Industry Update QA Documentation

Questions and Answers

The following were questions asked by participants during the Industry Update.

Encounter Data Formats

Q1: Is the 276 transaction an optional file submission that MAOs may use?
A1: The 276 is an optional transaction that MAOs may use to communicate with CMS and to determine the status of a particular claim. It is a benefit to the plan, but it is not mandated for use.

Q2: When 837 transactions are submitted, will a 277 transaction automatically be generated?
A2: When an 837 transaction is received, a 277CA will automatically be returned to the MAO identifying whether claims were accepted or rejected.

Q3: In cases where the 277CA is not complete as compared to the files submitted, should MAOs send a 276 transaction for records that do not have responses?
A3: There is currently not enough information to determine preferences in using the 276 transaction. The workflow for 276 transactions is under development and the industry will receive information on submission of the 276 as soon as final determinations are made.

Q4: Are Dental (837-D) encounters included in all requirements regarding professional (837-P) and institutional (837-I) claims?
A4: Details regarding 837-D encounters are still under development. CMS will notify plans of the decisions regarding this process in the near future.

Q5: Is there a separate testing/Go Live schedule for dental encounters (837-D)?
A5: Details regarding 837-D encounters are still under development. CMS will notify plans of the decisions regarding this process in the near future.

Q6: In addition to the 837-I and 837-P transactions, there is now an 837-D as well. For the testing phase, are MAOs required to submit the 837-I, 837-P, and the 837-D?
A6: The initial systems testing emphasis will be on making sure that we have the processing systems in place to support Institutional (837-I) and Professional (837-P) claims. CMS is looking to receive as many examples of the 837-I and 837-P as possible. CMS is currently evaluating the use of the 837-D.

Q7: What is the 837-D?
A7: The 837-D represents Dental encounters.

Q8: Are dental claims received from providers on the CMS-1500 form submitted through the 837-P?
A8: We are currently investigating how CMS-1500 dental claim forms will be submitted. We will notify the industry as soon as a determination is made.

Q9: Will there be a standard format for 277 transactions?

A9: The standard Washington Publishing Company (WPC) 5010 format will be used for 277 transactions. The format is located on the WPC website at http://www.wpc-edi.com/content/view/817/1.

Q10: If a 276 transaction is submitted, will a 277 be returned?
A10: Yes, a 277 will be returned to the MA Organization when a 276 transaction is submitted.

Q11: For 2011 dates of service, what file format should plans use for the final submission deadline on 1/31/2013?
A11: The Risk Adjustment and Encounter Data Systems will run parallel until CMS can validate accuracy of data and calibrate the model. It is too soon to determine the accuracy of the encounter data collected and if the model will have been recalibrated for the 2012 payment year (covering 2011 dates of service). Further information regarding the file format to be used in final submission for reconciliation of Risk Adjustment data by 1/31/2013 will be announced at a later time.

Q12: Will an 837 file be limited to 5,000 encounters?
A12: It is recommended that the size of the transaction is limited to a maximum of 5000 CLM segments per ST-SE.

Submission of Encounter Data

Q1: Is the entire EDI Agreement process online or is part of the process through paper submission?
A1: The EDI agreement process is currently under development, and the industry will be notified as soon as the online version is prepared. The intention is to have the majority of this process online, but the EDI agreement would remain a paper submission, as an original signature from the person in authority in your organization is required. The signed EDI agreement, in paper form, will accompany the original document to be sent to CSSC to complete the EDI agreement process.

Q2: Are MA Organizations required to submit claims denied due to internal processing errors (i.e. incorrect member number or a provider ID issue)?
A2: MA Organizations are required to submit only claims that were denied for payment purposes. Rejected claims should not be submitted.

Q3: Currently, our plan scrubs certain diagnosis codes prior to sending the RAPS file. For example, if a member has a history of breast cancer but the provider submits a diagnosis of breast cancer. Should plans continue to scrub diagnosis codes for the Encounter Data System (EDS)?
A3: MAOs should submit encounters as they are received and should not conduct any additional filtering or scrubbing processes.

Q4: Will paid encounters be re-priced by CMS for payment calibration?
A4: Submitted encounters will go through CMS' processing and pricing system. Claims will be repriced according to the Fee-For-Service fee schedules and pricers.

Q5: Have Companion Guides to be used in conjunction with the Implementation Guides been published?
A5: Companion Guides will be published in Summer of 2011.

Q6: Are Medicare Cost Plans required to submit encounter data?
A6: Details regarding Cost Plans requirements are currently under development.

Q7: If one Encounter equals one claim, will there be a limit on the number of lines for an Encounter?
A7: It is suggested that there be no more than 450 lines per encounter.

Q8: If one encounter is equal to one claim, is this driven by the date of service (Meaning one date of service is equal to one encounter)?
A8: A claim is a submission for the purpose of reimbursement (e.g., from fee-for-service providers) and an encounter is a submission that is not linked to payment (e.g., from capitated providers). Both terms refer to evidence that a medical service was provided on a given date of service.

Q9: When will there be a final decision regarding the Chart Review data submission option?
A9: A final decision regarding methods for submitting Chart Review data will be determined prior to the end of front-end testing of the Encounter Data Front-End System (EDFES). Plans will receive further policies regarding the Chart Review process at a later time.

Q10: What is the timeline for submission of supplemental data from chart reviews?
A10: All Encounter Data, including those submitted via chart review, must be submitted according to the Patient Protection and Affordable Care Act Section 6404 and within the 12-month timely filing rules (http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf).

Q11: If we submit a 25 line professional encounter, will the entire 25 line encounter be accepted or denied as a whole or will it be accepted/ denied by line item?
A11: Claim line items will be accepted or rejected. When correcting a line item, the entire claim must be replaced or deleted. The CLM segment is used for all claims, and data element CLM05-3"(Claim Frequency Type Code) value "7" = replacement and value "8" = deletion. When values “7” or “8” is used in data element CLM05-3, the CAS segment must be populated. Data element CAS01 (Claim Adjustment Group Code) should have the value “CR” Correction or “OA” Other/Deletion.

Q12: How should encounters from atypical providers be submitted?
A12: MA Organizations will receive further guidance on the submission of encounter data from atypical providers during the Encounter Data Work Groups in the second quarter of 2011.

Q13: Are plans required to submit all data with the exception of claims routed incorrectly and denied for a member not being on file, etc.?
A13: MA organizations should submit all data that has been paid or denied from all types of service to CMS for the collection of Encounter Data. Data that is rejected should not be submitted.

Q14: Should encounters denied for being medically inappropriate be submitted?
A14: Encounters that are rejected due to being medically inappropriate (i.e., invalid gender with diagnosis code) should not be submitted.

Q15: Are plans required to filter out rejected claims prior to submission (i.e. missing data, duplicate claims, and member enrollment issues)?

A15: MA organizations should submit all data that has been paid or denied from all types of service to CMS for the collection of Encounter Data. Data that is rejected should not be submitted.

Q16: Many plans use self-defined modifiers for services to capture 'Pay for Performance' quality measures. Will these modifiers need to be filtered out prior to encounter data submission?
A16: Plans should not filter their data. CMS will conduct all filtering on the collected encounter data and will share this filtering logic with MA Organizations so that they can replicate it when reconciling data.

Encounter Data Timeline

Q1: On January 1, 2012, will MAOs only send claims with dates of service after January 1, 2012?
A1: Yes, on January 3, 2012 the expectation is that MAOs will only send claims with dates of service after January 1, 2012.

Q2: If MA Organizations are submitting encounter data files every 30 days, would the first file submission be on January 31, 2012?
A2: Yes, the first file submission for encounter data should be at the end of January 2012.

Q3: Will plans be submitting claims with dates of service after January 1, 2012 only?
A3: Yes, after the 'go live' date for encounter data, MAOs will only send claims with dates of service after January 1, 2012.

Q4: Are plans required to submit a front-end test file by 3/30/2011 or 6/30/2011?
A4: Front-end testing occurs from March 30, 2011 through June 30, 2011. Plans may submit a test file any time between the test dates.

Q5: What date does Institutional and Professional data need to be certified by?
A5: MA Organizations must certify their data by October 2011 in order to submit production data by January 2012.

Encounter Data Front-End Testing (EDFES) Testing

Q1: Will the test system be available for MAOs to use if there are system changes at the MAO following implementation of the Encounter Data System (EDS)?
A1: Yes. However, in order to test the new system, the system must be recertified if major modifications are made following initial certification.

Q2: Will the 5010 errata version be ready by the front-end testing phase beginning in March 2011?
A2: Yes, 5010 errata will be accepted by the front-end system testing phase beginning in March 30, 2011. The front-end testing phase will begin March 30, 2011 and continue through June 30, 2011. MAOs will have until June 30, 2011 to submit a test file to the Encounter Data Front-End System (EDFES).

Q3: What EDI Translator will CMS be using?
A3: Please see the approved of list of HIPAA compliant translators at http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp.

Q4: What is the name of the COTS vendor utilized by CMS?
A4: Please see the approved of list of HIPAA compliant translators at http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp.

Q5: What is the difference between test data and actual data?
A5: Test data consists of formatted values that will process through the edits (i.e., numeric data in numeric only fields) which may not be true beneficiary data. Actual data consists of real beneficiary data.

Q6: Does the Front End Test File have to contain production data, or can it contain test data?
A6: While actual data would be ideal, the Front-End test file can contain test data.

Q7: Are plans required to submit real data for the front-end testing or will dummy data suffice?
A7: While actual data would be ideal, the Front-End test file can contain test data. Please note that the test data must be valid (i.e., CPT codes must be true CPT codes).

Q8: What level of SNIP edits will be applied during Front-End testing and in the production system?
A8: CMS will apply translator, Implementation Guide, and CEM (claim-level) edits.

Adjustment and Cancellation Processes

Q1: Are adjustment claims included in the submission process?
A1: Plans are required to submit adjudicated claims. If the need arises to adjust an adjudicated claim, the submitter should use the CAS segment, value "CR" Correction, in data element CAS01 (Claim Adjustment Group Code), and CLM segment, value "7" Replace Prior Claim, in data element CLM05-3 (Claim Frequency Type Code).

Q2: How will MAOs perform corrections/deletions of individual fields or line items on a claim?
A2: The plan must replace or delete the entire claim and not a line item or field. The CLM segment is used for all claims, and data element CLM05-3"(Claim Frequency Type Code) is the data element that will indicate if the claim is an original "1", a replacement "7" or a deletion "8". When values "7" or "8" is used in data element CLM05-3, the CAS segment must be populated. Data element CAS01 (Claim Adjustment Group Code) should have the value "CR" Correction or "OA" Other/Deletion.

Q3: If cancellations will be made at the claim level, how will plans remove or change an individual diagnosis on a claim with multiple diagnoses?
A3: The plan must replace or delete the entire claim and not just a diagnosis on the claim. The CLM segment is used for all claims, and data element CLM05-3"(Claim Frequency Type Code) is the data element that will indicate if the claim is an original "1", a replacement "7" or a deletion "8". When values "7" or "8" is used in data element CLM05-3, the CAS segment must be populated. Data element CAS01 (Claim Adjustment Group Code) should have the value "CR" Correction or "OA" Other/Deletion.

Q4: What is the difference between a denied and rejected claim?

A4: Plans can deny a claim for policy or payment reason but the claim is "good." CMS wants MAOs and submitters to send these claims. Plans can reject claims as a result of incorrect formats, values, codes, etc. CMS does not want these claims.

Q5: Is a claim deletion the same as cancelling a claim using the CLM05 segment?
A5: Claim deletion and cancelation will be performed the same. The following should be used: CLM segment, data element CLM05-3 value "8" indicating Deletion, and CAS segment, data element CAS01 "OA" indicating Other/Deletion.

Q6: If there are several diagnosis codes on an encounter and one of the diagnosis codes submitted needs to be removed based on an internal audit, does the plan need to request that the provider re-bill based on the corrected diagnosis code?
A6: The provider would not need to resubmit. The plan would submit the diagnoses using the CAS segment "CR" for correction or "OA" indicating Other/Deletion.

Q7: What frequency code should be entered for adjustment claims (07 or 08)?
A7: The CLM segment is used for all claims, and data element CLM05-3"(Claim Frequency Type Code) value "7" = replacement and value "8" = deletion. When values "7" or "8" is used in data element CLM05-3, the CAS segment must be populated. Data element CAS01 (Claim Adjustment Group Code) should have the value "CR" Correction or "OA" Other/Deletion.

Q8: What segments must be populated to denote that a claim has been adjusted or cancelled?
A8: MAOs must populate the CAS and CLM05 segments to denote a claim cancellation or adjustment. The CLM05 segment should be populated with a '1' for an original claim and an '8' for a voided, cancelled, or deleted claim.

ICD-10 Transition

Q1: Will there be an ICD-10 conversion for RAPS?
A1: Yes, Risk Adjustment will undergo an ICD-10 conversion. Further information on the conversion will be provided during the Regional Trainings in the Summer of 2011. Please refer to http://www.cms.gov/ICD10/ for CMS guidance on ICD-10.

Q2: What will happen to RAPS if the parallel processing fails before the scheduled ICD-10 conversion?
A2: RAPS and the Encounter Data System (EDS) will run parallel until CMS can validate that the encounter data collected is high quality data, which can be used to calibrate the Risk Adjustment model. Parallel processing is being used to ensure that there is no impact to plan payments during this transition. The conversion to ICD-10 occurs in October 2013 and should not impact the parallel processing established for RAPS and EDS.

Encounter Data Pilot Testing

Q1: Is CMS considering increasing the amount of data submitted for the Encounter Data Pilot Test (all scenarios may not be captured)?

A1: The amount of data submitted during the Pilot Test has already been established. There may be scenarios that are not captured during the Pilot Test. However, CMS expects that those scenarios will be addressed during the Front-End testing phase from 3/30/2011 - 6/30/2011.

Q2: If the pilot testing package is not received on January 21, 2011, does this mean that the plan was not chosen for participation in the Encounter Data Pilot Test?
A2: The first round of invitations will be distributed by January 21. Based on responses to the request, a second round of invitations will be distributed during the first week of February.

12 Month Timely Filing

Q1: Will Chart Review data have to be submitted within the 12-month timely filing requirement?
A1: CMS is currently developing the final policy regarding the 12-month timely filing requirement as it relates to Encounter Data.

Q2: Are adjustment claims required to be submitted within 12 months of the date of service?
A2: Final policy regarding the 12-month timely filing requirements are under development with regards to the encounter data.

Q3: Section 6404 of the PPACA gives CMS the authority to specify exceptions for a 1-year limit. Will CMS create an exception for submission of data discovered during medical record reviews more than one year after the date of service? If not, why?
A3: CMS is currently developing the final policy regarding the 12-month timely filing requirement as it relates to encounter data.

Q4: Does the 12-month filing requirement (requirement 5) apply to adjustment claims that were originally submitted within the acceptable timely filing timeframe?
A4: CMS expects adjustment claims to be submitted within 12 months. Final policy regarding the 12-month timely filing requirements is under development.

5010 Format

Q1: Are all dollar fields on capitated claims to be filled with 0.00?
A1: Yes, if there are no actual amounts available, then plans submitting capitated data should fill dollar fields with 0.00.

Q2: If a price amount is included in the 'paid' column on a Capitated or Staff Model claim, will this affect anything?
A2: If capitated or staff model plans include a pricing amount in the 'paid' column, this will not affect CMS pricing calculations of the encounter data. CMS wants plans to include this data when it is available, rather than changing it to '0.00'.

Q3: Is '0.00' entered in the paid amount field for denied encounters (as well as Capitated claims)?
A3: Yes, '0.00' is entered in the paid amount field for rejected encounters as well as for capitated model plans' encounter claims.

Q4: It was previously stated that CMS would be verifying taxonomy through NPPES. Are MAOs required to include the taxonomy on the claim since CMS will be obtaining taxonomy from NPPES?
A4: This topic needs to be explored further. Currently, MAOs must populate all required fields in the 5010 format if the information is available.

Q5: When including the taxonomy for the 5010 format, sometimes there are discrepancies between the taxonomy given by the provider and what is listed on NPPES. How can MA organizations prevent claim errors when taxonomies reported from the providers and taxonomies listed in NPPES do not match?
A5: The pilot testing phase will enable CMS to determine what the risks are in populating certain fields of the 5010 and whether fields such as taxonomy should be populated by the MAOs or if a different procedure is needed. We are currently investigating this issue and will provide the industry with a determination as soon as possible.

Q6: If CMS is applying an edit to ensure that health plans are submitting taxonomy on the 5010, is the expectation that the plans demand this information from the providers?
A6: CMS is planning to use any of the required fields that are also required in Fee-For-Service. Currently, the expectation is that plans are populating the fields that are required based on Fee-For-Service standards. If taxonomy is a required field then it should be populated. Therefore, provider outreach will be necessary, just as it will be for the conversion from ICD-9 to ICD-10 and using 5010 format overall.

Q7: For the Institutional and Professional Processing and Pricing system end-to-end testing, what is the expectation for completeness of the test file, since plans will be converting from 4010 data?
A7: MA Organizations are expected to populate all required fields on the 5010, as is required by HIPPA, so that CMS is able to evaluate the internal systems.

Q8: What is the PWK01 Segment Report?
A8: The PWK Segment reports claim supplementation information. PWK01 segment reports the specific name of the document.

Q9: Will the 835 format be used to report EDPS results back to the plans?
A9: The ANSI reports that will be returned to the plans are TA1, 999, and 277CA. If CMS determines that the remittance advice will be used, it will be in the 835 format. All other reports will be customized for encounter data purposes.

Provider Validation

Q1: Will an online provider file be available for MA organizations?
A1: CMS is currently researching the ability to provide an electronic file to plans with a listing of providers and will update the industry if this can be done.

Q2: Is an active NPI on NPPES the only requirement to qualify a provider as a valid Medicare provider or must the provider also possess a Medicare identifier on NPPES?
A2: CMS is currently developing processes for verifying valid Medicare providers. If MA organizations have any additional input on this topic, please send comments to eds@ardx.net.

Durable Medical Equipment (DME)

Q1: Is CMS going to filter out DME claims following the 'go live' date of 01/03/2012?
A1: Yes, it is anticipated that the Encounter Data DME Processing and Pricing System's 'go live' will be May of 2012, any DME claims received prior to this date will be stored for processing once the DME Encounter Data Module is developed.

Q2: Will plans receive a 277CA response for the DME claims that are being stored until DME testing begins in 2012?
A2: Plans will not receive a 277CA reflecting any DME claims prior to the testing of the CEDI module, currently scheduled for May 2012.

Q3: Are DME claims submitted using the 837-P?
A3: Yes, DME claims are submitted through the 837-P. DME claims received by CMS will process through the front-end system and then be filtered out and sent to the DME processor.

Q4: Will DME claims distributed through a doctor's office still go through the DME process due to the presence of a certain DME or HCPC code?
A4: Yes, all DME claims will be submitted using the 837-P and will be processed through the DME processing system.

Q5: Will there be a new 837 for DME transactions?
A5: No. DME claims will be submitted using the 837-P.

Q6: Is DME processed in the same way as Professional (837-P) and Institutional (837-I) claims?
A6: DME claims will be processed through the DME pricing processor, not the professional pricing processor.

Parallel Systems Testing

Q1: How long will the Encounter Data and RAPS systems be running in parallel?
A1: The Encounter Data System (EDS) and RAPS will run parallel until CMS can validate that the data collected is high quality and can be used to calibrate the Risk Adjustment model. CMS has decided to run the systems parallel to ensure there is no impact to plan payments.

Q2: During the parallel testing phase, are plans required to submit corrections for both the Encounter Data and RAPS systems?
A2: Yes, during parallel testing plans will have to submit corrections for both the Encounter Data System and RAPS. Data will be processed using a separate submitter ID number, and communications/reports will be sent via a separate mailbox.

Q3: Since chart audit data would follow the initial encounter submission, CMS is likely to receive a high percentage of adjustment encounters containing the PWK segments with chart audit data. Will this present an issue due to the current use of RAPS 502?
A3: Until CMS can determine the volume of adjustment encounters that will be submitted with chart audit data, benchmarks for data submission cannot be established. Further policies regarding encounter data quality benchmarks will be forthcoming.