



**Department  
of Health**

# Standard Companion Guide Transaction Information

Statewide Planning and Research Cooperative  
System (SPARCS)

# Contents

- Preface .....2
- 1 Transaction Instruction (TI) Introduction .....3
  - 1.1 Background .....3
    - 1.1.1. Overview of Health Care Service: Data Reporting Transactions.....3
    - 1.1.2 HIPAA Role in Implementation Guides .....3
  - 1.2 Intended Use .....3
- 2 Included ASC X12 Implementation Guides.....4
- 3 File and Claim-Level Guidance.....5
  - 3.1 General Reminders.....5
  - 3.2 Preparing data for submission to SPARCS .....5
    - 3.2.1 Formatting Names .....5
    - 3.2.2 Formatting Addresses.....6
    - 3.2.3 Patient and Subscriber Demographics and Identifiers.....6
    - 3.2.4 Reporting Source of Payment .....6
    - 3.2.5 Guidance for Submitting Claims for Newborn Patients.....7
    - 3.2.6 Expected Health Care Information Code Sets .....7
    - 3.2.7 Claim Note (NTE) Segment .....7
  - 3.3 Avoiding Duplication of Claims .....8
    - 3.3.1 Inpatient Claims.....8
    - 3.3.2 Outpatient Claims.....8
  - 3.4 Instruction Tables.....9
- 4 Note (NTE) Segment Format, Uses, and Guidance..... 15
- 5 Adjustment-Void Processing ..... 17
  - 5.1 Overview of Adjustment and Void Process..... 17
  - 5.2 Matching Records Using Facility Patient Control Number ..... 17
- 6 Additional Resources..... 19
- Appendix A: International Classification of Diseases Clinical Modification (ICD-10-CM)  
External Cause of Morbidity Code Reporting ..... 20
- Appendix B: Acronyms..... 21

# Preface

This Companion Guide (CG) serves as supplemental instructions for using the ASC X12 Implementation Guide to submit mandatory data to the New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS) database.

This CG contains Transaction Instructions to aid facilities submitting Statewide Planning and Research Cooperative System (SPARCS) data in meeting all SPARCS compliance requirements. Failure to follow the guidance in this document will result in claim rejections and the need to correct and resubmit data.

# 1 Transaction Instruction (TI) Introduction

## 1.1 Background

### 1.1.1. Overview of Health Care Service: Data Reporting Transactions

After submission by medical facilities, Statewide Planning and Research Cooperative System (SPARCS) data is combined with data from other sources to create the All-Payer Claims Databases. This necessitates the adoption of a single pre-adjudicated healthcare service data reporting standard. SPARCS data must be submitted using the ASC X12 837R (research) file format.

The 837R file format has many similarities with the 837I (institutional reimbursement) format, but there are some additional fields that are required in 837R. This guide will specify the requirements for SPARCS 837R files.

This standard serves to:

- Support analysis performed by All-Payer Claims Databases
- Promote consistency in pre-adjudicated health care service data reporting
- Reduce administrative costs

### 1.1.2 HIPAA Role in Implementation Guides

The Health Care Service: Data Reporting Implementation Guide was developed for use by the health care industry. At this time, it has not been adopted as a HIPAA standard and is not a HIPAA covered transaction under 45 Code of Federal Regulations Part 162.

## 1.2 Intended Use

The Transaction Instruction component of this Companion Guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents.

The New York State Department of Health (the Department) expects providers to collect, maintain, and submit information contained within the provider's systems as required by the associated X12 Implementation Guide and this Companion Guide. This information is essential for the Department to perform health care analytics. This companion guide conforms to the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

## 2 Included ASC X12 Implementation Guides

Table 1: X12N Implementation Guides below lists the X12N Implementation Guides for which specific Transaction Instructions apply, and which are included in Section 3 of this document. Implementation Guides are available at <https://x12.org/>.

Table 1: X12N Implementation Guides		
Unique ID	Name	Description
005010X225A2	Health Care Service: Data Reporting (837R)	Data submitted to SPARCS by medical facilities (submitters)
005010X231A1	Implementation Acknowledgment for Health Care Insurance (999)	Response file sent to submitters to confirm that there were no high-level structural issues with the data submitted
005010X214	Health Care Claim Acknowledgment (277)	Response file sent to submitters that summarizes the number of claims accepted and providing details of any claims rejected due to errors

## 3 File and Claim-Level Guidance

This section provides broad guidance on formatting data for SPARCS submissions, followed by tables showing loops and segments where SPARCS expectations are more specific than the instructions included in the X12 Implementation Guide.

### 3.1 General Reminders

1. Facilities must submit files at least monthly
2. Each submission file may contain data for only one Facility ID (PFI)
3. All patient encounters must be reported to SPARCS, not just billed or reimbursable claims
4. Each submission file name is recommended to include:
  - a. The file type (e.g., Test for a test file, Prod for a production file)
  - b. Claim type (e.g., IP for inpatient) of the records
  - c. Time period (e.g., month, year) of the records
5. Facilities must never include personal identifying information (PII) in any field that does not explicitly require it. Patient or Subscriber first and last name, date of birth, social security number, or address must not be included in any field that is not designed to receive it. Examples of fields where facilities have exposed PII by submitting it inappropriately include: PAYR\_NAME (payor name), PAYR\_ID (payor ID), PAT\_GRP\_NUMB (patient group number), POL\_NUMB (policy number), MED\_REC\_NUMB (medical record number), and PAT\_CTRL\_NUMB (patient control number). Facilities must remain vigilant in protecting patient privacy by complying with X12 standards as designed.

Note: Medical record numbers that routinely include only the final four digits of patients' social security numbers are acceptable.

### 3.2 Preparing data for submission to SPARCS

1. The "Transaction Set Identifier Code" must be 837
2. The "Version, Release, or Industry Identifier" must be 005010X225A2
3. The "Submitter Identifier" must be the Collector Code assigned to the facility by the Department
4. The "Transaction Segment Count" (SE01) must match the actual count of segments in the file
5. The National Provider ID (NPI) must be included for every provider referenced in each claim

#### 3.2.1 Formatting Names

1. First names are required for all providers, subscribers, and patients

2. First names must be a minimum of 1 character and a maximum of 35 characters
3. Last names are required for all providers, subscribers, and patients
4. Last names must be a minimum of 2 character and a maximum of 60 characters; if the last name is only 1 character, add “z” to meet the minimum character limit

### 3.2.2 Formatting Addresses

1. All addresses within New York State must include a valid county code (see [Federal Information Processing Series \(FIPS\) County Codes](#))
2. Where patient or subscriber address is not available (for example in the case of an unhoused patient with no shelter or other temporary address to report), use the facility address to complete the required address information
3. All addresses outside the United States must include a [valid country code](#) (refer to the X12 Implementation Guide for more details)

### 3.2.3 Patient and Subscriber Demographics and Identifiers

1. A minimum of two iterations of the “Composite Race or Ethnicity Information” segment are required for each individual: one to report ethnicity and one to report race
2. The X12 Implementation guide uses the terms “sex” and “gender” interchangeably. All of the current “gender” fields are intended to capture the patient’s sex assigned at birth. The “U” value is intended to be used in cases where patient sex cannot be determined at birth (as in the case of intersex patients) or is genuinely unknown.
3. Social Security Number (SSN) is not required for any patient/subscriber, but if a partial SSN is reported, it must be left-filled with “0”s to make a total of 9 characters (e.g., 000001234)
4. A Medical Record Number (MRN) must be included for all patients; must not be blank or include only “0”s or only “9”s (see special guidance for reporting “Mother’s Medical Record Number” in the following section)

### 3.2.4 Reporting Source of Payment

1. When using National Association of Health Data Organizations (NAHDO) source of payment typology codes, Medicare claims must use one of the “1” series codes Medicaid claims must use one of the “2” series claims, and private managed care claims must use the code series connected to the specific commercial payer. Do not use any of the “7” series codes for known Medicare, Medicaid, or commercial payer claims.
2. If patient is the payer, enter “self” as the payer name. Do not enter the patient’s first and last name or any other patient identifying information.

### 3.2.5 Guidance for Submitting Claims for Newborn Patients

1. The birthing parent's Medical Record Number must be reported in the "Mother's Medical Record" segment when a valid newborn diagnosis is reported in the "Principal Diagnosis Code"; if the birthing parent is not admitted to the hospital, the "Mother's Medical Record Number" field may be all "9"s
2. Birthweight must be reported in whole number grams (without decimals) for all claims where the patient is a newborn; the minimum acceptable birthweight is 99g and the maximum acceptable birthweight is 12500g

### 3.2.6 Expected Health Care Information Code Sets

1. SPARCS adheres to the X12 837R implementation guide specification of external code sources that are acceptable for data submission.
2. National Uniform Billing Committee (NUBC) code sets are used where indicated by the implementation guide.
3. Inpatient Claims are defined by the NUBC Data Specifications Manual.
  - a. SPARCS expects International Classification of Disease, Tenth Revision, Clinical Modification Codes (ICD-10-CM) for inpatient diagnoses
  - b. SPARCS expects International Classification of Disease, Tenth Revision, Procedural Codes (ICD-10-PCS) for inpatient procedures.
4. Outpatient Claims are defined by the NUBC Data Specifications Manual.
  - a. SPARCS expects International Classification of Disease, Tenth Revision, Clinical Modification (ICD-10-CM) codes for outpatient diagnoses.
  - b. SPARCS expects Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes for outpatient procedures.
5. SPARCS accepts National Drug Codes (NDCs) for pharmacological items within both inpatient and outpatient claims.
6. Refer to [Appendix A](#) for information about situationally required external cause of injury ICD-10-CM codes. Note that failure to include external cause of injury codes as specified is one of the most frequent reasons for claim rejections when submitting SPARCS data.

### 3.2.7 Claim Note (NTE) Segment

Refer to Section 4 for guidance on how to include required information for additional payers, claim adjustments and voids, and myocardial infarctions

## 3.3 Avoiding Duplication of Claims

### 3.3.1 Inpatient Claims

Claims are considered Inpatient records if the Facility Type Code in the CLM05-01 segment is equal to any of the following: 11, 18, 21, 28, 41, 65, 66, 86. The SPARCS Intake system uses the following fields to identify potential duplicate inpatient claims:

1. Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
2. Statement To and From Date (Loop 2300 DTP when DTP01=434)
3. Patient Control Number (Loop 2300 – CLM01)

Refer to [Section 5.2](#) for additional details about avoiding creating duplicate inpatient records.

### 3.3.2 Outpatient Claims

Any values other than 11, 18, 21, 28, 41, 65, 66, 86 for Facility Type Code in the CLM05-01 segment position will be considered Outpatient records. The SPARCS Intake system uses the following fields to identify potential duplicate outpatient claims:

1. Statement From and To Date (Loop 2300 – DTP03 when DTP01=434),
2. Principal Diagnosis Code – (Loop 2300 – HI segment HI01-2),
3. Claim Facility Type/Type of Bill Code (Loop 2300 – CLM05-01),
4. Facility PFI (Loop 2010AA REF02 when REF01=1J),
5. Medical Record Number (MRN) (Loop 2300 REF02 when REF01 = EA),
6. Revenue Code (Loop 2400 – SV201)
7. Procedure Code (Loop 2400 – SV202-02)
8. Procedure Modifier 1 (Loop 2400 SV202-03)
9. Procedure Modifier 2 (Loop 2400 SV202-04)
10. Procedure Modifier 3 (Loop 2400 SV202-05)
11. Procedure Modifier 4 (Loop 2400 SV202-06)
12. Service Line Date (Loop 2400 – DTP03 when DTP01=472)

It is vital that outpatient facilities use the appropriate NUBC procedure modifiers in cases of multiple similar procedures for one individual on the same day to avoid having claims incorrectly rejected as duplicates.

### 3.4 Instruction Tables

**Table 2. ASC X12/005010X225A2 Health Care Services: Data Reporting (837R) Instructions**

**Legend**

SHADED rows represent “segments” in the X12N Implementation Guide.

NON-SHADED rows represent “data elements” in the X12N Implementation Guide.

Loop ID	Reference	Name	Requirement
n/a	ST01	Transaction Set Identifier Code	Must be "837"
n/a	ST03	Version, Release, or Industry Identifier	Must equal "005010X225A2"
1000A	NM1	Submitter Name	
1000A	NM102	Entity Type Qualifier for Submitter	Must equal "2"
1000A	NM109	Submitter Identifier	Must equal the SPARCS Collector Code assigned by the Department.
1000B	NM1	Receiver Name	
1000B	NM103	Receiver Name	Must equal “SPARCS”.
1000B	NM109	Receiver Primary Identifier	the Department expects to receive “SPARCS”.
2010AA	REF	Service Provider Secondary Identification	
2010AA	REF01	Reference Identification Qualifier	The Department must receive an iteration of this segment with “1J” - Facility ID Number.
2010AA	REF02	Service Provider Secondary Identifier	In the “1J” - Facility ID Number iteration, this must equal the Permanent Facility Identifier (PFI).
2000B	SBR	Subscriber Information	
2000B	SBR01	Payer Responsibility Sequence Number Code	Must equal “P”. Source of Payment Typology I reported in the NTE segment must be the typology for this payer. See section 4.
2010BA	NM1	Subscriber Name	
2010BA	NM103	Subscriber Last Name	The subscriber last name must be a minimum of 2 characters. In the case of a single character last name, fill with "z." The maximum character length is 60.
2010BA	NM104	Subscriber First Name	The minimum character length for subscriber first name is 1. The maximum length is 35.
2010BA	NM109	Subscriber Primary Identifier	For insured subscribers, the Department expects to receive the Plan’s member identifier for the subscriber. For patients with no insurance, the Department expects to receive “No Insurance”.
2010BA	N3	Subscriber Address	

Loop ID	Reference	Name	Requirement
2010BA	N301	Subscriber Address Line	For unhoused patients, use the address reported by the patient (e.g., shelter address). For patients whose address is unknown, use the facility address.
2010BA	N4	Subscriber City, State, and Zip Code	
2010BA	N401	Subscriber City Name	For unhoused subscriber, use the city name reported by the patient (e.g., shelter address). For subscribers whose address is unknown, use the facility city name.
2010BA	N402	Subscriber State or Province Code	For unhoused subscriber, use the state code reported by the patient (e.g., shelter address). For subscribers whose address is unknown, use the facility state code.
2010BA	N403	Subscriber Postal Zone or Zip Code	For unhoused subscribers, use the zip code reported by the patient (e.g., shelter address). For subscribers whose address is unknown, use the facility zip code.
2010BA	N406	Location Identifier (County Code)	For unhoused subscribers, use the county code reported by the patient (e.g., shelter address). For subscribers whose address is unknown, use the facility county code.
2010BA	DMG	Subscriber Demographic Information	
2010BA	DMG03	Subscriber Gender Code	Required when subscriber is patient. Must be valid code. The X12 Implementation guide uses the terms "sex" and "gender" interchangeably. All of the current "gender" fields are intended to capture the patient's sex assigned at birth. The "U" value is intended to be used in cases where patient sex cannot be determined at birth (as in the case of intersex patients) or is genuinely unknown. Additional guidance on submitting information about patient gender to SPARCS is under development.
2010BA	DMG05	Composite Race or Ethnicity Information	The Department expects to receive a minimum of 2 iterations. One with the race code and a second with the ethnicity code. Note: the "R" or "E" at the beginning of each code must be capitalized. <u>SPARCS currently supports CDC Race and Ethnicity Code System v. 1.0.</u>

Loop ID	Reference	Name	Requirement
2010BA	REF	Subscriber Secondary Identification	NOTE: Social Security Number is not a mandatory segment.
2010BA	REF02	Subscriber Secondary Identifier	Social Security Number is not a required segment. If submitting a partial Social Security Number, right justify and left fill the Social Security Number with zeros (i.e., 000001234).
2010BB	NM1	Payer Name	
2010BB	NM103	Payer Name	For insured subscribers, The Department expects to receive the Plan Name. If no insurance, the Department expects to receive "SELF". Do not enter patient's first and last name or any other patient identifying information.
2010BB	NM109	Payer Identifier	For insured subscribers, the Department expects to receive the Plan Identifier. If payer identifier is unknown or unavailable, the Department expects to receive "UNKNOWN".
2010CA	NM1	Patient Name	
2010CA	NM103	Patient's Last Name	Patient last name is required if the patient is not the subscriber. The patient last name must be a minimum of 2 characters. In the case of a single character last name, fill with "z." The maximum character length is 60.
2010CA	NM104	Patient's First Name	The minimum character length for patient first name is 1. The maximum length is 35.
2010CA	N3	Patient Address	
2010CA	N301	Patient Address Line	For unhoused patients, use the address reported by the patient (e.g., shelter address). For patients whose address is unknown, use the facility address.
2010CA	N4	Patient City, State, and Zip Code	
2010CA	N401	Patient City Name	For unhoused patients, use the city name reported by the patient (e.g., shelter address). For patients whose address is unknown, use the facility city name.
2010CA	N402	Patient State or Province Code	For unhoused patients, use the state code reported by the patient (e.g., shelter address). For patients whose address is unknown, use the facility state code.

Loop ID	Reference	Name	Requirement
2010CA	N403	Patient Postal Zone or Zip Code	For unhoused patients, use the zip code reported by the patient (e.g., shelter address). For patients whose address is unknown, use the facility zip code.
2010CA	N406	Location Identifier (County Code)	For unhoused patients, use the county code reported by the patient (e.g., shelter address). For patients whose address is unknown, use the facility county code. The county code must be the full 5-digit FIPS code. See <a href="#">Federal Information Processing Series (FIPS) County Codes</a> .
2010CA	DMG	Patient Demographic Information	
2010CA	DMG03	Patient Gender Code	Must be valid code. The X12 Implementation guide uses the terms “sex” and “gender” interchangeably. All of the current “gender” fields are intended to capture the patient’s sex assigned at birth. The “U” value is intended to be used in cases where patient sex cannot be determined at birth (as in the case of intersex patients) or is genuinely unknown. Additional guidance on submitting information about patient gender to SPARCS is under development.
2010CA	DMG05	Composite Race or Ethnicity Information	The Department expects to receive a minimum of 2 iterations. One with the race code and a second with the ethnicity code. Note: the “R” or “E” at the beginning of each code must be capitalized. <a href="#">SPARCS currently supports CDC Race and Ethnicity Code Set System v. 1.0.</a>
2010CA	DMG05-2	Patient Race/Ethnicity Qualifier	SPARCS requires all relevant Race/Ethnicity details for all claim types.
2010CA	DMG05-3	Patient Race/ Patient Ethnicity	SPARCS requires all relevant Race/Ethnicity details for all claim types.
2010CA	REF	Patient Secondary Identification	
2010CA	REF02	Unique Personal Identifier for Patient / Insured Policy Number for Patient Name	Social Security Number is not a required segment. If submitting a partial Social Security Number, right justify

Loop ID	Reference	Name	Requirement
			and left fill the Social Security Number with zeros (i.e., 000001234).
2300	CLM	Claim Information	
2300	CLM05-1	Facility Code Value	SPARCS requires <u>NUBC</u> codes
2300	CLM05-3	Claim Frequency Type Code	Must use "1" for original claims, "7" for adjustments, "8" for voids
2300	DPT	Admission Date/Hour	
			Must be on or before Statement From date. Must be on or before the SPARCS processing date. Admission hour must be reported in HHMM format. For outpatient (OP) claims, use "9999" for hour portion. For Emergency Department (ED) claims only, the Admission/Start of Care date can be within 4 days from Statement From - Through period to account for observation time.
2300	DTP03	Admission/Start of Care Date and Hour	
2300	CL1	Institutional Claim Code	
2300	CL101	Type of Admission	SPARCS requires <u>NUBC</u> codes
2300	CL102	Point of Origin	SPARCS requires <u>NUBC</u> codes
2300	REF	Medical Record Number	
2300	REF02	Medical Record Number	Must not be zero or all 9's. Special characters are invalid.
2300	REF	Mother's Medical Record Number for Newborns	
2300	REF01	Mother's Medical Record Identification Code Qualifier	Must equal "MRN"
			Must be reported when a valid newborn diagnosis is reported in the Principal Diagnosis Code. All 9's allowed when mother is not admitted to the hospital.
2300	REF02	Mother's Medical Record Number	
2300	NTE	Note Segment	
2300	NTE01	Note Reference Code	The Department must receive an iteration of this segment with "UPI" (Updated Information).
2300	NTE02	Claim Note Text	In the "UPI", the Department must receive data as specified in <u>Section 4</u> .
			The Department expects to receive External Cause of Injury codes for diagnosis codes requiring an external cause of injury as specified in <u>Appendix A</u> .
2300	HI	External Cause of Injury	

Loop ID	Reference	Name	Requirement
2300	HI	Value Information	All relevant Value Codes are expected to be submitted. There will no longer be a limited subset of accepted Value Codes.
2300	HI	Newborn Birthweight and Low Birthweight	For value code 54 - Newborn Birthweight in Grams the value code amount must be a whole number from 99 -12500gm (inclusive).
2300	HI	Condition Information	All relevant Condition Codes are expected to be submitted.
2300	HI	Principal Procedure Information	The Department will recognize ICD codes only.
2300	HI	Other Procedure information	The Department will recognize ICD codes only.
2320	SBR	Other Subscriber Information	
2320	SBR01	Payer Responsibility Sequence Number Code	Must not be "P". Source of Payment Typology II reported in the NTE segment must be the typology for the secondary payer "S". Source of Payment Typology III reported in the NTE segment must be the typology for the tertiary payer "T". See Section 4.
2400	SV2	Institutional Service Line	
2400	SV202	Composite Medical Procedure Identifier	The Department will recognize HCPCS codes only.
2410	LIN	Drug Identification	
2410	LIN03	Product/Service ID	This must be an 11-digit code with no special characters.

## 4 Note (NTE) Segment Format, Uses, and Guidance

Every case loop submitted to SPARCS must contain an NTE\*UPI segment that includes the [Source of Payment Typology](#). Links to the National Association of Health Data Organizations (NAHDO) Source of Payment Typology codes can be found in the Resources section of the SPARCS Data Submissions website:

<https://www.health.ny.gov/statistics/sparcs/submission/>. When using NAHDO source of payment typology codes, Medicare claims must use one of the “1” series codes Medicaid claims must use one of the “2” series claims, and private managed care claims must use the code series connected to the specific commercial payer. Do not use any of the “7” series codes for known Medicare, Medicaid, or commercial payer claims.

As shown in the table below, there are additional elements that are situationally required in the NTE segment for each case based on other details.

For SPARCS data submission, the NTE segment for each case uses a delimited format with up to seven specific elements. The delimiter between the data elements must be “]”. The “]” delimiter must not be used as the Component Element Separator. The elements of the NTE segment are shown in order in the table below:

Table 3. NTE Segment Instructions				
Element	Required/Situational	Format	Max Length	Situational Rule
Source of Payment Typology I	Required	AN	5	Must be present for each case submitted.
Source of Payment Typology II	Situational	AN	5	Required when there is a secondary payer.
Source of Payment Typology III	Situational	AN	5	Required when there is a tertiary payer.
Heart Rate	Situational	AN	3	Required when the principal diagnosis is myocardial infarction. Refer to the <a href="#">SPARCS Acute Myocardial Infarction Diagnosis Code Set</a> .
Blood Pressure Systolic	Situational	AN	3	Required when the principal diagnosis is myocardial infarction. Refer to the <a href="#">SPARCS Acute</a>

Element	Required/ Situational	Format	Max Length	Situational Rule
				<a href="#">Myocardial Infarction Diagnosis Code Set.</a>
Blood Pressure Diastolic	Situational	AN	3	Required when the principal diagnosis is myocardial infarction. Refer to the <a href="#">SPARCS Acute Myocardial Infarction Diagnosis Code Set.</a>
Previous Patient Control Number (CLM01)	Situational	AN	20	Required when processing an adjustment/void and the Patient Control Number in CLM01 does not match the Patient Control Number on the claim to be adjusted/voided. <a href="#">See Section 5.</a>

### Examples:

1. In an initial record for a patient where the principal diagnosis is NOT a myocardial infarction and there is a single source of payment (in this case a Commercial Managed Care – HMO), the NTE segment would appear as: **NTE\*UPI\*511~**
2. In an adjustment record for a patient where the principal diagnosis is NOT a myocardial infarction, there is a single source of payment (in this case a Commercial Managed Care – HMO), and the Patient Control Number has changed from ABC123 in the original claim to ABC1231 in the adjusted record, the NTE segment would appear as: **NTE\*UPI\*511]]]]]]ABC123~**
3. In an initial record where myocardial infarction is the principal diagnosis and there are two sources of payment, the NTE segment would appear as: **NTE\*UPI\*511]612]]90]149]95~**

# 5 Adjustment-Void Processing

## 5.1 Overview of Adjustment and Void Process

The Extract, Transform, Load (ETL) process ensures adjustment and void transactions correspond with an active transaction in SPARCS transaction history. SPARCS must maintain the history of the original transaction which was adjusted or voided with a clear indication that the transaction was modified by the processing of the adjustment or void transaction.

A SPARCS adjustment or void transaction will fail the Adjustment-Void edit and will be rejected by the system if no corresponding transaction is found in the SPARCS database. Conversely, if a facility does not follow the instructions for submitting voids or adjustments and submits changes as original claims, [duplicate records](#) may be created which reduce the accuracy of SPARCS data.

To submit an adjustment to an existing transaction, the Claim Frequency Code<sup>1</sup> must be changed from “1” to “7.” To submit a void, the Claim Frequency Code must be changed from “1” to “8.” Refer to your X12 implementation Guide for more details.

To correct instances of duplicated case records, a void must be submitted for each extra version of the case record. For example, if three versions of the same case record made it into the SPARCS system, two void transactions would be submitted to remove all but one of the matching case records.

*If the intent of the transaction is to alter the Permanent Facility Identifier, Patient Control Number or Statement To and From Date, the existing transaction must be voided and a new original transaction must be submitted with the new identifiers and a Claim Frequency Code of “1.”*

## 5.2 Matching Records Using Facility Patient Control Number

For the purposes of voids and adjustments, inpatient transactions are matched based on the following details:

- Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
- Statement To and From Date (Loop 2300 DTP when DTP01=434)
- Patient Control Number (Loop 2300 – CLM01)

**Facilities are strongly encouraged to maintain the link to the previously processed Patient Control Number (PCN) when processing adjustments or void requests.** If the Patient Control Number has changed, the Previous Patient Control Number must be included in a NTE segment for the claim ([see Section 4](#)). When the

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<sup>1</sup> 2300 — CLAIM INFORMATION CLM05 - 3 1325 Claim Frequency Type Code

previously processed PCN is included in the NTE segment, it will be used in place of the new PCN as part of the matching routine to help ensure the correct transaction is being replaced:

- Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
- Statement To and From Date (Loop 2300 DTP when DTP01=434)
- Previous Patient Control Number (NTE)

If the previous PCN is not included in the NTE segment, it will be assumed that the PCN in the replacement transaction is the same PCN that was used in the original/previous transaction.

## 6 Additional Resources

1. New York State Department of Health SPARCS Data Submissions website: <https://www.health.ny.gov/statistics/sparcs/submission/>
2. SPARCS Submissions Portal: <https://sparcs.optumoi.com/home>
3. SPARCS Portal User Guide: [https://www.health.ny.gov/statistics/sparcs/training/docs/sparcs\\_portal\\_user\\_guide.pdf](https://www.health.ny.gov/statistics/sparcs/training/docs/sparcs_portal_user_guide.pdf)
4. SPARCS Compliance Reports: <https://www.health.ny.gov/statistics/sparcs/reports/>
5. [SPARCS Submissions Companion Guide Change Log](#)
6. Centers for Disease Control and Prevention Race and Ethnicity Code Sets: <https://www.cdc.gov/phin/php/vocabulary/index.html>
7. Diagnosis Code Sets with Additional Requirements or Specifications:
  - a. [SPARCS Injury, Cause, and Place Code Set \(N0002/N0003 Edits\)](#)
  - b. [SPARCS Injury Secondary Diagnosis Required Code Set \(N0004 Edit\)](#)
  - c. [SPARCS Secondary Diagnosis Required Code Set \(N0007 Edit\)](#)
  - d. [SPARCS Acute Myocardial Infarction Diagnosis Code Set \(N0015 Edit\)](#)
  - e. [SPARCS Low Birthweight Edits \(N0010/N0016 Edits\)](#)
8. [Federal Information Processing Series \(FIPS\) County Codes](#)
9. [ISO 3166 Country Codes](#)
10. National Uniform Billing Committee website: <https://www.nubc.org/>

# Appendix A: International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Morbidity Code Reporting

External cause codes are required for SPARCS data submission as authorized under Section 400.18(b)(2) of the NYS Rules and Regulations for the collection of additional data elements. This aligns with Chapter 20 of the [ICD-10-CM Official Guidelines for Coding and Reporting](#), which notes that external cause codes may be required if subject to state-based reporting mandate.

## **SPARCS Injury, Cause, and Place Code Set Data**

The Department annually updates the **SPARCS Injury, Cause, and Place Code Set Data**, which lists the specific ICD-10-CM diagnosis codes that are required to be reported with external cause codes. This code set data can be found under the **Resources** section of the [SPARCS Data Submission website](#).

## Appendix B: Acronyms

Acronym	Description
AN	Alpha Numeric
AS	Ambulatory Surgery
ASC	Accredited Standards Committee
CG	Companion Guide
ED	Emergency Department
ETL	Extract, Transform, Load
FIPS	Federal Information Processing Series
HIPAA	Health Insurance Portability and Accountability Act
HCPCS	Healthcare Common Procedure Coding System
ICD	International Classification of Diseases
IG	Implementation Guide
II	Standard Unique Health Identifier for Each Individual in the United States
IP	Inpatient
MI	Member Identification Number
NPI	National Provider Identifier
NTE	CLAIM NOTE Segment
NYSDOH	New York State Department of Health
OP	Outpatient
PCN	Patient Control Number
PFI	Permanent Facility Identifier
SPARCS	Statewide Planning and Research Cooperative System
TR3s	Technical Report Type 3
UPI	Updated Information