Encounter Data User Group Q&A Documentation

Questions and Answers – March 21, 2013 Live Session

Q1: If an institutional chart review encounter is submitted to add a single admitting diagnosis code, should the MAO or other entity submit the admitting diagnosis code in Loop 2300, HI01-1 = 'BK' or HI01-1 = 'BJ'?

A1: If the admitting diagnosis code is the only code submitted on the chart review encounter, MAOs and other entities should submit the admitting diagnosis code by populating 'BK' as the Code List Qualifier Code in the HI01-1 segment of Loop 2300 (i.e., Loop 2300 HI01-1 = 'BK').

Q2: Does CMS provide any guidance for MAOs or other entities to identify the differences between a Medicaid Home Health encounter versus Medicare Home Health encounter submissions?

A2: MAOs and other entities are encouraged to submit questions regarding specific Medicaid and Medicare Home Health encounters to eds@ardx.net for research and resolution.

Q3: For 2012 Dates of Service (DOS) encounter submissions, if an MAO or other entity receives an original claim and two (2) subsequent adjustment claims prior to submitting an original encounter, can the MAO or other entity omit sending the original encounter and the initial adjustment and submit only the second adjustment encounter (third claim)?

A3: MAOs and other entities should submit the original encounter and all subsequent encounters to identify the progression of each encounter transaction and the amount of time it takes for each adjustment to occur. Adjustment encounters should only be submitted after an accepted ICN has been received on an MAO-002 Report for the original or previously adjusted encounter. MAOs and other entities should also verify that each subsequent encounter adjustment uses the correct ICN.

Q4: For an original encounter that does not pass the Encounter Data Front-End System (EDFES) (i.e., 999 or 277) due to incorrect information, does CMS have a recommendation on how to handle the adjustment encounter(s) as the original encounter did not generate an ICN number?

A4: If an encounter is submitted through the EDFES and receives a 999 or 277CA reject acknowledgement report due to incorrect information, the encounter should be corrected and then resubmitted to the EDFES. Encounters containing data that is deemed invalid or inaccurate in the MAO or other entity's internal system should not be submitted to the EDS until the correct data has been obtained from the provider.

Similar questions are not listed separately, but combined and published as one question with one answer.

Q5: If an MAO or other entity uses a default National Provider Identifier (NPI) for the Billing Provider when submitting subrogation encounters, but has a valid NPI for the Rendering Provider, will the Rendering Provider's NPI be used for risk adjustment reporting?

A5: MAOs and other entities are encouraged to submit questions regarding specific risk adjustment processes to eds@ardx.net for research and resolution.

Q6: Does Edit 22220 – DOS Prior to Provider Effective Date validate the provider's effective date with Medicare or the provider's effective date with the respective Medicare Advantage organization?

A6: Edit 22220 – DOS Prior to Provider Effective Date refers to the provider's effective date with Medicare.

Q7: Concerning Health Insurance Prospective Payment System (HIPPS) code submission requirements effective for July 2013 DOS and beyond, should MAOs and other entities submit a charge of zero dollars ($0.00) for a service line using Revenue Code 0022, with additional service lines (i.e., room and board and different ancillaries) on the encounter?

A7: Zero dollars ($0) charges should be submitted on the Revenue Code 0022 service line because the HIPPS code and other data submitted calculates a rate. If multiple service lines are submitted with multiple room and board dates, the service lines should contain HIPPS codes specific to those room and board dates.

Q8: What is the effective date for MAOs and other entities to start using the proxy data reason codes (PDRCs)?

A8: MAOs and other entities may begin submitting encounters using PDRCs effective immediately.

Q9: Can MAOs and other entities use the Date of Birth (DOB) indicated in their enrollment file if the DOB is not submitted on the claim received from the provider?

A9: MAOs and other entities are encouraged to submit questions regarding specific enrollment procedures to eds@ardx.net for research and resolution.

Q10: Is the EDS file maximum of 255 files per day for NDM and Gentran/TIBCO applicable per submitter?

A10: Yes, NDM and Gentran/TIBCO users may submit a maximum of 255 files per day, per submitter.

Q11: When submitting a chart review encounter to delete multiple diagnosis codes, should MAOs and other entities concatenate the diagnosis codes or repeat the REF loop for each diagnosis being deleted?

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A11: Per TR3 requirements, MAOs and other entities should not repeat the REF segment in Loop 2300 to delete multiple diagnosis codes in a chart review encounter. MAOs and other entities should populate the multiple diagnosis codes being deleted in the Loop 2300 REF02 segment with a delimiter for each diagnosis code. The delimiter must be different from the delimiter indicated for the 837.

Q12: What resolution does CMS recommend when MAOs and other entities are unable to obtain ICD-9 codes from providers with the accurate level of specificity?

A12: MAOs and other entities are encouraged to submit specific ICD-9 questions to eds@ardx.net for research and resolution.

Q13: How should MAOs and other entities reconcile encounters that receive edit 98325 – Service Line(s) Duplicated on the MAO-002 Encounter Data Processing Status Reports, when the service lines are appropriate and required for the procedure codes populated on the encounters (i.e., medical injectables and allergy panels)?

A13: CMS is currently analyzing the logic for edit 98325 in order to determine a resolution for the submission of multiple service lines for the same procedure codes. CMS will provide a response to the industry after further analysis is complete.

Q14: MAOs and other entities are currently using Type of Bill (TOB) 89X for submission of sleep study encounters, which are resulting in rejections. Does CMS have any guidance on the TOB code needed for the submission of sleep study encounters?

A14: CMS is currently reviewing the TOB 89 submission rejections and will provide information for MAOs and other entities once analysis is complete.

Q15: In the Special Considerations – Ambulance examples given on slides 34, 35, and 36 of the March 21, 2013 User Group presentation, should the ZIP Code +4 default value read '9999' or '9998'?

A15: For the purpose of the examples provided in the March 21 2013 User Group presentation, either the '9999' or the '9998' +4 default value is correct. Currently, if the Zip Code +4 value is unavailable, MAOs and other entities may use a default value of either '9999' or '9998'. However, effective May 3, 2013, MAOs and other entities must populate the ZIP Code +4 default value as '9998' to avoid receiving errors.

Q16: Does CMS post Questions and Answers from the User Groups on the CSSC Operations website?

A16: Yes. CMS posts all Encounter Data User Group Questions and Answers on the CSSC operations website at:
http://csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Encounter%20Data~User%20Groups?open&expand=1&navmenu=Encounter^Data|| .

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Q17: Does CMS have a timeframe for when MAOs and other entities can begin submitting ICD-10 encounter data?

A17: As the ICD-10 implementation date gets closer, CMS will provide guidance for MAOs and other entities to submit ICD-10 data.