

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Code	Description
93	**Disability Insurance**
94	**Long-term Care Insurance**
95	**Worker's Compensation**
951	Worker's Comp HMO
953	Worker's Comp Fee-for-Service
954	Worker's Comp Other Managed Care
959	Worker's Comp, Other unspecified
96	**Auto Insurance (no fault)**
98	**Other specified (includes Hospice - Unspecified plan)**
99	**No Typology Code available for payment source**
ZZZ	**Unavailable / Unknown**