Statewide Planning and Research
Cooperative System (SPARCS)

NEW YORK STATE OF OPPORTUNITY. Department of Health

FREQUENTLY ASKED QUESTIONS
SPARCS Stakeholder Forum
September 13, 2017

SPARCS FILE SUBMISSION PROCESS:

Q1. Since the Files are being submitted to Optum, does this require a BAA with Optum?
A1. From the DOH perspective, regarding the BAA in talking with our legal department, the attorney told us that because the Optum clearinghouse contracts with the state the files are under the state's guidance where the BAA is not necessary. Optum is still in talks with their legal department and will let us know the outcome.

Q2. For rejections, is that going to be the full set of everything on SPARCS before it gets to the database? Or are we(facilities), going to get a separate rejection report afterwards?
A2. There's two levels of editing. One at the clearinghouse and one when it gets to the SPARCS translation process. The clearinghouse will not be consolidating these reports. There will be one 277CA and one error file(csv).

Q3. Will files be downloadable from the system?
A3. Yes, files will be downloadable from the system in the raw 277CA format.

Q4. What format will the files from the system be in?
A4. Raw format: 277CA & Human Format: HTML Zip File and CSV File

Q5. Is it still possible to do direct edits through the PC App?
A5. No. The PC app will no longer be supported. Editing should be aligned with 837I claim problems.

Q6. How will we(facilities) be able to make edits and send back the files?
6. Codification should be the same as sent to payer in the 837I to SPARCS 837R format. Facilities will now have to either: Correct the source information or make manual edits to the 837R file.

Q7. How much editing does Payers do to the files we(facilities) receive?
A7. Edits by payers vary, and not all payers perform edits. Furthermore, payer claims might not even make it through the SPARCS edits. Although there are differences, we are looking at all the SPARCS NYS specific edits to reduce them.

Q8. Will resubmission rejection claims be tracked to ensure that they are resubmitted?
A8. No.

Q9. Who is going to ensure all the users are with their corresponding facilities?
A9. Optum will set up accounts. Authorization will come from DOH. DOH will be contacting facilities to update the user and contact information prior to it being sent to Optum.

Q10. Will HOD data still be available for download?
A10. The ability to download HOD data will not be there, one will need to contact SPARCS operation for data.

Q11. As some payers require certain revenue codes, will there be a scrubber function that potentially changes

the data for specific edits for payers?
A11. Submissions should be based just as if was submitted to the primary payer. Revenue codes that define the claim type aren't the ones that get switched between Medicare and other payers. Those don't affect classification of claims.

Q12. Can facilities both do SFTP and Uploads?
A12. Yes.

Q13. The Self-Pay codes are different for 837I -837R. Which one do we send?
A13. There is a difference between 837I and 837R. Use the 837R code set - 09 is the value.

Q14. Will you be rejecting the ST-SE segment? Currently we send one claim per ST-SE segment.
A14. Rejection will be at the ST-SE level.

Q15. With organizations acquiring other facilities, can we define when these transactions occur? When are we dealing with long term remote medical care?
A15. This is up for further discussion.

Q16. Can a hospital's specific data be requested for release from Optum?
A16. No. We're not entertaining that.

Q17. Will Optum be able to work with EMR to create correct file to upload?
A17. No, they are completely different formats

Q18. Can we download error file with rejected claims?
A18. Yes

Q19. How do we sign up for an account?
A19. DOH will send contact info to Optum. Optum will be setting up accounts and sending emails to facilities.

Q20. Will the SPARCS PC App be updated for users to ask questions?
A20. At this time, the SPARCS PC app cannot be updated. It is just for the current version there aren't resources to create a new app.

COMPANION GUIDE QUESTIONS & ANSWERS:

Q1: I read that the APRDRG has been used to find newborns. Have you thought about using the APRDRG to use as an identifier for newborns?
A1. We can look into it. We are following the WHO's definition for newborns.

Q2. Every year I get babies without their mother's MRN (Medical Record Number) because the baby will be born in the parking lot, and when the mother insists that the baby is taken in, the mother is not registered. What should happen in that situation?
A2. The admission type should not be a birth in that situation. It's an external birth, followed by the admission. Babies born outside the hospital should not have an Admission Type Code is "4 – Newborn" which is part of the edit.

Q3. How will we identify foreign addresses? There won't be a state code for foreign addresses?
A3. Use the appropriate Country code. The X12 rule is that for foreign addresses excluding Canada, no state code is required.

Q4. How do you propose ID'ing the homeless population in the database?
A4. There will be a condition code that is currently collected in the national standard which is known as 17 for Homeless.

Q5. The registrars don't code the homeless condition code on their demographic or necessarily ask. Will registrars need to find out that the person is homeless and staying in a homeless shelter?
A5. In an ideal world, condition code should be submitted. It is currently all over the place in the addresses. To get a true representation of the homeless we need to follow the national standard.

Q6. Is it necessary to code the shelter address or just facility address?
A6. That depends on how the facility is capturing the information. If they have the shelter address, they should use that.

Q7. Are you going to require the FIPS codes for all states or just NYS?
A7. Just NYS.

Q8. When dealing with long term care - e.g. "Care Coordination in Home" where are differentiators going to be? Some transactions won't have discharges for years.
A8. At the current time, we do not know. Visits or discharges are being complete from that perspective. Our mandate is to have Article 28 - Inpatient, Outpatient (currently on the grounds of the hospital), Emergency Departments, Ambulatory Surgery Centers submit. That said, we anticipate opening the other two phases and will discuss when it is closer.

Q9. Is the level of logic for Adjustment/Voids the same?
A9. No, it is much more simplified - Four elements. PFI, Patient Control Number, Statement From and Statement To Date.

Q10. We use the same PCN for multiple claims for the same episode of care. These will have the same PCN and without the date, how will the original be identified?
A10. This will be reflected in the companion guide updates.

Q11. We've been optimizing our payment services. Please define home based services, long-term.
A11. Visits or services that are complete. Article 28 of the healthcare law - Inpatient, Outpatient services on the grounds of the hospitals, not looking for satellite offices.

Q12. When collecting the Social Security Number, do you want the full SSN or just the last four and pad the rest out with zeroes?
A12. We prefer the full SSN. At the very least, the last four digits.

Q13. In one of the webinars, you stated we could also leave SS blank as opposed to filling it out with zeroes and that you guys would populate the field with zeroes. Which process do you want us using?
A13. Do not report the segment if you do not have the minimum of the last four digits. By throwing in nine zeroes or nine blanks, it messes with the validation structure that is looking for certain values. Under the standard error format, a string of 9 zeroes would be thrown out. If you have the full SS number or at least the last four digits, report it. Otherwise do not report it.

Q14. In the description of 6 Appendix A - Note Segment Format (NTE), there is a left square bracket, while the examples at the end of the appendix use right square brackets. Which one do we use?
A14. We will fix that and specify which bracket to use.

Q15. Where is the indication that this is not a duplicate record submitted at a later time?
If you are using the same PCN number for two record submissions where one is an adjustment, how will you know it is a replacement?
A15. The record will show what kind of bill type it is, a seven or an eight, if it is an adjustment or a void respectively.

Q16. If the patient control number is the same, is it automatically a duplicate?
A16. No, duplicates are identified when multiple data elements are deemed identical between the current record and the new submission record. Patient Control Number is not one of those data elements used in the comparison for duplicates.

Q17. What are the data elements in duplicate edits?
A17. DOH will send out the details
Inpatient
For the inpatient Facility (Type of Bill) Type codes in the following table, a match on these data elements will constitute a duplicate transaction
• Unique Person ID
• Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
• Claim Facility Type/Type of Bill Code (Loop 2300 – CLM05-01)
• Medical Record Number (Loop 2300 – REF02 when REF01=EA – Medical Record Number)
• Overlap in Statement To and From Dates (Loop 2300 – DTP03 when DTP01=434 – Statement) excluding cases in which the Statement To date is equal to the Statement From date of another transaction
Outpatient
For the outpatient Facility (Type of Bill) Type codes in the following table, a match on these data elements will constitute a duplicate transaction.
• Unique Person ID
• Facility PFI (Loop 2010AA REF02 when REF01=1J – Facility ID Number)
• Claim Facility Type/Type of Bill Code (Loop 2300 – CLM05-01)
• Statement To and From Dates (Loop 2300 – DTP03 when DTP01=434 – Statement)
• Attending Provider NPI (Loop 2310A – NM109)
• Revenue Code (Loop 2400 – SV201)
• Procedure Code (Loop 2400 – SV202-02)
• Procedure Modifier 1 (Loop 2400 SV202-03)
• Procedure Modifier 2 (Loop 2400 SV202-04)
• Procedure Modifier 3 (Loop 2400 SV202-05)
• Procedure Modifier 4 (Loop 2400 SV202-06)
• Service Line Date (Loop 2400 – DTP03 when DTP01=472)

Q18. Going back to adjustments, let's say I'm doing physical therapy sessions and going every week, so I submit multiple claims. How will I adjust one period without looking at the from-through date, how do you know what period you'll be looking at since the patient control number will be the same for all those sessions?
A18. Patient Control Number is used in combination with the Facility PFI, Statement From and Statement Through Dates.
Adjustments:

- If one matching active transaction is found, the transaction in history will be flagged as inactive and the adjustment transaction being processed will be added as active.
- If multiple matching active transactions are found, the first active transaction found in history will be flagged as inactive and the adjustment transaction being processed will be added as active.

Voids:

- If one matching active transaction is found, the transaction in history will be flagged as inactive and the void transaction being processed will be added as inactive.
- If multiple matching active transactions are found, the first transaction found in history will be flagged as inactive and the void transaction being processed will be added as inactive.

Q19. The county codes need to be in the standard otherwise it is not going to be compliant.
A19. DOH will provide a map between FIPS and current county codes.

Q20. The edits between diagnosis codes and transgender sex are a problem. Can the condition code for transgender be used to make those exempt from the edit?
A20. Going forward the gender/sex edits with diagnosis and procedures will no longer be enforced. It will become a compliance/data quality review.

Q21. When will SPARCS no longer accept the Homeless for address?
A21. Going forward in the new system – March 24th

TIMELINE AND IMPLEMENTATION STRATEGY

Q1. When can we begin testing?
A1. January 23. If anyone wants to send test files before the portal is ready let us know. OTVM will be ready for testing. Files can be sent to SPARCS through HCS.

Q2. What will happen with Q2 and Q3 data of this year that will be submitted late, and how should they be submitted come January?
A2. You will still be able to make adjustments and voids to data submitted through the 3rd quarter 2017 until December 31st. When we go live in 2018 with the new system we would like to start with just new submissions. As facilities and vendors become more comfortable with the new system, then we will inquire on an individual basis about any adjustments or voids that a facility/vendor would like to work on, and will move forward from there.

Q3. So Q3 claims that do not get submitted on time for the 2017 cut-off date, will not get submitted via the old or the new system?
A3. You will be submitting them with the new system, just not at launch. It will be at about the end of March.
We encourage that you submit as much Q3 data as you can before December 31st. We will be expecting 100% of Q3 2017 claims to be submitted in the window of March to September in 2018.

Q4. During the testing phase of the new system, will we be using 2017 Q4 data to test?
A4. Yes

Q5. Will claims have to be submitted in the new format?
A5. Yes, the mainframe goes away. Claims must be submitted in the new format.

Q6. After we start testing, will there be a time where we have to resubmit all the test files for production?
A6. No, it will follow the same X-12 rules as always. There will be a T for a test and a P for production.

Q7. How long will we be able to retrieve data from the mainframe before it is shut down?
A7. For those who want data, the extraction process is not shutting down. The Q3 data will be uploaded via its normal process to our platform by mid-January. With the final run of the mainframe, it will be checking and updating all years back to 1982 before it is "shut down". The final database will be 1982-2017 Q3 until we launch the new system.

Q8. Is there a time frame for Phase 2 of SPARCS satellite clinics to submit their data?
A8. We do not have a timeline for that yet. For clarity, phase two and three are only focused on clinics that have their own unique PFI, not clinics that are an extension of a hospital and using the hospital's PFI.

Q9. We are a freestanding ASC, would our status fall under the satellite clinic status?
A9. No, because we require all ambulatory surgery centers SPARCS data. Hospital-based or independent.

Q10. When will the codes that go into effect be released? It would be nice if they were released far enough in advance to allow for updating the systems.
A10. Will have a discussion of the timeline including ICD 10 codes. We are working with the folks doing the determination. Everyone needs them to update edit structures including Optum. The changes should allow for earlier release - think the change will be a win-win.

SPARCS TRANSACTION CHANGE

Q1. Has there been coordination with the Department of Education to link NPIs to license numbers?
A1. An attempt has been made and failed.

Q2. Is the payer ID still going to be required in terms of 5 digit codes that SPARCS has been collecting historically?
A2. If they are known and readily available, please send them, but they are not required.

Q3. Expected Principle Reimbursement is being eliminated. Does that tie back to payer? What will crosswalk to that data?
A3. Source of Payment Typology solves that issue

Q4. I'm not sure why you're getting rid of the NTE data elements, such as the exempt unit indicator or procedure time. I've found that these elements can be crucial to some researchers.
A4. All of these have proven to be problematic for facilities to submit. The procedure time is when they are wheeled in and tracking that is very problematic. We can't find anyone in DOH who uses Exempt Unit Indicator. Since we can't find users and it's problematic for facilities so we are eliminating them.

Q5. From now on do "present on admission" indicators need to be recorded in a yes/no format? Previously we were not required to limit some of these indicators to those responses.
A5. We are still following the same rules. There are codes for "yes", "no", "unknown" and "not applicable"

Q6. How do we deal with Split Claims to achieve a "total claim" for certain situations?
A6. That is a Policy Question.