Encounter Data Work Group Summary Notes for Editing and Reporting: Key Findings and Recommendations

Editing and Reporting
Work Group 2 of 2

This report summarizes the findings of the Editing and Reporting Encounter Data Work Group conducted on March 02, 2011. Forty-four organizations participated in this Work Group and included:

- Abrazo Advantage
- Aetna
- Amerigroup Corporation
- ArchCare
- ARDX
- Atrio Health Plans
- Blue Care Network of Michigan
- Blue Cross Blue Shield of Alabama
- Blue Cross Blue Shield of Florida
- Blue Cross Blue Shield of Massachusetts
- Blue Cross Blue Shield of Tennessee
- Blue Shield of California
- Brand New Day
- Bravo Health
- CDPHP
- CIGNA Healthcare of Arizona
- CMS
- Commonwealth Care Alliance, Inc.
- CSSC Operations
- Emblem Health
- Essence Healthcare
- Gateway Health Plan
- Group Health Cooperative
- Health Alliance Plan of Michigan
- Health Net
- Health Net of Arizona
- HealthSpring
- Humana
- IMPAQ International
- Independent Care Health Plan, Inc.
- Inland Empire Health
- Leprechaun, LLC
- Mercy Health Plans
- MMM Holdings, Inc.
- Molina Healthcare of California
- National PACE Association
- Presbyterian Health Plan
- Primetime Health Plan
- Regence Blue Cross Blue Shield
- Samaritan Health Plan
- Security Health Plan of Wisconsin, Inc.
- Senior Whole Health
- Tufts Health Plan - Medicare Preferred
- University Physicians Health Plans

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 Editing and Reporting include:

- Discussion of edits to be used for claims processing and collection of encounter data,
- Identification of the reports to be used for encounter data and discussion of the reports reconciliation process, and
- Determining methodologies for linking data to show incremental data collection with the original encounter claim.

The expected discussion topics for this session were:

- Cumulative report for 277CA edits,
- Amount fields,
- Adjustments,
- Chart reviews, and
- Report suggestions.

The second session of the Editing and Reporting Work Group focused on providing updates and discussing development of a cumulative 277CA report of outstanding rejected claims, population of 5010 amount fields, submission processes for adjustment and chart review data, and review of current RAPS transaction and management reports in order to determine ideal layout and format for encounter data reports.

Introduction and Review of Discussion Slides

Before opening the forum for discussion, a review of the materials sent to plans prior to the work group was provided. Information regarding data collected from the first Editing and Reporting Work Group session was discussed, as well as feedback obtained from participants in response to previous actions items and assignments. The following were the main points discussed during review of the work group materials and participant feedback received since the first work group session.

Work Group Summary Reports and Materials

Summary Reports

Summary notes for previously conducted work groups through February 9, 2011 are posted at www.tarsc.info, including the summary notes and QA documentation for the first Industry Update conducted on January 19, 2011. Each of the work group summary report documents contains two sections: work group discussion topics, notes, participant questions, and responses addressed through the teleconference and the web-based chat QA. To review participant questions and responses addressed during the work group sessions participants should refer to the 'Additional Questions' section at the end of each document. Summary notes for the work groups are posted as soon as they are available.

Participants should review the most recent work group summary notes to reference the most accurate information. CMS is making policy decisions based on discussions from the work group sessions held each week.

Materials

The Encounter Data System (EDS) project team meets weekly to discuss issues addressed during the work groups. Issues and policy decisions from work group sessions are incorporated into the materials sent out to participants prior to scheduled work group sessions. In order to provide the most recent and updated information, materials, including the fact sheets, are sent to participants 1 to 2 days in advance of the scheduled work group session.

Encounter Data Inbox

Currently, questions and comments related to encounter data implementation should be sent to eds@ardx.net. Questions received through the inbox are documented and will be used to create a list of FAQ questions to assist MA plans with issues related to encounter data collection. When submitting questions to this inbox, plans can expect approximately a one (1) week response time.

Review of Previous Action Items and Participant Feedback

Participants of the first Editing and Reporting Work Group were asked to respond to action items and assignments outlined during the first session. During this work group, participant feedback received in response to action items of the previous Editing and Reporting session was reviewed.

Assignment 1: CEM Edits Not Impacting Risk Score Calculation and Payment

Participants of the first Editing and Reporting Work Group reported low quality of select data elements received from providers such as provider address. This could cause a high volume of edits to occur during Encounter Data processing. Participants were asked to provide a list of CEM edits that have no impact on risk adjustment payment calculation or pricing so that CMS can determine which edits to turn on or off for encounter data processing.

Participants reported that the following fields could cause rejections that are not directly related to pricing, if hard edits are applied:

- Provider Name,
- Provider Address (Multiple provider data feeds coming from different sources could have inconsistencies),
- Taxonomy Codes,
- Member Information (Name and Date of Birth),
- Member Address,
- Eligibility and Enrollment Data,
- Clinical Consistency Between Diagnostic and Procedural Information, and
- Medically Unlikely Edits.

Proposals to Assignment 1

Based on information received from participants, **Table 1** depicts those elements in which soft editing logic may be applied and those elements that are required to price an encounter.

Table 1: Data Elements using Soft Editing vs. Elements Required for Pricing an Encounter

Soft Editing Logic Applied	Hard Edit
Provider Name and Address	Member Date of Birth (validity edit)
Taxonomy Code	Eligibility and enrollment data including eligibility for type of service
Member Name and Address	Clinical consistency between diagnostic and procedural information
Medically Unlikely Edits	

The following clarifications and comments were addressed regarding data elements of Table 1:

- **Taxonomy**— A hard edit would not be applied to taxonomy codes.
- **Member Date of Birth**— The member's date of birth would be utilized as a validity check for the HICN as requested by participants of previous work group sessions. The date of birth is not required for risk adjustment processing and will not be edited against if it is not submitted on an encounter data claim. If date of birth is populated by plans on the 5010, then a validity edit will be applied and should be used by plans as a tool to make sure the HICN is accurate.
  - Several participants of the work group reported that date of birth would be difficult to populate.
- **Eligibility and Enrollment Data**— Eligibility and enrollment data would be required for pricing an encounter and would be edited against MA rules using Fee-For-Service processing methodology. Deductible and payment authorization information are not required for pricing purposes.
- **Medically Unlikely Edits**—Participants of the work group supported the application of soft editing logic for Medically Unlikely Edits. During the work group, more information was requested of participants on Medically Unlikely Edits in order to determine editing logic for the Encounter Data System (EDS).
  - Plans reported that Medically Unlikely Edits would already be applied prior to submission to the EDS.
  - If a Medically Unlikely Edit was in place the plan would deny the claim or communicate with the provider submitting the claim to correct the error. Denials due to medically unnecessary services would be submitted to CMS, since both paid and denied claims must be submitted. Therefore, soft editing logic needs to be applied for these types of edits.
  - One participant also reported that an MA plan may pay a claim even if a Medically Unlikely Edit occurred during adjudication.
    - Example: If a non-obese and healthy beneficiary needed gastric bypass surgery and this was the only procedure enabling the beneficiary to survive, then a Medically Unlikely Edit would occur. However, the plan may override the error in this example and pay the claim. Medically Unlikely Edits could also occur with regard to the allowable units of oxygen for beneficiaries.

- Participants reported that the driving force for Medically Unlikely Edits is provider billing and the National Correct Coding Initiative (NCCI) edits.
- Further research on the utilization of Medically Unlikely Edits and the impact on encounter data pricing is needed. Participants should send any additional information regarding this issue to eds@ardx.net.

Assignment 2: Paper Claim Fields Not Accounted for on the Electronic 5010

Participants of the first Editing and Reporting Work Group reported that there are more fields on the 5010 than what is received using paper claim submissions. MA plans currently convert paper claims to an electronic version and populate unavailable fields with default values. Participants of the first working session were requested to provide a list of paper claim fields not accounted for on the 5010 and/or current default values in place for submission of paper claims data.

Table 2, represents those paper claim fields reported by participants of the previous Editing and Reporting work group that do not currently map to the electronic 5010 format.

Table 2: List of Paper Claim Fields Not Accounted for on the 5010

5010 Format	Loop/Data Element	Description
837-P	2300 CLM08	Benefits Assignment Certification Indicator
837-I	2300 CLM07	Medicare Assignment Code
837-I	2300 CLM18	Yes/No Condition or Response Code

Proposals to Assignment 2

Further research on utilization of paper claim fields not accounted for on the 5010 is needed. Participants should send any additional information related to this assignment to eds@ardx.net.

Updates and Discussion Topics

During the work group CMS discussed updates regarding the 277CA, use of 5010 amount fields, submission of adjustment and chart review data, and review of current RAPS transaction and management reports. Following each discussion topic, participant comments and questions were addressed.

Report for 277CA Edits

Discussion of a Cumulative Report

Development of a weekly or monthly cumulative report of outstanding rejected encounters for the 277CA was requested by participants of the previous Editing and Reporting Work Group session. Participants requested that as they fixed an error, the report would reflect the updated number of rejected encounters still to be addressed. Based on current research and system development, it

appears that it is not plausible for the cumulative report to be programmed in a manner that would allow plans to see this change as rejected encounter errors are corrected.

Rejected and accepted encounters will be returned to plans on the 277CA report. However, only accepted encounters will be processed by CMS. Plans will need to resubmit the rejected encounters. Plans are responsible for balancing their reports in order to track those encounters that were rejected and not assigned an ICN. The rejected encounters will be returned with the submitter supplied identifier.

Participants identified that it is administratively burdensome to not store all rejected and accepted encounters. However, there is a concern with regard to the amount of data and the storage space needed to house this data on a long-term basis.

One option suggested by a participant was that CMS could store all rejected and accepted encounters for a specified period of time (at least a year) after implementation in order to assist with the administrative burden of storing all rejected and accepted encounters internally.

Participants were asked to provide feedback with regards to the purpose and benefit of a cumulative 277CA – Rejection report post-implementation of encounter data and CMS has ensured that the system is working as designed. Participants reported that if CMS would store all accepted and rejected encounters for the first year of the transition and implementation, then there may not be a need for a cumulative 277CA – Rejection report after implementation is complete. Storing the data during implementation affords plans the opportunity to work out any issues and determine best practices for reconciling data during the transition period. Participants would like to discuss the continued use and benefit of this cumulative report at the end of the first year of implementation (December 2012) to distinguish needs at that time.

Use of the Cumulative 277CA Report

The 277CA report should be used as a tool by the plans when tracking and correcting rejected encounters from the Encounter Data Front-End System (EDFES). Plans should contact CSSC to discuss claim rejection issues received using the 277CA – Rejection report.

When a plan submits an 837 to the front-end system (EDFES), the plan will receive a 277CA for rejected and accepted encounters. CMS expects to return the 277CA for rejected and accepted encounters within one business day, as is the current process with RAPS. CMS will completely accept or completely reject the entire encounter. The plan should reconcile these two files, so that the rejected and accepted reports equal the original submitted 837 transmission.

In addition, a plan can elect to submit a 276 as an optional mechanism to communicate with the EDFES in order to identify the status of a claim that the plan has not received a return 277CA. At this time, CMS is offering the 276 as an optional benefit for plans to inquire on the data submitted. It is not a required format that plans must use. However, CMS is interested in understanding the industry's perspective on the purpose and benefit of the 276.

Issues Identified

- One participant reported an increase in administrative burden if rejected claims would not be stored. Plans' internal systems would have to be developed in order to track rejected claims on an ongoing basis. Tracking these rejected claims will be complicated as plans continue to submit files monthly and there is a risk for potential overlap of rejected encounters month to month.
- One participant reported that it would cause an increased burden for both CMS and MA plans if rejected claims were stored long-term by CMS and a cumulative report of outstanding rejected encounters was generated.
    - Since an ICN is only available for accepted claims on the 277CA report returned to plans, then an additional matching identifier would need to be populated on the 5010 so that CMS could link rejected encounters being resubmitted to the rejected encounters stored in the database to generate a cumulative report of outstanding rejected encounters to plans monthly.
- Participant reported concern with the 'go live' date of the DME pricing and processing system and would like further information on the process of splitting those DME line items that may be submitted by a provider.

Participants' Comments and Recommendations

- A participant suggested storing rejected claims for at least one year following submission.
    - If CMS is only going to store rejected claims for the first year following the 'go live' date for encounter data collection, then an evaluation of the necessity and benefit of storing rejected claims long term should be completed.
- Participants should establish a tracking system internally to balance the rejected and accepted encounters. All rejected and accepted claims on the 277CA should match the number of claims submitted on the 837. The original claim number submitted and the ICN generated by CMS will be available on the 277CA report for accepted claims so that plans can track their rejected encounters internally.
    - Once a claim is rejected by the EDFES then the plan would be responsible for tracking and balancing their reports based on rejected claims using the claim number on the original submission and the ICN (for accepted claims) on the 277CA report.
- Participants recommended further discussion on the purpose and benefits of using the 276 claim status inquiry for the collection of encounter data.

Population of 5010 Amount Fields

Amount fields on claims submitted by capitated or staff model providers do not always have the true pricing charge available and populated. Participants of the work group were informed that for capitated or staff model plans, '0.00' should be populated in the amount fields before submitting to CMS, when pricing information is unavailable (i.e., as may be the case with a capitated arrangement). If pricing information is available on the encounter collected from the provider, then it must be submitted to CMS as is. Capitated claims submitted to CMS with '0.00' in the amount fields will be priced at 100% of the Medicare allowable amount when processed through the Encounter Data System.

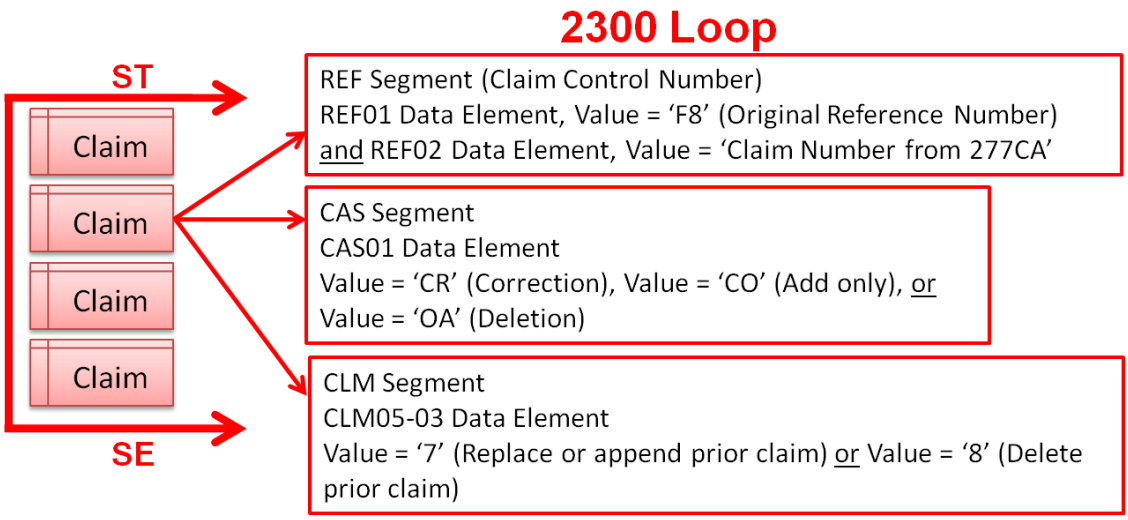
CMS is reviewing amount fields for capitated claims.

Submission of Adjustment Data

Rejected claims submitted to the EDFES will not be stored and in this case, MA plans would need to resubmit the claim as an initial or new submission. However, if an encounter originally submitted to the EDFES is accepted and later needs to be corrected or deleted, then MA plans should submit an adjustment claim. Adjustment claims submitted supersede the original submission. Therefore, MA plans must resubmit the entire claim consisting of all the necessary and accurate data related to the specific encounter. The following information was discussed regarding the process of submitting adjustment encounters:

- Adjustments will only be made at the claim level (ST—SE segments). Plans will not be able to submit line level adjustments. The CAS segment (CAS01 data element) within the 2300 loop of the 5010 will be used to identify the type of adjustment being made. **Figure 1** below displays the adjustment process and the loop/segments and data values that should be used when submitting an adjustment claim to the Encounter Data System (EDS).
- Plans must populate 3 segments for submission of an adjustment claim:
  - REF segment (claim control number)
    - The REF segment REF01 data element must be populated with value 'F8' (original reference number), and
    - The REF segment REF02 data element must be populated with the ICN (claim control number) received using the 277CA report.
  - CAS segment (CAS01 data element)
    - The CAS segment must be populated with one of the 3 value options available for submitting adjustment data:
      - 'CR'=Correction
        - This overwrites the submitted encounter and will replace any previously submitted data.
        - An adjustment indicator ('CR') within the CAS segment can only be used within the 2300 level loop not the 2400 level loop. Line level adjustments cannot be processed.
      - 'CO'=Add only
        - The 'CO' option will be used for MA plans adding more than the allowable number of diagnoses on a professional (837-P) or institutional (837-I) encounter (12 diagnoses are allowed on the 837-P and 25 diagnoses are allowed on the 837-I). Participants reported that more than 25 diagnoses would be associated with the majority of institutional encounters submitted.
      - 'OA'=Deletion
        - This allows a plan to delete previously submitted encounter data.
        - A deletion indicator ('OA') is submitted to delete an entire claim. Line level deletions cannot be processed.
  - CLM segment (CMS05-03 data element)
    - The CLM segment (CLM05-03 data element) within the 2300 loop of the 5010 will be populated with value '07' for replacing or appending a prior claim. This corresponds to the CAS01 values of 'CR' or 'CO.' Or the CLM05-03 data element could be populated with a value '08' for deleting a prior claim. This corresponds to the CAS01 value of 'OA.'

Figure 1: Loop and Segment Identifiers for Submitting Adjustment Data.



Submission of Chart Review Data

The following information was discussed regarding the process of submitting data obtained from chart review processes:

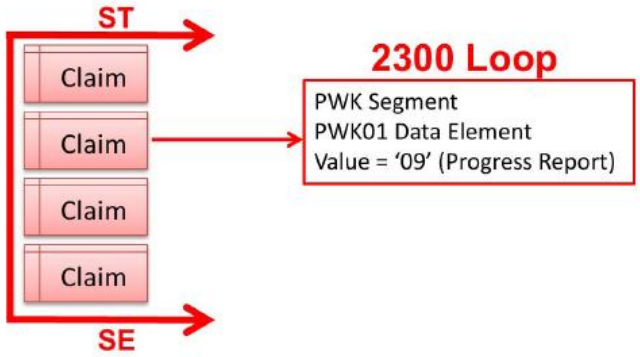
- The PWK segment within the 2300 loop of the 5010 will be used to identify chart review data submissions. **Figure 2** displays the chart review submission process in regards to the 5010 population requirements.
  - When submitting chart review data, the PWK01 data element should be populated with value '09.'
  - Currently, the value '09' is defined as 'progress reports' however, once the companion guide is completed, the definition will be changed to chart reviews for the purposes of encounter data.

Since chart reviews differ from regular claims submissions and are more limited in data content, flagging chart reviews using the PWK segment will allow these claims to process differently, editing only on necessary elements as it is processed through the Encounter Data Processing System (EDPS). As much data as possible should be submitted on chart review submissions. The more data that is submitted, the more data CMS can use for encounter pricing and calibration which ultimately affects plan payments.

- If an original encounter was submitted previously to CMS, chart review data should be linked to the original encounter submitted by using the ICN (claim control number) provided by CMS on the 277CA report.
  - If chart review data is being submitted in addition to data that was previously submitted on an original claim, then the plan should populate the REF segment (REF02 data element) with the ICN obtained from the 277CA report.
  - If chart review data is being submitted and there was no previous claim submitted for the encounter, then the ICN from the 277CA report would not be required. However, MA plans should populate additional beneficiary information based on data available in the medical records if no prior claim related to the encounter was submitted. Information on data

elements required for validation of chart reviews is needed to identify what additional elements MA plans will need to populate.

Figure 2: Loop and Segment Identifiers for Submission of Chart Review Data



CMS is in the process of establishing business rules and instructions for submission of chart review data. This information will be documented in the companion guide sections, which will be released as they are developed.

Return Reports

MA plans will receive return reports from the EDFES and the EDPS in data file formats so that plans are able to modify the files for internal purposes.

Description of EDFES Transaction Reports

MAOs will receive the following front-end reports from the EDFES:

- A TA1 report will be received when an error occurs within the interchange ISA/IEA functional groups of the transmission file.
- A 999R will be received when an encounter is rejected due to a fatal error occurring at the transaction set or batch level (ST—SE) of the transmission file.
- The 999E will be received if an encounter passes the 999 edits at the transaction set level and is accepted for further processing through the Encounter Data System (EDS).
- The 277CA will be received for each claim file and will show whether or not a claim was rejected as well as the reason for rejection.

Processing Reports

CMS is currently developing the format and necessary elements of the EDPS reports. Participants of the Editing and Reporting Work Group were asked to review the current RAPS reports (summarized in the tables below) in the 2008 Participant Guide for risk adjustment located at: http://www.csscoperations.com/internet/Cssc.nsf/files/participant-guide-publish_052909.pdf/$FIle/participant-guide-publish_052909.pdf, Module 5 –Edits and Reports.

Table 3 and Table 4 below display the current RAPS and management reports. Currently, the only report that is returned to plans in a flat file format is the RAPS return file. CMS plans to modify these reports/files to support encounter data and will offer these in a flat file. In addition to the reports listed in Tables 3 and 4, plans will continue to receive the MMR and MOR.

Table 3: Current RAPS Reports

RAPS Reports	
RAPS Return File	• Contains the entire submitted transaction • Identifies 300-, 400-, and 500-level errors • Flat file layout • Received the next business day after submission
RAPS Transaction Error Report	• Communicates errors found in CCC records during processing • Displays only 300-, 400-, and 500-level error codes • Report layout • Received the next business day after submission
RAPS Transaction Summary Report	• Summarizes the disposition of diagnosis clusters • Report layout • Received the next business day after submission
RAPS Duplicate Diagnosis Cluster Report	• Identifies diagnosis clusters with 502-error message • Clusters accepted, but not stored • Report layout • Received the next business day after submission

Table 4: RAPS Management Reports

RAPS Management Reports	
RAPS Monthly Plan Activity Report	• Provides monthly summary of the status of submissions by Submitter ID and Plan Number • Report layout • Available for download the second business day of the month
RAPS Cumulative Plan Activity Report	• Provides cumulative summary of the status of submissions by Submitter ID and Plan Number • Report layout • Available for download the second business day of the month
RAPS Monthly Error Frequency Report	• Provides a monthly summary of all errors associated with files submitted in test and production • Report layout • Available for download the second business day of the month
RAPS Quarterly Error Frequency Report	• Provides a quarterly summary of all errors on all file submissions within the 3-month quarter • Report layout • Available for download the second business day of the month following each quarter

Action Item for Processing Reports

Participants should create a list of ideal reports to assist in reconciling submissions. Plans should also submit comments about receiving all reports in flat files. This information should be submitted to eds@ardx.net by 3/16/11.

Additional Questions Addressed Throughout the Work Group

The following are questions asked by participants during the Editing and Reporting Work Group.

Questions asked by Participants

Q1: Where does the 276 transaction factor into the encounter data process?
A1: The 276 is an optional transaction MA plans can use to communicate with CMS about the status of a submitted claim that has not already been returned on a 277CA report. Participants should submit thoughts regarding the value and function of the 276 transaction to eds@ardx.net.

Q2: When will the 277CA report be returned to plans?
A2: Plans can expect to receive the 277CA report within one business day after submitting a claim.

Q3: Will accepted claims on the 277CA have an ICN?
A3: Yes, accepted encounters will have an ICN and rejected encounters will not.

Q4: Since the DME processing and pricing will be turned on at a later time and CMS will not be conducting line item level editing, how will pricing of DME items submitted on the same claim as other services be affected?
A4: Because DME is scheduled to 'go live' later in the encounter data timeline, this could impact pricing and processing of DME services. CMS will investigate this issue further.

Q5: Will claims be rejected at the line level or claim level?
A5: Encounters will be rejected at the claim level and will either be completely accepted or completely rejected.

Q6: For eligibility rejections, will MA plans be required to resubmit the entire claim?
A6: Yes.

Q7: Will CMS be monitoring claim rejections or will this be the responsibility of the MA plan?
A7: CMS will provide the 277CA acknowledgement report which will include claims that were rejected and those claims that were accepted. MA plans will be responsible for tracking their claim rejection corrections. At present, CMS is not developing a cumulative report of all claim rejects and accepts.

Q8: Will both the original claim number submitted by the plan and the ICN be available on the 277CA for accepted claims?
A8: Yes, both numbers will be reported back to the submitter for accepted claims. If a claim rejects, only the claim number submitted by the plan will be returned.

Q9: Should '0.00' be populated for any amount field or just the 'charge amount' field?

A9: '0.00' should be inputted for any amount field that a plan is unable to populate.

Q10: Should MA plans input '0.00' or zero out the charge and paid amount fields for capitated claims?
A10: No, '0.00' should only be inputted if the claim if there is no data available in the amount fields. If the pricing information is available, the encounter and pricing information should be submitted to CMS as is.

Q11: If CMS is going to be using the billed charges and pricing services at 100% of the Medicare allowable amount, why are plans required to submit the paid amount information?
A11: CMS will only be pricing encounters at 100% of the Medicare allowable amount for those claims in which '0.00' is inputted for the amount fields. MA plans should only input '0.00' for amount fields if data is missing when the claim is received. This may occur in cases where there is a capitated arrangement with the provider. By populating '0.00' this will allow the claim to process through the Encounter Data System (EDS) since these amounts fields are required to complete processing. If amount information is available the MA plan should submit the claim as is.

Q12: How will CMS identify if a claim is capitated?
A12: CMS is not currently considering flagging capitated claims. If a claim is capitated and no pricing data is available, then plans should input '0.00' for those amount fields with no pricing information.

Q13: For submission of chart review data, are MA plans required to populate all of the other fields on the 837, or just those necessary for RAPS payment adjudication?
A13: Plans should populate as much information as possible for encounter data. It will benefit plans long term because this information will be used for pricing and recalibration of the model which will ultimately affect plan payments. CMS is still making final determinations on the data elements that will be required for chart review validation and therefore populated on the 837 format.

Q14: How would an MA plan delete codes from a chart review submission?
A14: If a plan finds in a chart review that erroneous diagnosis codes were previously submitted, then this would be submitted as an adjustment using the CAS segment to delete erroneous items. If an MA plan is only adding codes from a chart review, then the PWK01 segment and ICN would be used.

Q15: Will chart review submissions be subject to the 12-month timely filing rule?
A15: CMS is currently evaluating the timely filing requirements for the purposes of encounter data submission. Plans will be notified once guidance is released.

Q16: If plans are able to link chart review data to an original claim, would MA plans follow the pattern of submitting an adjustment claim (replacing or appending a prior claim)?
A16: No, chart review data should be submitted separately from adjustment data. If plans are able to link chart review data to an original encounter, then the PWK segment should be populated with the value '09' and the ICN on the 277CA report for the original claim submission should be inputted in the REF segment.

Q17: What if there is no prior claim to link chart review data?
A17: The MA plan should populate the PWK segment with value '09'. The ICN from the 277CA report will not be required since there was no initial claim submitted for the encounter. Plans will be required to

populate additional fields based on what is available in the medical record. CMS is evaluating what fields will be required for chart review validation.

Q18: To add more than 12 diagnosis codes to a professional claim (837-P), do plans submit the initial claim and then wait for the 277CA to return with the ICN before sending the second claim with the additional diagnosis codes?
A18: Yes.

Q19: Will a claim reject if an MA organization submits more than 12 diagnosis codes on a professional claim (837-P)?
A19: The maximum allowable amount for diagnosis codes on the 837-P is 12 diagnosis codes, so plans will be unable to input more than 12 diagnosis codes according to 5010 standards. Plans must wait for the initial encounter to process and receive the 277CA report with an ICN in order to submit an additional encounter with more diagnosis codes.

Q20: Will the companion guide contain the 277 CEM edits?
A20: Yes.

Key Conclusions and Recommendations for Encounter Data Editing and Reporting Work Group

Based on the information discussed in the Editing and Reporting Work Group held on March 02, 2011, the following recommendations were provided to CMS to ensure successful implementation of the collection of encounter data.

Participants' Conclusions and Recommendations

- Participants recommended applying soft editing logic to Medically Unlikely Edits.
- If both the original claim number submitted by the plan and the ICN is available on the 277CA report for accepted claims, a cumulative 277CA report of outstanding rejected claims may not be necessary.
    - MA plans will be able to track and balance claim rejections if both numbers are returned on the 277CA report.

Action Items and Information needed from Participants

The next Industry Update will be held on March 16, 2011.

By Wednesday March 9, 2011, work group participants should send the following items to eds@ardx.net:

- Additional thoughts about whether a cumulative 277CA report of outstanding rejected encounters is necessary and the function and purpose for plans utilizing this type of report.
- Information regarding Medically Unlikely Edits and reasons supporting the application of soft or hard editing logic.
- Data element and formatting ideas for transaction reports from the EDPS and initial thoughts about sending all EDPS reports in a data file format.