Encounter Data System

Test Case Specifications

Encounter Data PACE Test Case Specifications related to the 837 Health Care Claim: Professional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X222A1

Test Case Specifications: 2.0
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Preface

The Encounter Data System (EDS) Test Case Specifications contain information to assist PACE organizations in the submission of encounter data for EDS testing. Following the completion of **25-50 unique encounter data submissions for Encounter Data Front End System (EDFES) testing,** PACE organizations are required to submit data for testing the Encounter Data Processing System (EDPS). This document provides an outline of test case submissions required for PACE end-to-end testing.

Questions regarding the contents of the EDS Test Case Specifications should be directed to eds@ardx.net.

REVISION HISTORY

Version	Date	Organization/Point of Contact	Description of Changes
1.0	08/20/12	ARDX	Base Document
2.0	08/28/12	ARDX	TC03-Capitated Provider Submission and TC11-Bundled Payment were removed from the test case specifications and the total number of test cases has been modified to reflect a total of 12 cases.

Table of Contents

1.0 Overview

2.0 Introduction

3.0 Test Case Details

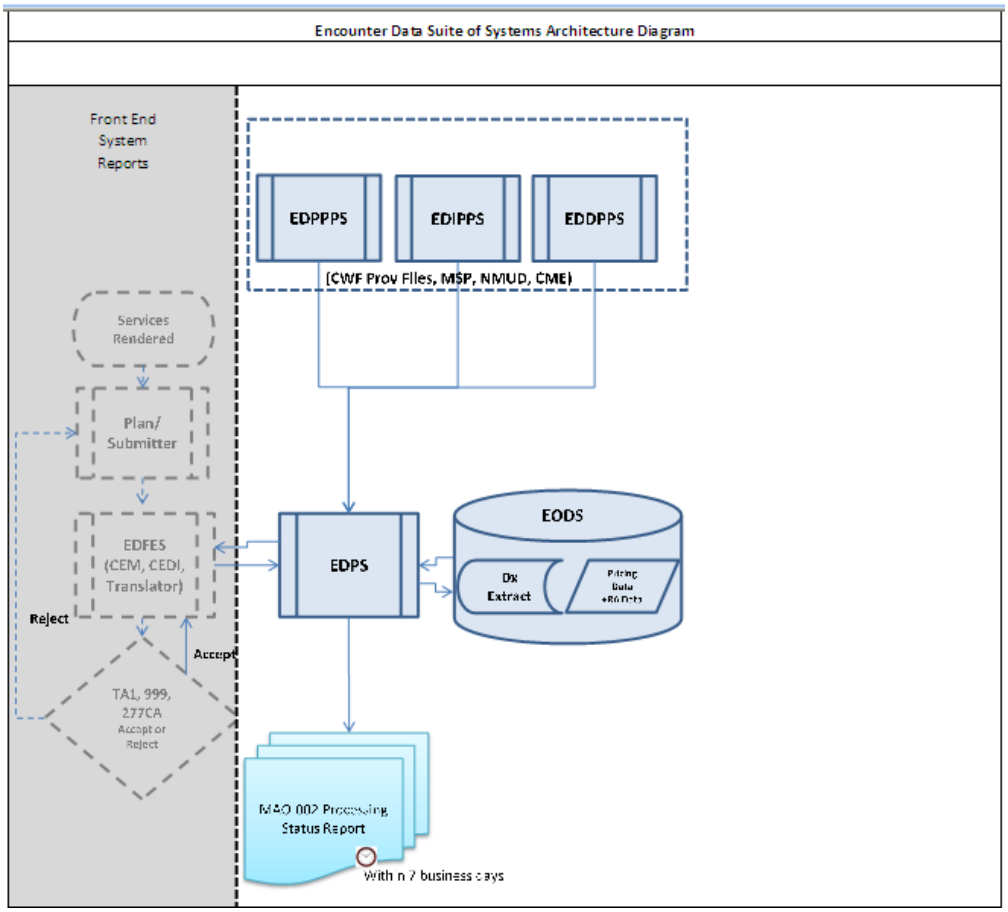
4.0 Acronyms

1.0 Overview

This document may be used in conjunction with the business case examples referenced in the EDS 837 Professional Transaction Companion Guide. Additional Test Scenario Specification documents may be incorporated and referenced at a later date.

The purpose of EDS end-to-end testing is to validate the following:

Files are received by the EDFES
Files are processed through the translator
Files are processed through the CEM
Submitter receives acknowledgment reports (TA1, 999, 277CA) from the EDFES
EDFES data are received by the Encounter Data Processing System (EDPS)
Data are processed and priced in the EDPS
Submitter receives Encounter Data Processing Status MAO-002 from the MAO-002 from the EDPS



2.0 Introduction

CMS has provided the submission guidelines for end-to-end testing, to include test cases necessary for PACE testing. PACE testing is intended to allow PACE organizations the ability to determine system performance based on the submission of non-PACE day care center services. Non-PACE day care center services are submitted on an inpatient or outpatient Institutional or Professional claim form. **Professional encounter testing begins 11/16/2012 and ends 12/31/2012.**

2.1 Professional End-to-End Testing

The 837-P certification files are submitted in two (2) files. The first file includes all unlinked test cases (8) and the second file includes the linked test cases (4). All test cases included in the first file must be completely accepted as indicated on the MAO-002 report before the second file is submitted. PACE organizations must receive a 95% acceptance rate to be deemed certified.

The first test file must include the 16 encounters (2 encounters per test case) otherwise EDS will reject the file. Rejected files must be corrected and resubmitted until all 16 encounters pass translator and CEM editing at 100% before it can be processed in the EDPS. PACE organizations must use the following guidance when preparing all unlinked (8) and the linked (4) test cases:

> The encounters submitted must comply with the TR3, CMS edits spreadsheet and Encounter Data Companion Guide.
> All encounters must include 2012 DOS only (no future dates).
> Files must be identified as a test case submission using ISA15='T' and CLM01 by appending "TC<test case #>" to the end of the Plan Encounter ID (CCN).

PACE organizations must not submit any Institutional or DME test cases with the Professional file submissions. PACE organizations should exclude PACE center services at this time. PACE organizations will receive the TA1, 999, and 277CA within 48 hours of submission. The MAO-002 report will be returned to the submitter within seven (7) business days of EDFES submission receipt. PACE organizations must correct errors identified on the reports and resubmit data with a 95% acceptance rate in order to pass end-to-end certification. Acceptance notifications will be communicated to MAOs and other entities upon certification.

2.2 Test Case Summary

During the end-to-end testing, the following types of test case scenarios are required:

I. Beneficiary Eligibility
   a. Standard MA Member Submission

II. Provider Data Validation Submissions
   a. Atypical Providers
   b. Ambulance TOS
   c. Coordination of Benefits (COB)

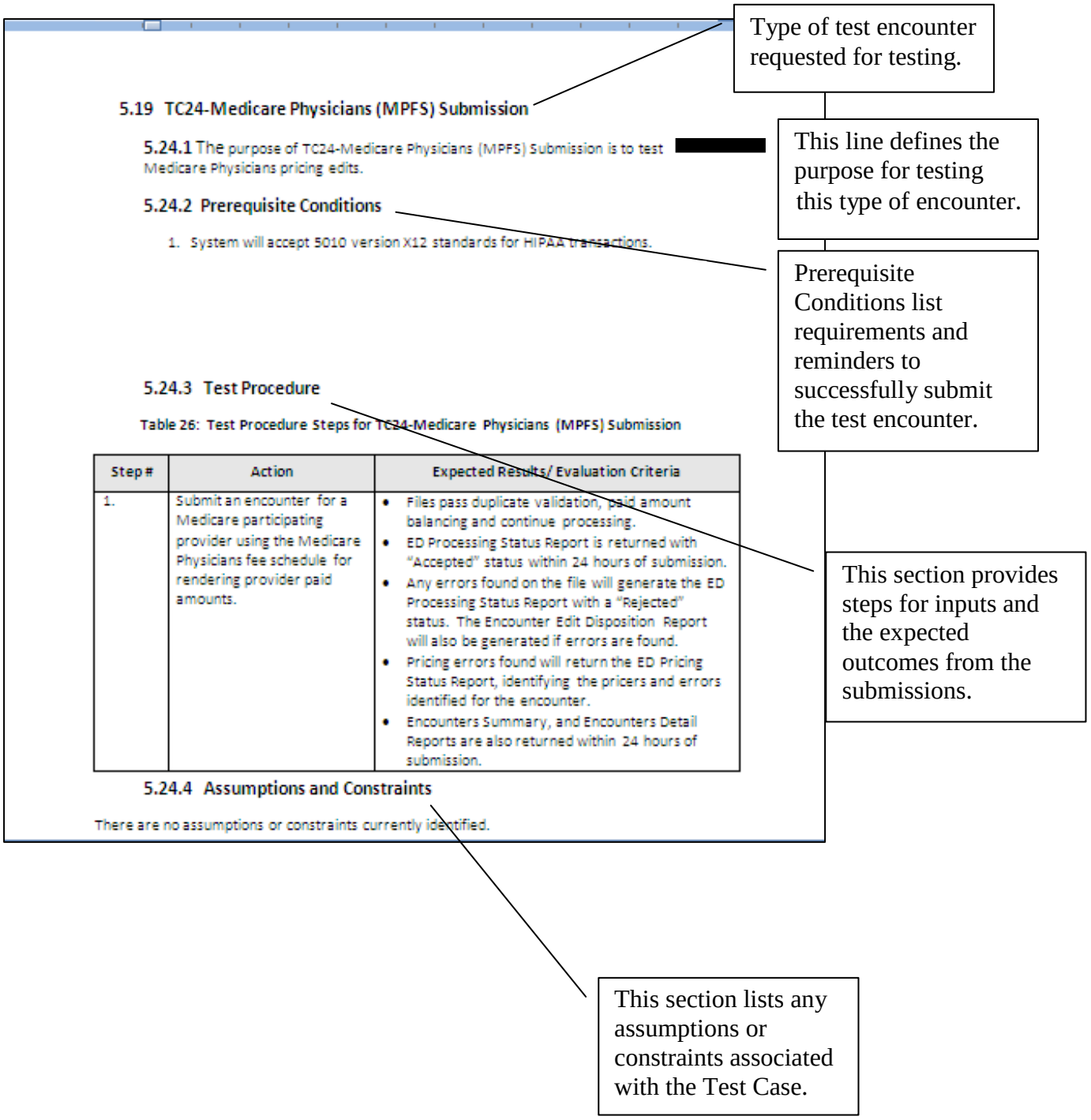
III. Processing
   a. Correct/Replace
   b. Void/Delete
   c. Chart Review – Linked
   d. Chart Review – Unlinked
   e. Duplicate
   f. Paper Generated
   g. Zip Code + 4

IV. Risk Adjustments
   a. Diagnoses not included in the model diagnoses

Test Case Summary Table

Test Case/Script Identifier	Test Case/Script Title
Beneficiary Eligibility-Current MA Member	TC01-Standard MA Member Submission
Provider Data Validation	TC02-Atypical Provider Submission
Provider Data Validation	TC03-Ambulance TOS Submission
Provider Data Validation	TC04-Coordination of Benefits Submission
Encounter File	TC05-Correct/Replace
Encounter File	TC06-Void/Deleted
Encounter File	TC07-Chart Review – Linked
Encounter File	TC08-Chart Review – Unlinked
Encounter File	TC09-Duplicate
Encounter File	TC10-Paper Generated
Encounter File	TC11-Zip Code +4
Risk Adjustment	TC12-Diagnoses Included in Model Diagnosis Codes

For each test case scenario, details are provided to assist with encounter data test submissions:



5.19 TC24-Medicare Physicians (MPFS) Submission

5.24.1 The purpose of TC24-Medicare Physicians (MPFS) Submission is to test [redacted] Medicare Physicians pricing edits.

5.24.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

5.24.3 Test Procedure

Table 26: Test Procedure Steps for TC24-Medicare Physicians (MPFS) Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a Medicare participating provider using the Medicare Physicians fee schedule for rendering provider paid amounts.	• Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 24 hours of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status. The Encounter Edit Disposition Report will also be generated if errors are found. • Pricing errors found will return the ED Pricing Status Report, identifying the pricers and errors identified for the encounter. • Encounters Summary, and Encounters Detail Reports are also returned within 24 hours of submission.

5.24.4 Assumptions and Constraints

There are no assumptions or constraints currently identified.

3.0 Test Case Details

3.1 TC01-Standard MA Member Submission

3.1.1 Purpose

The purpose of TC01-Standard MA Member Submission is to test eligibility rules for a standard Medicare Advantage encounter submission.

3.1.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

3.1.3 Test Procedure

Table 1: Test Procedure Steps for TC01-Standard MA Member Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a standard Medicare Advantage member.	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission

3.1.4 Assumptions and Constraints

It is assumed that all beneficiaries are eligible and enrolled in the plan and can be found in enrollment reports and table for verification.

3.2 TC02-Atypical Provider Submission

3.2.1 Purpose

The purpose of TC02-Atypical Provider Submission is to test encounters submitted by atypical providers with the designated default NPI and tax ID number for editing, processing, and appropriate pricing of submissions.

3.2.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

3.2.3 Test Procedure

Table 2: Test Procedure Steps for TC02-Atypical Provider Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an atypical provider 837-P file using the following default codes: Payer ID-80882 NPI-1999999984 EIN-199999998 ICD-9 diagnosis code: '78099'-Other General Symptoms Loop 2300, NTE01='ADD', NTE02='NO NPI ON PROVIDER CLAIM NO EIN ON PROVIDER CLAIM'	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission

3.2.4 Assumptions and Constraints

The default diagnosis codes provided are only used for testing purposes. Relevant diagnosis codes should be determined by coordinating with the provider and atypical service provider. Diagnoses captured from atypical provider types (as notated by the default atypical provider NPI) will not be priced or used for risk adjustment calculation; however, it will be stored for beneficiary utilization data and analysis.

3.3 TC03-Ambulance TOS Submission

3.3.1 Purpose

The purpose of TC03-Ambulance TOS Submission is to test editing, processing, and appropriate pricing of ambulatory services.

3.3.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

3. Remember to submit an NPI that is valid for an ambulance type of service and the HCPCS codes listed are valid for ambulatory services.

4. Ensure a valid zip code is included in the submission file.

3.3.3 Test Procedure

Table 3: Test Procedure Steps for TC03-Ambulance TOS Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with a valid pick-up service address in Loop 2310E and drop-off address in Loop 2310F.	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate to the ED

Step #	Action	Expected Results/ Evaluation Criteria
		Processing Status Report with a “Rejected” status within seven (7) business days of submission.

3.3.4 Assumptions and Constraints

The ambulance fee schedule will be used for pricing all services identified on the encounter submission.

3.4 TC04-Coordination of Benefits Submission

3.4.1 Purpose

The purpose of TC04-Coordination of Benefits Submission is to test editing, processing, and appropriate pricing of multi-payer or Medicare secondary payer submissions.

3.4.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

3. Submit an original transaction to a primary payer.

3.4.3 Test Procedure

Table 4: Test Procedure Steps for TC04-Coordination of Benefits Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a true coordination of benefits submission using the following guidance: **1st iteration of COB loops** – MAO information (**Primary Payer)** Loop 2320 AMT01='D', AMT02=MAO Paid Amount Loop 2330B – MAO Information Loop 2430 – MAO Service Line Adjudication Information SVD – Service Level Payment Amount CAS – Service Level Amount NOT Paid	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission.

Step #	Action	Expected Results/ Evaluation Criteria
	2nd iteration of COB loops – True COB (**Tertiary Payer)** Loop 2320 AMT01='D', AMT02=True COB Paid Amount CAS – Claim Level Amount NOT Paid by True COB Loop 2330B – Other Payer Information DTP*573-Other Payer Adjudication Date *NOTE – there is **NO** True COB Service Level Payment Amount information	

3.4.4 Assumptions and Constraints

There are no assumptions and constraints identified at this time for coordination of benefits submissions.

3.5 TC05-Correct/Replace

3.5.1 Purpose

The purpose of TC05-Correct/Replace is to test for editing, processing, and appropriate pricing of replacement submissions.

3.5.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. The original submission must be identified as "Accepted" status on the ED Processing Status Report. This submission must be sent with the ICN associated with the "Accepted" encounter.

3. At least two (2) encounters are submitted for each type of test case scenario.

3.5.3 Test Procedure

Table 5: Test Procedure Steps for TC05-Correct/Replace

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with a correction/replacement code '7' in Loop 2300, CLM05-3 on the 837-P. Populate Loop 2300, REF01='F8' and REF02 = ICN of the prior encounter.	The 999A and 277CA Reports are returned within 24 hours of submission. Validation is performed against the original encounter stored in the EODS: o Loop 2300 ▪ REF01=F8 ▪ REF02=ICN Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with

Step #	Action	Expected Results/ Evaluation Criteria
		"Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission.

3.5.4 Assumptions and Constraints

It is assumed that MAOs have access to the CMS website where diagnosis models for risk adjustments are available as a reference. There are no constraints identified for the submission of a replacement encounter.

3.6 TC06-Void/Deleted

3.6.1 Purpose

The purpose of TC06-Void/Deleted submission is to ensure an original encounter is deleted from the system.

3.6.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. The original submission must be identified as "Accepted" status on the ED Processing Status Report. This submission must be sent with the ICN associated with the "Accepted" encounter.

3. At least two (2) encounters are submitted for each type of test case scenario.

3.6.3 Test Procedure

Table 6: Test Procedure Steps for TC06-Void/Deleted

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with a void/deleted code '8' in Loop 2300, CLM05-3 on the 837-P. Populate Loop 2300, REF01='F8' and REF02 = ICN of the prior encounter.	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission.

3.6.4 Assumptions and Constraints

It is assumed that any information that is incorrect for a void/deleted submission is captured and rejected at the CEM/CEDI edit level therefore would reach the processing level. There are no constraints identified for the submission of a deletion file.

3.7 TC07-Chart Review – Linked

3.7.1 Purpose

The purpose of TC07-Chart Review – Linked submission is to ensure supplemental chart review information associated with an encounter is captured in EODS for editing, processing, and appropriate pricing of submissions.

3.7.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. The original submission must be identified as "Accepted" status on the ED Processing Status Report. This submission must be sent with the ICN associated with the "Accepted" encounter.

3. At least two (2) encounters are submitted for each type of test case scenario.

4. Remember to include a valid Provider Tax ID and the Rendering Provider NPI number.

3.7.3 Test Procedure

Table 7: Test Procedure Steps for TC07-Chart Review Linked Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a chart review linked to an existing ICN with a PWK01 = "09" and PWK02 = "AA". Submit the chart review with a minimum of four (4) diagnosis codes for testing.	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission.

Step #	Action	Expected Results/ Evaluation Criteria
		Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission.

3.7.4 Assumptions and Constraints

An existing ICN must be linked to the chart review submission.

3.8 TC08-Chart Review – Unlinked

3.8.1 Purpose

The purpose of TC08-Chart Review-Unlinked Submission is to ensure supplemental chart review information without an associated encounter is captured in EODS for editing, processing, and appropriate pricing of submissions.

3.8.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. At least two (2) encounters are submitted for each type of test case scenario.

3. Remember to include a valid Provider Tax ID and the Rendering Provider NPI number.

3.8.3 Test Procedure

Table 8: Test Procedure Steps for TC08-Chart Review – Unlinked Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a chart review with no link to an ICN with a PWK01 = "09" and PWK02 = "AA".	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission. The chart review with no linked ICN is processed

Step #	Action	Expected Results/ Evaluation Criteria
		through the EDPS. Encounter data is checked against processing edits.

3.8.4 Assumptions and Constraints

There can be no existing ICN linked to the submission of a chart review – unlinked, and the data will not be priced in EDPS.

3.9 TC09-Duplicate

3.9.1 Purpose

The purpose of TC09-Duplicate Submission is to ensure information is not duplicated and stored for pricing and risk adjustment in EODS.

3.9.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. At least two (2) encounters are submitted for each type of test case scenario.

3. An original submission should be "Accepted" in EDPS prior to submitting a duplicate encounter submission.

4. Ensure that the interchange date and time (ISA09 and ISA10) are unique in the ISA-IEA interchange header file.

3.9.3 Test Procedure

Table 9: Test Procedure Steps for TC09-Duplicate Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a duplicate 837-P encounter to the EDFES with duplicate data in all of the following fields: Beneficiary HICN Beneficiary Last Name Date of Service Place of Service Type of Service Procedure Code (and 4 modifiers) Rendering Provider NPI Paid Amount	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount The file is rejected due to duplicate data contained in EODS. ED Duplicates Report is generated and returned within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status

Step #	Action	Expected Results/ Evaluation Criteria
		within seven (7) business days of submission.

3.9.4 Assumptions and Constraints

It is assumed that the submission matches an existing encounter in the system.

3.10 TC10-Paper Generated

3.10.1 Purpose

The purpose of TC10-Paper Generated submissions is to test editing, processing, and appropriate pricing of submissions.

3.10.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. At least two (2) encounters are submitted for each type of test case scenario.

3.10.3 Test Procedure

Table 10: Test Procedure Steps for TC10-Paper Generated

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a paper claim encounter with required minimum data elements, including PWK01 = "OZ" and PWK02 = "AA".	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission

3.10.4 Assumptions and Constraints

Provider NPIs should be submitted as appropriate, however if an NPI does not exist, PACE organizations may submit encounters using the default NPI = '199999998'.

3.11 TC11-Zip Code + 4

3.11.1 Purpose

The purpose of TC11-Zip Code + 4 Submission is to test editing, processing, and appropriate pricing of submissions.

3.11.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. At least two (2) encounters are submitted for each type of test case scenario.

3.11.3 Test Procedure

Table 11: Test Procedure Steps for TC11- Zip Code + 4 Submissions

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with the zip code + 4 postal box identifier. Use "9999" as a default for the last four (4) digits of the zip code for one submission to test the case where this information does not exist on the original submission file.	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission.

3.11.4 Assumptions and Constraints

It is assumed that all encounter submissions will include submitter names.

3.12 TC12-Diagnoses Included in Model Diagnosis Codes

3.12.1 Purpose

The purpose of TC12-Diagnoses Included in Model Diagnosis Codes Submission is to test editing, processing, and appropriate pricing of submissions.

3.12.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. At least two (2) encounters are submitted for each type of test case scenario.

3.12.3 Test Procedure

Table 12: Test Procedure Steps for TC12-Diagnoses Included in Model Diagnosis Codes Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a standard encounter with four (4) diagnoses from the model diagnoses spreadsheet, found at the following: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk_adjustment.html	The 999A and 277CA Reports are returned within 24 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount Files pass duplicate validation, paid amount balancing and continue processing. ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission.

3.12.4 Assumptions and Constraints

It is assumed that MAOs have access to the CMS website where diagnoses models for risk adjustment are available for reference. There are no constraints identified for the submission of original encounter data.

ACRONYMS

CMS	Centers for Medicare & Medicaid Services
EDFESC	Encounter Data Front End System Contractor
EDFES	Encounter Data Front End System
EDIPPS	Encounter Data Institutional Pricing and Processing System
EODS	Encounter Data Operational Data Store
EDPPPS	Encounter Data Professional Pricing and Processing System
EDDPPS	Encounter Data DME Pricing and Processing System
EDPS	Encounter Data Processing System
EDPSC	Encounter Data Processing System Contractor
EDS	Encounter Data System
MA	Medicare Advantage
MAO	Medicare Advantage Organization