Encounter Data User Group Q&A Documentation

Questions and Answers

The following were questions submitted by participants for discussion during the November 17, 2011 Encounter Data User Group Call.

Q1: Where can MAOs and other entities find materials from the October 27, 2011 Industry Update and November 3, 2011 User Group session?

A1: All outreach materials can be found at the TARSC website at www.tarsc.info. Materials from the User Group and Industry Update can be found on the Home page under Important Links. For your convenience, you may also go to the CSSC Operations (www.csscoperations.com) website under the encounter data resources link.

Q2: Should MAOs and other entities submit correct/replace or deletion encounters for interest and penalty payments or overpayments to providers?

A2: No, MAOs and other entities are not required to submit interest and penalty payments and/or adjustments for overpayments to providers.

Q3: Does failing an edit in the EDPS mean the encounter will not be priced or used for risk adjustment?

A3: If an encounter passes front-end editing but does not pass EDPS editing, the MAO or other entity will be required to resubmit the encounter in order to be correctly priced and/or used for risk adjustment. For example, if a modifier does not match a procedure code, it will be processed as an invalid encounter and therefore, will be rejected and no further processing will take place, including using the diagnosis for risk score calculation.

Q4: If a member is admitted to the hospital in 2011 but is discharged in 2012, should that claim be submitted for encounter data?

A4: MAOs and other entities must submit claims and encounter information for 2012 dates of service. For hospital inpatient claims, the submission is based on the member's date of discharge. If the inpatient discharge date is in 2012, the data is acceptable for encounter data submission.

Q5: Will there ever be situations where an 837-D claim should be converted to an 837-P or 837-I encounter record? If so, please provide a list of those situations?

A5: MAOs and other entities should not convert 837-D claims to an 837-P or 837-I encounter record. Only those dental services that are incident to an institutional or professional visit should be submitted on an 837-I or 837-P. 837-D claims should not be submitted for encounter data purposes.

Q6: Does End-to-End testing require adjudication? Should the 50-100 encounters sent for end-to-end testing also be adjudicated claims only?

A6: MAOs and other entities are not required to submit adjudicated data for End-to-End testing; however, the test data that is submitted must be valid. MAOs and other entities should be mindful when preparing test data that CMS requires that MAOs and other entities put claims through an adjudication process prior to submission of production data.

Q7: How can MAOs and other entities verify that encounters successfully processed through the EDFES? Is there any acknowledgement report that will notify MAOs and other entities that an encounter processed without errors?

A7: The 277CA provides information on accepted (processed without errors) and rejected encounters. The encounters that have successfully processed through the CEM will be assigned an ICN, which will be on the 277CA acknowledgement report.

Q8: If a claim is rejected as a duplicate, is that duplicate stored by CMS? If yes, does CMS assign a new ICN to the duplicate claim?

A8: All encounters are stored in the Encounter Operational Data Store. Encounters that pass front-end processing will receive an ICN. Encounter/claim level duplicate checks are performed in the Encounter Data Processing System. As a result, duplicates will receive an ICN. If the encounter associated with an ICN fails the duplicate check, you will see that reflected on your Encounter Data Duplicates report, which has been identified as MAO-001. Please see Slide #28 of the October 27, 2011 Industry Update for details on the encounter/claim level duplicate logic.

Q9: On the October 27, 2011 Industry Update call, it was mentioned that, if there is no diagnosis on the claim for Atypical Providers, MAOs and other entities should submit the default diagnosis code of 78099. Please identify which providers to which this refers. Specifically, is the Servicing Provider considered atypical or do you mean any provider (Billing, Operating, Attending, etc.)?

A9: Atypical provider refers to the servicing provider, such as Meals on Wheels, transportation services, language interpreters, etc. Atypical provider encounters will not be priced or used for risk adjustment purposes.

Q10: What is CMS' expectation for submission of encounters for services where Medicare would not be liable for payment in a claims setting? In the past, CMS has advised that diagnoses from non-covered encounters could be submitted as long as they met the requirement of a face-to-face encounter with a physician provider. Should services covered under workers compensation, self-funded employer groups, and other third party liability services be included in encounter data submissions?

A10: MAOs and other entities should submit all encounters regardless of who is liable for payment. In this example, a true COB exists. In the first iteration of the COB loops, the MAO should populate the plan paid amount and in the second iteration of the COB loop, the workers compensation amount should be populated.