



Encounter Data Work Group

Summary Notes for

Capitated and Staff Model Plans:

Key Findings and Recommendations

Capitated and Staff Model Plans

Work Group 1 of 2

This report summarizes the findings of the Capitated and Staff Model Plans Encounter Data Work Group conducted on February 9, 2011. Forty-seven organizations participated in this Work Group and included:

- Abrazo Advantage
- Aetna
- AIDS HEALTHCARE FOUNDATION
- America First Choice
- ArchCare
- ARDX
- Association for Community Affiliated Plans
- BCN Advantage
- BlueCross BlueShield of MN
- BlueCross BlueShield
- Brand New Day
- Bravo Health
- BRAVO HEALTH TEXAS, INC.
- Capital Blue Cross
- CareMore
- CarePlus Health Plan
- CIGNA
- CIGNA HealthCare of Arizona
- Citizens Choice Health Plan
- CMS
- Commonwealth Care Alliance, Inc.
- CSSC Operations
- Emblem Health
- Essence Healthcare
- Florida Health Care Plan, Inc.
- Freedom Health
- Group Health Cooperative
- Health Choice Generations
- Health Net
- Humana
- IMPAQ International
- Inland Empire Health Plan
- Inter Valley Health Plan
- Kaiser Permanente
- L.A. Care Health Plan
- Mercy Health Plans
- MetroPlus
- Molina healthcare of California
- National PACE Association
- Orange County Health Authority
- Partnership Health Plan
- Presbyterian Health Plan
- Priority Health Medicare
- Regence Blue Cross Blue Shield
- Tufts Health Plan
- WellCare
- WellPoint



The primary purpose of the Encounter Data Work Groups is to provide a forum for communication between the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage Organizations (MAOs), and Third Party Submitters to determine and discuss issues while creating possible solutions for final implementation of Encounter Data.

The goals for this series of sessions for Capitated and Staff Model Plans include:

- Identification of coding issues, and
- Coding requirements and solutions for use of the 5010 format.

The expected discussion topics for this session were:

- Data elements/fields capitated plans are unable to populate due to current data collection methods.
- Capitated and Staff plan current processes for monitoring utilization of services.
- Current staffing in capitated plans and accessibility of certified medical coders to code ICD-9 and CPT/HCPCS.
- Challenges and solutions to ensuring providers can submit encounter data needed using fee-for-service methods.
- Capitated and Staff plans use of *Amount* fields on the 5010 format. Describe current processes for populating amounts internally. Discuss methods for plans to analyze their per member per month costs using capitated arrangements.
- Capability of plans to submit and transmit 5010 data beginning in March 2011.

The first session of the Capitated and Staff Model Plans Work Group focused on population of data elements/fields on the 5010 required for pricing, current processes for monitoring utilization of services, suggested methods for utilization of amount fields on the 5010, and issues related to provider compliance and education.

Introduction and Review of Materials

Before opening the forum for discussion, a review of the work group materials sent to plans was provided. The review included an overview of the front-end testing timeline and requirements, and description of the purpose of encounter data collection. The following are main points stated during the review of the work group materials (guideline slides and fact sheet):

- Of the 18 organizational participants in the Encounter Data Survey, 56% of participants reported using a mixed model arrangement with providers including FFS, capitated, staff, and other contractual agreements.
- Beginning January 3, 2012, MA plans will be required to submit encounter data via the HIPAA mandated 5010 X12 format.
- Encounter Data Front-End Testing Requirements
 - MA Organizations are required to submit a new submitter packet and enter into an EDI Agreement with the Customer Service and Support Center (CSSC) prior to the front-end testing beginning in March 2011.
 - Submitter packages will be available on the CSSC website no later than March 15, 2011 (www.csscoperations.com).
 - MA organizations should register for email notifications of CSSC website updates.



- MAOs may use any of the following CMS approved connections to transmit 5010 X12 encounter data transaction reports to the Encounter Data Front-End System (EDFES). These include:
 - Connect:Direct (NDM),
 - Secure File Transfer Protocol (SFTP),
 - Hypertext Transfer Protocol Secure (HTTPS), and
 - Gentran.
- Purpose of Encounter Data Collection
 - Achieve accurate recalibration of the MA Risk Adjustment model based on MA beneficiary health care utilization data. Medicare FFS pricing of the encounters will have to be used because MA payments to providers will not be available. The utilization patterns of MA enrollees will be captured in a model calibrated on encounter data.
 - Risk score calculation methodology will not change and will continue to be driven by diagnostic and demographic data.

Population of 5010 Data Elements/Fields

MA organizations will need to be able to populate and submit 5010 data by January 3, 2012. For discussion purposes, Table 1 displays the initial 5010 data elements that the work group participants identified as important for pricing and they would be able to populate.

Table 1: Initial 5010 Elements Required for Pricing an Encounter

Field Name	Loop ID	Segment
Patient Name	2010CA	NM1
Subscriber Number	2010BA	NM109
Date of Service	2400	DTP03
Procedure Code	2400	SV101
Total Claim Charge Amount	2300	CLM02
Billing Provider Name	2010AA	NM1
Billing Provider Address	2010AA	N3
Billing Provider Tax ID	2010AA	REF
Diagnosis Code	2300	HI
Revenue Code	2400	SV201
Line Item Charge Amount	2400	SV102 (837-P), SV203 (837-I)
NPI	2010AA	NM108, NM109
Diagnosis Pointers	2400	SV107
Procedure Code Modifiers	2400	SV202, SVD03, SV101
Service Units (Revenue Codes)	2400	SV205, SV104
Rendering Provider	2310D	NM109
Place of Service	2300, 2400	CLM05, SV105
Member Cost Share Amounts		



5010 Data Population Issues

Participants reported that the most challenging data element to populate on the 5010 is the “Claim Charge Amount.” The “Claim Charge Amount” often does not represent an accurate charge amount due to capitated arrangements with providers. Inaccurate amount field population may affect claims pricing because calculation is based on a specific Medicare charge amount or physician fee schedule.

For claims submitted by capitated providers, MA plans receive a single Tax ID and license number but the provider may be affiliated with several organizations (i.e. Radiology services may be paid to a single Tax ID but performed by multiple radiology centers). This will not affect pricing of encounters but may be an issue if the same licensed provider number is not submitted on the encounter.

Potential Solutions:

- One suggestion was to utilize a loop/segment on the 5010 to identify or flag capitated encounters.
 - Editing logic would be modified for submission of capitated encounters and amount fields could be defaulted to 100% of Medicare allowable charges for these services.
 - MA organizations would not be responsible for pricing or filtering claims data, editing and pricing of capitated encounters would occur during Encounter Data System (EDS) processing.
 - The PWK01 segment could be used to identify capitated encounters.
- A participant reported using the CN101 segment of the 2400 loop currently to identify capitated services on the ANSI X12 4010.
- One participant reported using the BHT06 segment to distinguish between capitated and FFS services on an encounter.

Collection of Required Encounter Data and Valid Procedure Codes

Capitated and Staff Model Plans must populate and submit valid CPT codes on the 5010, as this is necessary for accurate encounter data pricing. Participants identified multiple issues regarding capability to collect and submit valid CPT codes from providers, as well as, collecting full encounter data in general.

Issues Identified:

Utilization of Customized or “Home Grown” Procedure Codes

A small percentage of professional providers use a customized billing system or “home grown” procedure codes to document non-coded services due to capitated arrangements.

- These local systems are created at the level of the provider or physician.
- Providers use these codes to control their billing software and change the claim price to \$0.00 for services not included in their capitated payment.
- MA organizations are unable to define these codes and therefore are not capable of cross walking “home grown” codes with standard CPT codes.
- “Home grown” procedure codes do not provide the level of detail necessary for Encounter Data submission.
- Providers are not responsive to requests made by the MA organizations to use standardized coding systems (CPT) for submission of encounters.



Work Group Polling Question Results

Throughout the Capitated and Staff Model Work Group, participants were asked to participate in 4 polling questions regarding issues discussed. Tables 3-6 below display the results of each polling question conducted.

Table 3: Poll 1

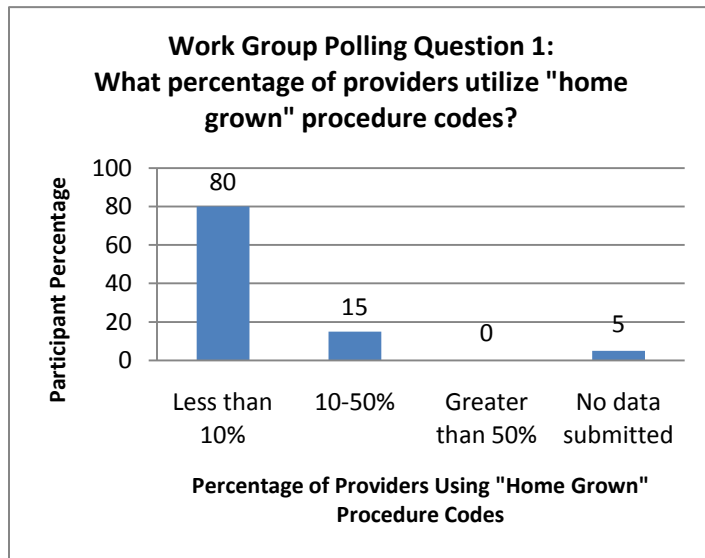


Table 4: Poll 2

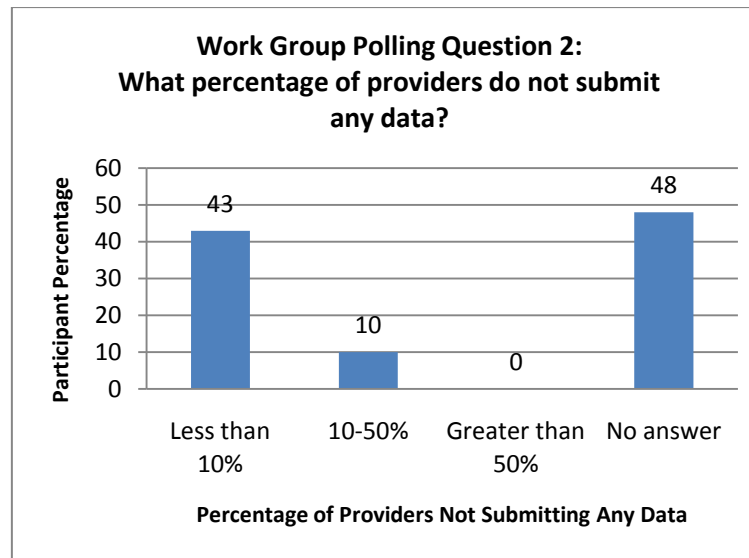




Table 5: Poll 3

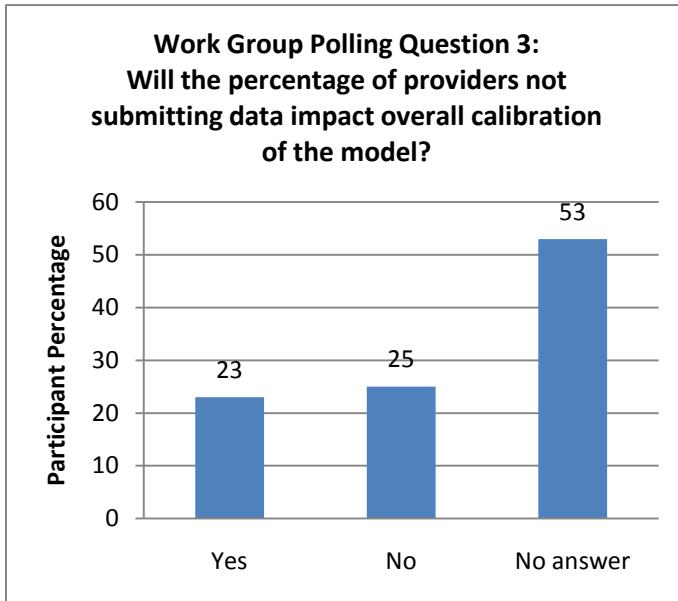
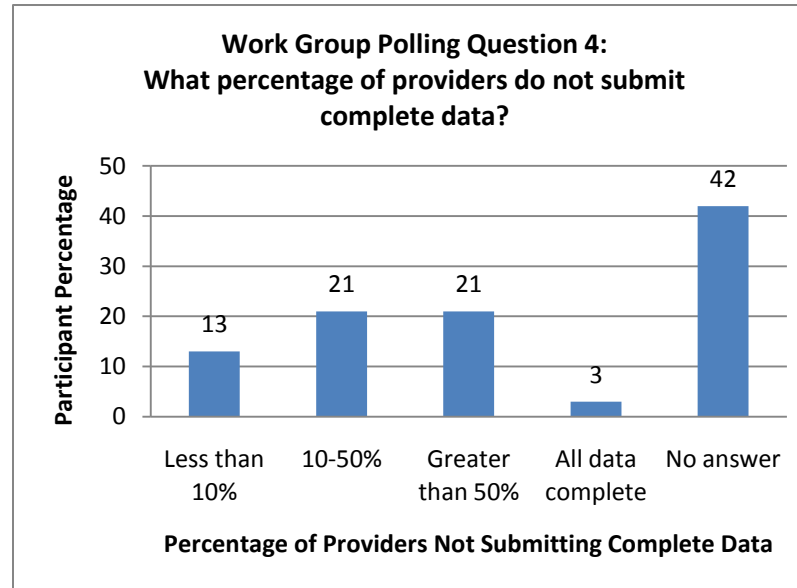


Table 6: Poll 4





Additional Questions Addressed Throughout the Work Group

The following are additional questions discussed by participants during the Capitated and Staff Model Plans Work Group.

Questions asked by Participants

Q1: What is the deadline for MA organizations to participate in the Encounter Data Front-End (EDFES) testing?

A1: Front end testing begins March 30, 2011 and ends June 30, 2011. MA plans must submit a 5010 test file during that time period.

Q2: For the March through June 2011 testing of the front-end system, how many transactions should be submitted?

A2: At least 1 institutional and 1 professional claim must be submitted for the test. Test data can be used because only the file format is being tested. Test data should meet all formatting requirements and values should be valid, despite the data not corresponding to an actual beneficiary. However, it is ideal for plans to submit real data. The data must pass all TA1 and 999 edits. Files larger than 100 claims should not be submitted. For Gentran users, specifics of testing requirements will be provided.

Q3: Should MA plans input a "\$0.00" value for amount fields received with actual charges before submitting to CMS?

A3: No, the claim should be submitted as it is received. The "0.00" is only used in situations where the actual charges are not populated.

Q4: Will an encounter be rejected if it contains a mixture of "\$0.00" values and charge amounts?

A4: Yes, the claim will be rejected as incomplete.

Q5: Can capitated and FFS claims be submitted to CMS in the same file?

A5: Yes.

Q6: CMS stated that the Risk Adjustment Processing System (RAPS) and the Encounter Data System (EDS) will run in parallel until the EDS is validated and working correctly. Will MA organizations be notified in advance of the date RAPS will no longer be running?

A6: Yes, plans will be given advanced notice of this. Premiums should be paid based on RAPS until plans hear otherwise.

Q7: Are Tax ID and Taxonomy Codes equivalent?

A7: No, Tax ID does not reference the Health Care Provider Taxonomy Code. They are not equivalent.

Q8: Will the National Provider Identification (NPI) number be required for claims submission?

A8: Yes, NPI will be required.

Q9: If the NPI will be required on the 5010, why is the Tax ID necessary?

A9: The Tax ID is being evaluated and may not be a required field on the 5010, but NPI will definitely be required.



Q10: Does the CSSC submitter package need to be completed for participants of the pilot test?

A10: The submitter packet does not need to be completed for the pilot test. All plans must complete the submitter package prior to the Encounter Data Front-End Testing (EDFES) beginning March 30, 2011. The application will be available for download on the CSSC operations website (www.cssc.operations.com) no later than March 15, 2011.

Q11: For the pilot test, are plans submitting to the Front-End Risk Adjustment System (FERAS)?

A11: No, plans should refer to the pilot testing package for submission directions. Please use the contact information included in the pilot test package for questions.

Q12: Should duplicate claims be submitted to CMS?

A12: No, duplicate claims should not be submitted. A benchmark will be set for the submission of duplicate claims.

Q13: Should billed amounts on capitated claims be submitted to CMS?

A13: Yes, capitated claims should be submitted as they are received.

Q14: Is a duplicate defined as all fields of an encounter being the same (i.e. service date, diagnosis code, ID numbers, etc.)?

A14: Yes.

Q15: How would a diagnosis code be added to a claim?

A15: An adjustment claim would be submitted using the CAS segment. The adjustment claim would supersede the original claim and should be submitted as the finalized claim.

Q16: Can MA organizations submit more than 12 diagnosis codes on a professional claim?

A16: No, professional claims only allow 12 diagnosis codes. Institutional claims allow a maximum of 25 diagnosis codes.

Q17: When will the Industry Update notes be available on the TARSC website?

A17: Notes from the Industry Update will be available on the TARSC website (www.tarsc.info) within two weeks

Q18: If the diagnosis code is not valid for pricing, do we still get risk adjustment credit for diagnosis codes?

A18: A diagnosis code must be valid and pass all edits, before the diagnosis will be stored. The stored diagnosis will be used for risk adjustment purposes, assuming the diagnosis is included in the risk adjustment model.

Q19: When will the companion guide be released?

A19: The companion guide is scheduled to be released at the end of summer 2011.

Q20: If Diagnosis Pointers are omitted from the 5010, will the encounter reject or will the diagnosis codes apply to all procedures?



A20: Yes, the claim will reject. No, the pointers will not apply to all procedures. Diagnosis pointers will be a required field on the 5010 and will be edited on.

Key Conclusions and Recommendations for Encounter Data Capitated and Staff Model Plans Work Group

Based on the information discussed in the Capitated and Staff Model Plans Work Group held on February 9, 2011, the following recommendations are provided to CMS to ensure successful implementation of the collection of encounter data.

Recommendations

- CMS suggested utilizing a loop/segment on the 5010 to identify capitated encounters so that editing logic can be changed for amount fields of these services.
 - One participant suggested using the CN101 segment of the 2400 loop to identify capitated services on the ANSI X12 4010.
 - One participant suggested using the BHT06 segment to distinguish between capitated and FFS services on an encounter.
- CMS should mandate the use of procedure codes (CPT).
- Assist MAOs with provider education and compliance for collection of encounter data by:
 - Creating a letter to providers explaining the importance of encounter data collection.
 - Publicize and promote the encounter data program within provider organizations such as AMA or State Medical Societies.
 - Develop and promote an educational aide similar to the Physician CD provided to MA plans in the past to help educate providers on risk adjustment processes, would be beneficial.
 - Facilitate a national teleconference for providers.

Action Items and information needed from Participants

The next Encounter Data Work Group for Capitated and Staff Model Plans will be held on March 30, 2011. The next Industry Update will be held on March 16, 2011.

Work group participants should send the following items to eds@ardx.net:

- Additional recommendations regarding collection and submission of encounter data for Capitated and Staff Model Plans.
- Any further questions related to encounter data.