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

Last updated September 2019

Overview of SPARCS Data Submission History

Background

- SPARCS has been in existence for over 35 years. It was established 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.

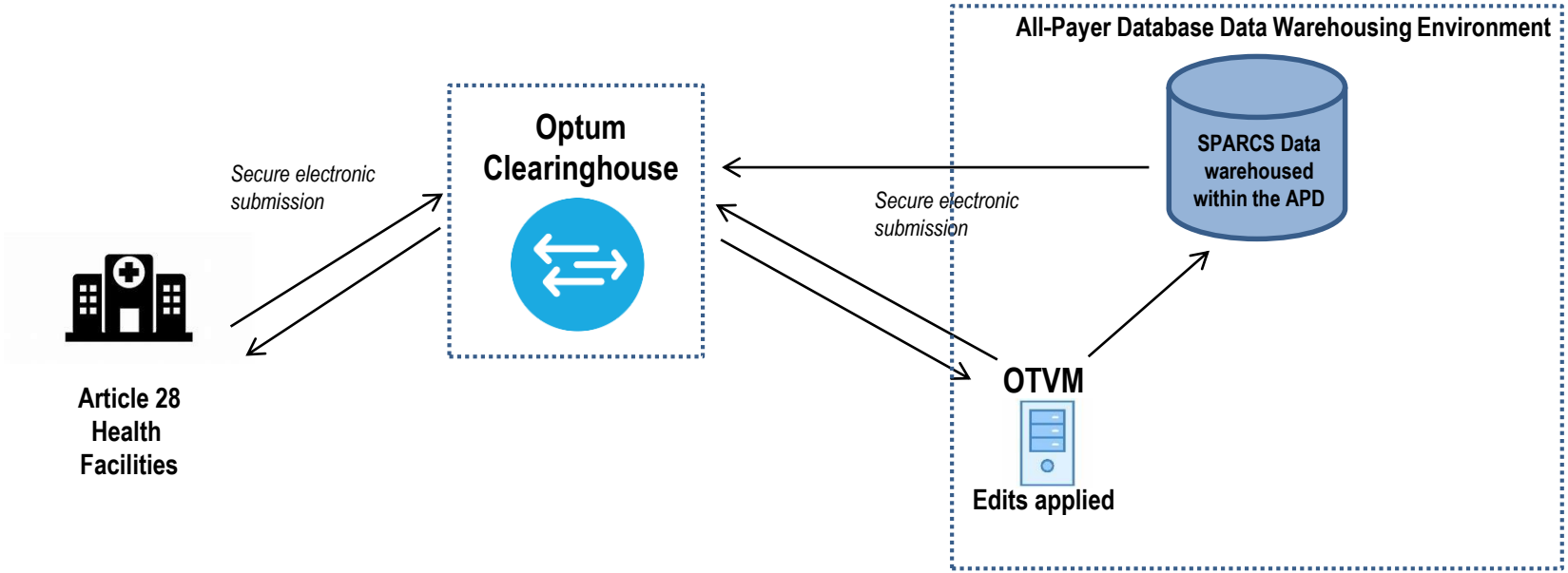
- Health care facilities submit SPARCS data necessary to meet New York State purposes.

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.

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.

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.

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.

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

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

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

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** Code identifying type of claim	O 1	ID	1/2

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)

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.

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~

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

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.

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.

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)

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

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

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”.

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

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.

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.

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.

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

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

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.

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

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

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

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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