CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2012 Regional Technical Assistance Participant Guide

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Encounter Data

ARDX
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INTRODUCTION

Purpose

The purpose of this guide is to provide participants with the resources necessary to prepare their systems for the collection, submission, and processing of encounter data. Medicare Advantage Organizations (MAOs) and other entities will also become familiar with the encounter data policies, reports generated from the Encounter Data System (EDS), and edit resolution.

ICON KEY

Definition

Example

Reminder

Resource

About this Training

This technical assistance session is organized into 10 modules, including the Introduction module. Table A provides an outline of the modules and a brief description.

TABLE A – MODULE TITLES AND DESCRIPTIONS

Module Title	Description
Overview	Identifies the common terms, processing systems, data flow, and resources for encounter data.
Policy, Monitoring, and Compliance	Provides new information regarding encounter data policy, monitoring, and compliance. Specifics on new encounter data submission policies will be shared.
Professional Submission	Provides detailed requirements for submitting Professional/Physician services acceptable for encounter data and common Professional submission themes.
Institutional Submission	Provides detailed requirements for submitting Institutional services acceptable for encounter data and common Institutional submission themes.
Durable Medical Equipment (DME) Submission	Provides detailed requirements for submitting DME services acceptable for encounter data and common DME submission themes.
EDFES Reports	Identifies EDFES acknowledgement reports, including the TA1, 999, and 277CA; and instruction to resolve edits.
EDPS Reports	Identifies reports generated from the processing system and instruction to resolve edits and reconcile reports.
Special Considerations	Provides guidance for the submission of encounter data from PACE Organizations, Cost Plans, and Special Needs Plans.
Best Practices	Demonstrates best practices to assist MAOs and other entities in submitting accurate and timely encounter data.

Future Use

The Participant Guide, slides, and Companion Guides are designed to serve as reference guides. Additional copies of the training materials can be obtained by accessing www.csscoperations.com. While the information provided in the Participant Guide, slides, and Companion Guides is current as of the release dates, MAOs and other entities must be aware that CMS revises training materials when decisions or new information that impacts these documents is made available. Organizations are encouraged to register at www.csscoperations.com to receive notifications of updates. Table B identifies the training tools used to assist in facilitation of this module.

TABLE B – TRAINING TOOLS

Section	Description
Participant Guide	Detailed description of relevant encounter data information Exercises Answer Keys
Slides	Organized by module
Companion Guide	837-I (Institutional) 837-P (Professional) 837-P (DME Specific)
Other Resources	Official CMS Notices List of Acronyms List of web-based resources

Audience

This technical assistance program is designed for those MAOs and other entities that will submit encounter data. CMS requires the following types of organizations to collect and submit encounter data:

- Medicare Advantage (MA) Plans
- Medicare Advantage-Prescription Drug Plans (MA-PDPs)
- Health Maintenance Organizations (HMOs)
- Special Needs Plans (SNPs)
- Local Preferred Provider Organizations (PPOs)
- Regional PPOs
- Employer Group Health Plans (EGHP)
- Programs for All-Inclusive Care for the Elderly (PACE) Plans
- Cost Plans (1876 Cost HMOs/CMPs and 1833 HCPPs)
- Medical Savings Account (MSA) Plans
- Private Fee-For-Service (PFFS) Plans
- Religious Fraternal Benefit Plans (RFBs)
- Provider Sponsored Organizations (PSOs)

Learning Objectives

At the completion of this technical assistance session, participants will be able to:

- Identify the encounter data rules and information regarding monitoring and compliance actions.
- Understand the acceptable Physician/Professional, Institutional, and DME services.

- Interpret and reconcile data communicated on the EDFES and EDPS reports.
- Determine edits generated from the front-end and processing systems.
- Describe the encounter data rules specific to PACE Organizations, Special Needs Plans, and Cost Plans.
- Understand the best practices for collection, submission, and processing of encounter data.

Contacts

In an effort to ensure that participating MAOs and other entities have the necessary tools and information to successfully submit encounter data, the resources described in Table C have been provided for support and technical assistance.

TABLE C – ENCOUNTER DATA PROCESS POINTS OF CONTACT

Organization	Role	Contact Information
Customer Service and Support Center (CSSC)	Manages the Encounter Data Front-End System (EDFES) and the CSSC.	CSSC Operations: http://www.csscoperations.com/internet/cssc.nsf/Home
A. Reddix & Associates (ARDX)	Provides project integration, industry outreach, business requirements, systems specifications and is the training contractor responsible for encounter data training initiatives, including regional training programs and work groups.	EDS Inbox: EDS@ardx.net Encounter Data Outreach Registration: www.tarsc.info

MODULE 1 - ENCOUNTER DATA SYSTEM (EDS) OVERVIEW

Purpose

Successful implementation of the Encounter Data System (EDS) is dependent upon Medicare Advantage Organizations (MAOs) and other entities' understanding the process of collecting and submitting accurate encounter data. The purpose of this module is to provide participants with important encounter data terms, outline the encounter data process flow, and utilize encounter data resources to assist with understanding encounter data.

Learning Objectives

At the completion of this module, participants will be able to:

- Define common encounter data terminology.
- Demonstrate knowledge in interpreting key components of the encounter data process.
- Identify encounter data outreach efforts available to organizations.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1.1 Common Encounter Data Terms

The implementation of encounter data requires an understanding of key terms related to the collection, submission, and processing of data through EDS. This section introduces new terminology related to EDS processing and establishes common definitions for existing industry terms that are important to understanding the encounter data process.

1.1.1 Claims Processing Systems

The EDS is comprised of five (5) systems which are designed to perform editing, processing, pricing, and storage of encounter data. Table 1A provides definitions for the Encounter Data Front-End System (EDFES) and different components that are included in Encounter Data Processing System (EDPS) and Medicare Fee for Service (FFS) shared or base systems.

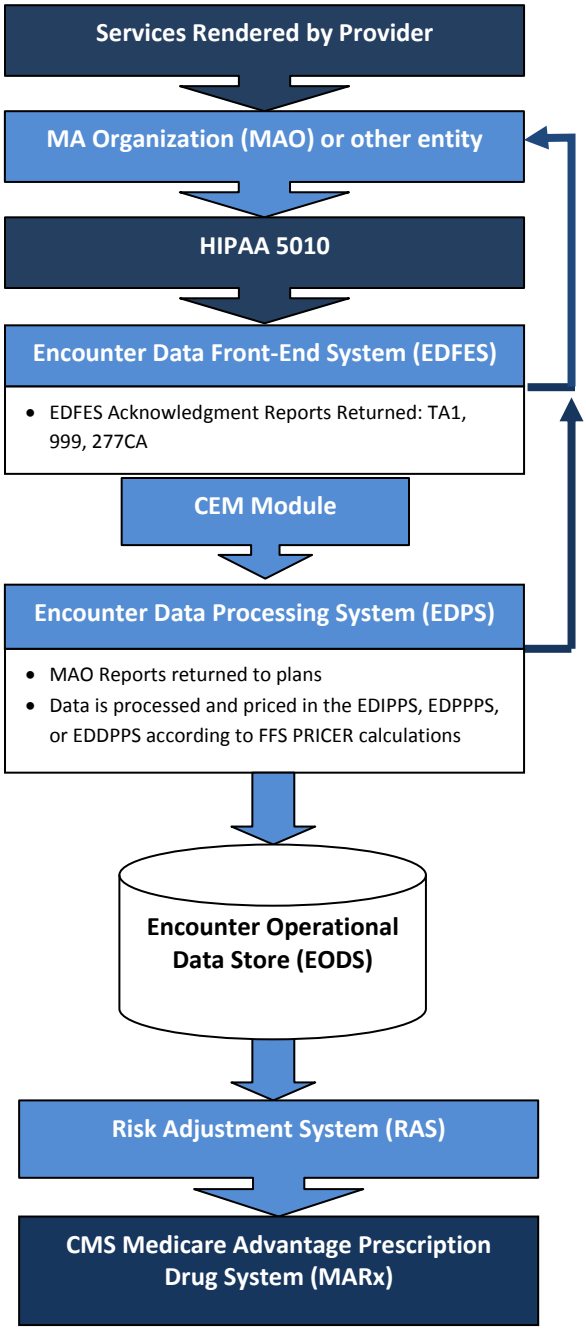
TABLE 1A – CLAIMS PROCESSING SYSTEMS

Term	Definition
Encounter Data Common Working File (EDCWF)	The EDCWF is a central database containing eligibility and claims history for all Medicare beneficiaries for encounter data purposes. For claims processing, the EDCWF verifies beneficiary enrollment and eligibility for the dates of service of the claim.
Encounter Data DME Processing and Pricing Sub-system (EDDPPS)	The Encounter Data DME Processing and Pricing Subsystem will process and price DME encounter data. The EDDPPS is based on VMS processing.
Encounter Data Front-End System (EDFES)	The Encounter Data Front-End System includes the Electronic Data Interchange (EDI) Commercial Off-the-Shelf (COTS) Translator, the Institutional Common Edits and Enhancements Module (CEM), the Professional CEM, and the Durable Medical Equipment (DME) CEM.
Encounter Data Institutional Processing and Pricing Sub-System (EDIPPS)	The Encounter Data Institutional Processing and Pricing Subsystem will process and price Institutional encounter data. The EDIPPS is based on FISS processing.
Encounter Data Professional Processing and Pricing Sub-System (EDPPPS)	The Encounter Data Professional Processing and Pricing Subsystem will process and price Professional encounter data. The EDPPPS is based on MCS processing.
Encounter Data Processing System (EDPS)	The Encounter Data Processing System is comprised of the Encounter Data Institutional Processing and Pricing Sub-System (EDIPPS), the Encounter Data Professional Processing and Pricing Sub-System (EDPPPS), and the Encounter Data DME Processing and Pricing Sub-System (EDDPPS).
Encounter Data System (EDS)	A data collection system used for the collection, processing, pricing, and storage of encounter data.
Encounter Operational Data Store (EODS)	The CMS repository for encounter data submissions. All encounter data is stored in the EODS.
Fiscal Intermediary Shared System (FISS)	The standard Medicare claims processing system used for all Institutional claims. The EDIPPS is based on FISS processing.
Multi-Carrier System (MCS)	The standard Medicare claims processing system for physician and supplemental services (i.e., lab) claims. The EDPPPS is based on MCS processing.
ViPS Medicare System (VMS)	The standard Medicare claims processing system that processes Durable Medical Equipment (DME) claims from DME suppliers. The EDDPPS is based on VMS processing.

1.2 Encounter Data Flow

- Providers submit claims data to the MAO or other entity.
- The MAO or other entity submits the encounter data in the HIPAA compliant version 5010 837X format transaction file to CMS.
- Data is sent to the EDFES to process through the COTS EDI Translator, and then to the CEM module for editing.
- Submitter receives acknowledgement reports based on various levels of editing performed in the EDFES.
- After encounters successfully process through the EDFES, they are sent to the EDPS for detailed editing and validation.
- Once processed, the encounters may take various paths. If the data is able to be priced, the data is priced and stored in EODS.
- If the data falls into exception categories (i.e. capitated claim, atypical provider), the data will bypass pricing edits and move to storage. NOTE: This is not depicted in graphic
- Submitters receive encounter data transaction and management reports based on the results of the EDPS edit checks.
- The EODS stores all encounter data.
- Model diagnoses are extracted from accepted encounters and sent to RAS for risk score calculation.
- MARx is used to calculate and determine plan payments.

Figure 1A – Encounter Data Flow



1.3 Encounter Data Resources

CMS has provided several outreach efforts to keep the industry abreast of developments and updates to ensure successful collection and submission of encounter data. MAOs and other entities must reference the most current information. When reviewing the resources, it is important to understand the hierarchy most appropriate to reference materials. Table 1B provides the hierarchy of resources, beginning with the most generic.

TABLE 1B – RESOURCE HIERARCHY

Hierarchy Level	Resource Name	Resource Description	Resource Link
1	Type 3 Technical Report	The Washington Publishing Company (WPC) has a grouping of documents that addresses the 837-I and 837-P. It provides rules that MAOs and other entities must support in order to submit encounter data. It is intended to be compliant with the data standards mandated by HIPAA.	www.wpc-edi.com
2	CMS CEM Edits Spreadsheets	CMS provides X12 5010 file format technical edits spreadsheets for the 837-I and 837-P. The edits included in the spreadsheet are intended to clarify the WPC instructions or add Medicare specific requirements.	http://www.cms.gov/Medicare/Billing/MFFS5010D0/Technical-Documentation.html
3	Encounter Data Companion Guides	CMS publishes Companion Guides as supplements to the Technical Report 3 (TR3). The 837-I Companion Guide is a supplement to the HIPAA standard 837I005010X223 A2 Type 3 Technical Report (TR3). The 837-P Companion Guide is a supplement to the HIPAA standard 837P005010222 A1 Technical Report (TR3).	http://csscoperations.com/internet/cssc.nsf/docsCat/CSSC~Encounter%20Data~EDS%20Companion%20 Guides?open
4	EDPS Bulletin	Published bi-weekly and provides MAOs and other entities with updates to assist with successful submission of data to the EDPS. The bulletin documents common edits, general updates, and EDS report updates.	http://csscoperations.com/internet/cssc.nsf/docsCat/CSSC~Encounter%20Data~EDPS%20Bulletins?open&cat=CSSC~Encounter%20Data~EDPS%20Bulletins
5	EDS Incident Report Tracking Tool	An online form available to MAOs and other entities to report issues with encounter data reports and edit logic. The input gathered from MAOs and other entities is captured for inclusion in the EDPS Bulletin based on data submitted prior to Friday at 5:00pm EST.	http://www.csscoperations.com/internet/cssc3.nsf/docsCatHome/CSSC%20Operations (EDS Incident Report Tracking Tool)
6	User Group and Industry Update Slides and Q&As	As an outreach method, CMS conducts User Groups and Industry Updates. To ensure accurate delivery of messages, CMS documents slides containing content delivered during the sessions	http://www.csscoperations.com/Internet/Cssc.nsf/docsCat/Encounter%20Data~EDS%20User%20Groups?open.

1.4 Connectivity

Prior to submitting encounter data, MAOs and other entities must establish a secure connection to CMS systems. MAOs and other entities use the electronic connection not only to submit encounter data to CMS, but also to receive EDFES acknowledgement and EDPS processing status reports.

New submitters must complete an Encounter Data Electronic Data Interchange (EDI) Agreement with CMS and submit to CSSC prior to submitting encounter data. The EDI Agreement is a contract between the MAO or other entity and CMS attesting to the accuracy of the data submitted. An officer (e.g., CEO) that represents the MAO or other entity must sign this document.

1.5 File Size Limitations

Due to system limitations, the combination of all ST-SE transaction sets per file cannot exceed certain thresholds depending upon the connectivity method of the submitter. FTP and NDM users cannot exceed 85,000 encounters per file. Gentran users cannot exceed 5,000 encounters per file. For all connectivity methods, the TR3 allows no more than 5000 CLMS per ST-SE. Table 1C provides the file size limits due to connectivity methods:

TABLE 1C – FILE SIZE LIMITATIONS

Connectivity	Maximum Number of Encounters	Maximum Number of ST-SE
FTP/NDM	85,000	5,000
Gentran	5,000	5,000

1.6 Encounter Data Certification Timeline

For the first year of the EDS implementation, CMS required MAOs and other entities to complete certification of EDFES testing by January 3, 2012. During EDFES testing, MAOs and other entities submitted 837-I and 837-P test files containing at least one (1) Institutional file with a mix of inpatient and outpatient Institutional encounters and one (1) Professional file with no more than 50-100 encounters per file.

End-to-end testing began on January 4, 2012. CMS implemented a multi-tiered approach to allow EDS and MAOs and other entities to submit and process test encounter data prior to the submission of production data. Tier 1 testing required MAOs and other entities to submit specific test cases in two (2) separate files. Tier 2 testing is optional and allows for Professional, Institutional, and DME testing of specific test case scenarios with a maximum of 2,000 encounter submissions per file. CMS will continue to provide updates on Tier 2 requirements during User Groups and other outreach methods.

Existing MAOs and other entities will not be required to re-certify after initial certification unless the MAO or other entity implements a new processing system. New MAOs and other entities will be required to pass EDFES and end-to-end testing prior to certification. Table 1D provides important dates for the first year of encounter data implementation.

TABLE 1D – CERTIFICATION TIMELINE

Event	Start Date	End Date	Production Begins
EDFES	September 15, 2011	January 3, 2012	May 1, 2012
EDPPPS	January 4, 2012	May 31, 2012	May 1, 2012
EDIPPS	April 30, 2012	August 31, 2012	May 1, 2012
EDDPPS	June 15, 2012	August 31, 2012	June 16, 2012

A certification timeline for 2013 encounter data submission is provided in Table 1E below, which includes important dates for the second year of encounter data implementation.

TABLE 1E – 2013 CERTIFICATION TIMELINE

Event	Start Date	End Date
Certification EDFES EDPS	January 3, 2013	February 28, 2013
Production	January 4, 2013	No later than March 1, 2013

1.7 Training and Support

To support MAOs and other entities in gaining valuable data for successful EDS submission, CMS has implemented outreach efforts, as described in Table 1F.

TABLE 1F – TRAINING AND SUPPORT

INITIATIVE	DESCRIPTION
Customer Service & Support Center (CSSC)	The toll free help line (1-877-534-2772) is available Monday – Friday, 8:00 A.M. EST to 7:00 P.M. EST (with the exception of corporate observed holidays) to provide assistance. CSSC provides ongoing encounter data assistance.
www.csscoperations.com	The CSSC website, www.csscoperations.com is the gateway to EDS. Visitors to the site can access information about the EDS, including opportunities for enrollment to submit encounter data and obtain comprehensive information about encounter data submission and EDS testing requirements. In addition, the site provides valuable links to CMS instructions and other official resources. Work Group and other training information is regularly posted.
User Groups, Industry Updates, and Work Groups	Conducted as announced. The purpose of the Encounter Data User Groups, Industry Updates, and Work Group meetings is to provide MAOs and other entities with information regarding the progress of, and updates for, encounter data implementation. Q&As are provided. To register online for scheduled Encounter Data User Groups and view previous work group notes and Q&As, go to www.tarsc.info.
www.tarsc.info	The website includes information about trainings and work groups, training dates, locations, online registration, and encounter data FAQs.
eds@ardx.net	Provides a method for MAOs and other entities to submit encounter data policy and operational questions during the planning and implementation phases of EDS.

1.8 Encounter Data Acronyms

Table 1F provides a list of commonly used acronyms relevant to the encounter data process. A complete listing of all acronyms of significance for encounter data can be located in the Encounter Data Resources.

TABLE 1G – ENCOUNER DATA ACRONYMS

Term	Definition
A	
ACA	Affordable Care Act
ANSI	American National Standards Institute
ASCA	Administrative Simplification Compliance Act
C	
CAS	Claims Level Adjustment Segment
CEM	Common Edits and Enhancement Module
CMP	Competitive Medical Plan
COTS	Commercial Off-the-Shelf
CPT	Current Procedural Terminology
D	
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment Prosthetics, Orthotics, and Supplies
E	
EDCWF	Encounter Data Common Working File
EDDPPS	Encounter Data DME Processing and Pricing Sub-System
EDFES	Encounter Data Front-End System
EDFESC	Encounter Data Front-End System Contractor
EDI	Electronic Data Interchange
EDIPPS	Encounter Data Institutional Processing and Pricing Sub-System
EDPPPS	Encounter Data Professional Processing and Pricing Sub-System
EDPS	Encounter Data Processing System
EDPSC	Encounter Data Processing System Contractor
EDS	Encounter Data System
EODS	Encounter Operational Data Store
F	
FFS	Fee-For-Service
FISS	Fiscal Intermediary Standard System
FS	Fee Schedule
FTP	File Transfer Protocol
H	
HCPC	HCFA Common Procedure Code
HCPCS	Healthcare Common Procedure Coding System
HCPP	Health Care PrePayment Plan
HIPAA	Health Insurance Portability & Accountability Act of 1996
HIPPS	Health Insurance Prospective Payment System
HMO	Health Maintenance Organization
I	
IG Edits	Implementation Guide Edits
I/OCE	Integrated/Outpatient Code Editor
M	
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MCE	Medicare Code Editor
MCS	Multi-Carrier System

TABLE 1G – ENCOUNTER DATA ACRONYMS (CONTINUED)

Term	Definition
MUE	Medically Unlikely Edits
N	
NCCI	National Correct Coding Initiative
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NUCC	National Uniform Claim Committee
O	
OASIS	Outcome and Assessment Information Set
P	
PACE	Program for All-Inclusive Care for the Elderly
PDE	Prescription Drug Event
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
PPS	Prospective Payment System
R	
RAPS	Risk Adjustment Processing System
S	
SNF	Skilled Nursing Facility
T	
TOB	Type of Bill
TOS	Type of Service
V	
VMS	ViPS Medicare System
W	
WPC	Washington Publishing Company

1.9 Summary

The implementation of encounter data is designed to improve the risk adjustment and MA payment system by providing complete and accurate data which allows CMS to accurately measure and analyze MA utilization and costs. The success of encounter data implementation and accurate submission and collection of data is dependent on understanding the terminology and processes of encounter data. This module provided the common terms associated with the EDS, as well as an index of acronyms specific to encounter data, while also providing participants with an overview of the dataflow.

MODULE 2 – POLICY, MONITORING, AND COMPLIANCE

Purpose

CMS requires Medicare Advantage Organizations (MAOs) and other entities to submit encounter data that will be analyzed for the purpose of determining beneficiary utilization, while ensuring accurate payment and appropriate program oversight. This module provides MAOs and other entities the policy guidance that supports the encounter data program.

Learning Objectives

At the completion of this module, participants will be able to:

- Identify the legislative history and requirements for encounter data.
- Clarify encounter data policies.
- Clarify next steps with regard to monitoring and compliance actions.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

2.1 Background

The final 2009 Inpatient Prospective Payment System (IPPS) rule, published August 19, 2008 – 73 FR48434 ff – revised 42 CFR 422.310(d), clarified that CMS has the authority to require MAOs and other entities to submit encounter data for each item and service provided to beneficiaries. Consistent with this authority, CMS required MAOs and other entities to submit encounter data for dates of service January 1, 2012, and later. With the exception of encounter data on Durable Medical Equipment (DME) encounters, which CMS anticipated collection to begin on May 7, 2012, MAOs and other entities would also be required to submit data for all other types of Institutional and Professional services provided to beneficiaries on or after January 1, 2012.

Section 1853 of the Act requires CMS to make advance monthly payments to a Medicare Advantage Organization (MAO) or other entity for each beneficiary enrolled in an MAO or other entity offered for coverage of Medicare Part A and Part B benefits. Section 1853(a)(1)(C) of the Act requires CMS to adjust the monthly payment amount for each enrollee to take into account the health status of MAO or other entity enrollees. Under the CMS-Hierarchical Condition Category (HCC) risk adjustment payment methodology, CMS determines risk scores for MAO or other entity enrollees for a year and adjusts the monthly payment amount using the appropriate enrollee risk score.

Under section 1853(a)(3)(B) of the Act, MAOs and other entities are required to "submit data regarding inpatient hospital services . . . and data regarding other services and other information as the Secretary deems

necessary" in order to implement a methodology for "risk adjusting" payments made to MAOs or other entities. Risk adjustments to payments are made in order to take into account "variations in per capita costs based on [the] health status" of the Medicare beneficiaries enrolled in an MAO or other entity. Submission of data on inpatient hospital services has been required with respect to services beginning on or after July 1, 1997. Submission of data on other services has been required since July 1, 1998.

While CMS initially required the submission of comprehensive data regarding services provided by MAOs and other entities, including comprehensive inpatient hospital encounter data, they subsequently permitted MAOs and other entities to submit an "abbreviated" set of data. CMS collected limited risk adjustment data from MAOs and other entities, primarily diagnosis data under OMB No. 0938-0878.

From calendar years 2000 through 2006, the application of risk adjustment to MAO and other entity payments was "phased in" with an increasing percentage of the monthly capitation payment subjected to risk adjustment. Prior to calendar year 2000, and in diminishing proportion from 2000-2006, CMS also adjusted monthly capitation payments based on "demographic" factors such as age, disability status, gender, and institutional status. Beginning with calendar year 2007, 100 percent of payments to MAOs and other entities have been risk-adjusted. Given the increased importance of the accuracy of CMS' risk adjustment methodology, § 422.310 was amended in August of 2008 to authorize the collection of data from MAOs and other entities regarding each item and service provided to an enrollee. Collection of such data would allow CMS to incorporate the MAO or other entity utilization in the development of the risk adjustment models for the Medicare Advantage program.

Once MA enrollee encounter data are available, these data can be used to develop and calibrate CMS–HCC risk adjustment models that reflect the diagnoses and utilization patterns of MAOs and other entities. Using such models to pay MAOs and other entities can improve payment accuracy. As stated in the amendment to § 422.310, CMS will also use the data for such things as calculating Medicare DSH percentages, Medicare coverage purposes, and quality review and improvement activities.

2.1.1 Implementation

The complete encounter data implementation will span six (6) years, beginning in 2008 and ending in 2014. The Encounter Data System (EDS) was initially implemented in 2008 and continues to progress as the data collection process continues. The following sections will identify significant aspects of the EDS Implementation and the timeline for its progress.

2.1.2 Milestones

Since 2008, CMS has realized substantial milestones in the EDS Implementation process. In collaboration with the Encounter Data Front-End System, the Encounter Data Processing System developers, and the participating MAOs and other entities that have provided comments and recommendations, CMS has achieved the key milestones that are represented in Table 2A below.

TABLE 2A – ENCOUNTER DATA MILESTONES

Year	Milestone(s)
2008	• Published FY 2009 Inpatient Prospective Payment (IPPS) Final Rule which clarified CMS' authority to collect data from MA organizations for each item and service provided. CMS subsequently obtained support from leadership to develop and implement a system to collect this additional data.
2009	• Engaged contractors to initiate project planning for implementation of encounter data collection and, based on discussions with subject matter experts to ensure the appropriate processing and pricing rules to be integrated, developed a Business Process Model to support the needs of encounter data collection and processing. • Engaged stakeholders to begin synchronization of the EDS with Fee-for-Service (FFS) processing and methodology. • Conducted a gap analysis to explore the incorporation of the current risk adjustment process with the goals for encounter data implementation
2010	• Conducted the Encounter Data (ED) Survey in April 2010 which consisted of 18 phone interviews with health plans to gather information on industry capabilities related to systems and business performance in preparation for encounter data implementation. • Established an industry outreach program to obtain information and feedback to determine next steps towards the implementation of encounter data collection. • Conducted a National Encounter Data Meeting to disseminate information regarding high-level requirements for encounter data collection, transition activities, and the targeted implementation schedule. • Launched the quarterly distribution of newsletters including information and updates for risk adjustment processes and encounter data implementation.
2011	• Recruited six (6) plans to participate in an EDFES Pilot Test, which assisted CMS in identifying issues, prior to the Front-End implementation, to determine information that would be accepted during processing, editing, and testing. • Conducted eight (8) Encounter Data Work Groups of various submission topics to determine and discuss issues and create possible solutions for final implementation of Encounter Data. Work group topics included: Third Party Submitters, Chart Review Submission, Editing and Reporting, PACE Organizations, and Collection Strategies for Capitated and Staff Model Plans. • Conducted four (4) Industry-Wide Updates and one (1) Encounter Data Teleconference to provide information to MAOs and other entities regarding the progress of and updates for encounter data implementation. • Launched the EDS Inbox providing a communication forum for the industry to submit feedback and questions related to encounter data implementation.

TABLE 2A – ENCOUNTER DATA MILESTONES (CONTINUED)

Year	Milestone(s)
2011	• Worked with the industry to identify, address, and create solutions for issues related to the collection and submission of encounter data through the EDS. • Executed testing of the EDFES to validate processing of the 5010 transmission X12 file format through the EDI Translator and subsequent Institutional and Professional CEMs located at the Front-End. • Executed the EDIPPS and EDPPPS End-to-End Testing and plan certification to submit encounter data.
2012	• Implemented the EDS on January 3, 2012 for submission and processing of encounter production data. • Executed testing of the complete Encounter Data System (EDS) to validate the processing, editing, pricing, and storage of the 5010 transmission X12 file format and its associated data elements. • Rolled-out the generation and submission of encounter data MA-002 Encounter Data Processing Status Reports to MAOs and other entities. • Worked with the industry to address and create solutions for new issues related to the collection and submission of encounter data subsequent to the implementation of production data submission. • Launched the EDS Incident Tracking Tool for submission of issues/questions relating to edits received by MAOs and other entities on the generated MAO-002 reports. • Conducted two (2) Encounter Data PACE-specific Work Groups to determine and discuss issues and create possible solutions for final implementation of Encounter Data. • Conducted one (1) Industry Update and 14 Encounter Data User Group Teleconference sessions to provide information to MAOs and other entities regarding the progress of and updates for encounter data implementation. Some of the User Group topics included: Compliance, End-to-End Testing, Tier 2 Testing, Submission of Production Data for the EDS, Editing and Reporting, Chart Review, and Paper Claim Submission.

2.2 Data Collection

All Medicare Advantage Organizations (MAOs), PACE organizations, Demonstration Plans, and Cost Plans (including both §1876 Cost HMOs/CMPs and §1833 HCPPs) are required to submit encounter data. The types of MAOs include: Coordinated Care Plans (including Special Needs Plans), Private Fee For Service Plans, and Medical Savings Accounts, as well as Medicare Advantage – Prescription Drug plans and Employer Group Health Plans (both "direct contract" with an employer group and those that are offered by MAOs). Table 2B below provides organization and policy requirements for encounter data submission.

TABLE 2B – ORGANIZATION AND POLICY REQUIREMENTS

Organization Type	Policy Requirements
Medicare Advantage Organizations	• Submit all accepted and denied adjudicated claims data according to CMS guidelines
Cost Plans	• §1876 Cost HMOs/CMPs and §1833 HCPPs will only be required to submit encounter data for Medicare covered items/services for which plans claim Medicare costs on their CMS Cost Reports. Virtually all §1876 Cost HMOs/CMPs and HCPPs (with the exception of one "billing option 2" Cost HMO/CMP) will only need to collect and submit Professional and DME encounters according to CMS guidelines. Since Institutional encounter data will generally not be required, virtually all Cost Plans will not need to perform front-end or end-to-end Institutional testing (identified in Module 8 – Special Considerations)
Program of All-Inclusive Care for the Elderly (PACE) Organizations	• For 2013, PACE will submit claims based encounters only.
Special Needs Plans (SNPs)	• Submit only Medicare services according to EDS guidelines (identified in Module 8 – Special Considerations)

2.3 Adjudicated Claims Submission

MAOs and other entities must collect and adjudicate claims in the MAO or other entities' claims processing systems prior to submission to EDS. Although claims may have a final disposition of "accepted", "denied", or "rejected" in the MAO or other entities' claims processing systems, for the purposes of encounter data processing, only fully adjudicated claims with a final disposition of "accepted" or "denied" may be submitted to EDS. Adjudicated claims with a denied status must also include the reason for the denial. Table 2C defines each disposition type and indicates if the claim is acceptable for encounter data submission.

TABLE 2C – DISPOSITION TYPE

Disposition	Definition
Accepted	Claims/lines deemed "processable" and given a final disposition of "payment" within the MAOs and other entities' claims processing system
Denied	Claims/lines deemed "processable" and given a final disposition of "no payment" within the MAOs and other entities' claims processing systems
Rejected	Claims/lines deemed "unprocessable" (i.e., Invalid HCPCS or diagnosis code) at any stage in the MAOs and other entities' adjudication process

MAOs and other entities must utilize the definitions provided in Table 2C above to determine appropriate submission of claims data to EDS. Claims deemed rejected in encounter data terms will not pass EDFES edits and will be rejected back to the submitter for correction and resubmission. MAOs and other entities may not submit claims in a pending status.

2.4 Submission Requirements

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities must use when electronically conducting certain health care administration transactions, such as claims, remittance, eligibility,

and claims status requests and responses. Through subtitle F of Title II of HIPAA, the Congress added to Title XI of the Social Security Act (the Act) a new Part C, titled "Administrative Simplification." Part C of title XI of the Act now consists of sections 1171 through 1180. These sections define various terms and impose several requirements on HHS, health plans, health care clearinghouses, and certain health care providers concerning electronic transmission of health information.

2.4.1 Submission Format

In accordance with HIPAA regulations and to facilitate encounter data processing and reduce burden, MAOs and other entities must ensure that data is submitted using the appropriate HIPAA compliant standard Health Care Claims ANSI X12 V5010 format. All required data elements specific to the collection of encounter data must be populated on the 837-I (Institutional) or 837-P (Professional and DME Supplier) 5010 format.

Module 3 (Professional Submission), Module 4 (Institutional Submission), and Module 5 (DME Submission) provide further information on submission requirements

2.4.2 Submission of Proxy Data in a Limited Set of Circumstances

MAOs and other entities will be allowed to submit proxy data in a limited set of circumstances for dates of service in 2012, as identified and explained in Table 2D. MAOs and other entities cannot submit proxy data for any circumstances, other than those listed in Table 2D. CMS will use this interim approach for the submission of encounter data for 2012 and will provide additional guidance for the submission of 2013 encounter data. In each circumstance where proxy information is submitted, MAOs and other entities are required to indicate in the NTE field the reason for the use of proxy information. More detailed information on the use of proxy information may be found in the modules for Institutional, Professional, and DME encounter data. If there is any question, about the submission of proxy encounter data and when it may be used, CMS should be contacted for clarification. CMS will provide MAOs and other entities with additional guidance concerning proxy data in the near future.

TABLE 2D – PROXY DATA

Limited Set of Circumstances Where Proxy Data May be Used	Reason for the Use of Proxy Data - to be Indicated in the NTE Field
To submit encounters with 2011 Dates of Service (DOS), the "from" and "through" dates must be revised to show DOS on January 1, 2012 or later, with an exception of TOBs 11X, 18X, and 21X	DOS CLAIM CHANGE DUE TO 2011 DOS DURING EDS IMPLEMENTATION PERIOD
Rejected Line Extraction	REJECTED LINES CLAIM CHANGE DUE TO REJECTED LINE EXTRACTION
Medicaid Service Line Extraction	MEDICAID CLAIM CHANGE DUE TO MEDICAID SERVICE LINE EXTRACTION
EDS Acceptable Anesthesia Modifier	MODIFIER CLAIM CHANGE DUE TO EDS ACCEPTABLE ANESTHESIA MODIFIER
Default NPI for atypical, paper, and 4010 claims	NO NPI ON PROVIDER CLAIM
Default EIN for atypical providers	NO EIN ON PROVIDER CLAIM
Chart Review Default Procedure Codes	DEFAULT PROCEDURE CODES INCLUDED IN CHART REVIEW

Module 3 (Professional Submission) and Module 4 (Institutional Submission) provide detailed guidance on proxy data submission requirements

If MAOs and other entities have any questions about submission of proxy claim information, with regard to any situation outlined in the Participant Guide, contact CMS at eds@ardx.net

2.4.3 Chart Reviews

Chart reviews may be performed by MAOs and other entities for the purpose of diagnosis code validation. Because diagnoses drive risk adjustment, all chart review encounters must be supported by the medical record. MAOs and other entities may submit chart reviews that are linked to an original encounter stored in EDS (linked ICN chart reviews) or chart reviews that are not linked to an original encounter stored in Encounter Operational Data Store (EODS) (unlinked ICN chart reviews). All chart review encounters should be flagged by MAOs and other entities.

Module 3 (Professional Submission) and Module 4 (Institutional Submission) provide detailed guidance chart review submission

2.4.4 Bundled Claims

Bundled claims refer to the bundling of claim lines meeting the definition of the National Correct Coding Initiative (NCCI) or the bundling of claim lines in adjudication to match the benefit structure of the MAO or other entity. The NCCI was developed to promote correct coding methodologies and to control improper coding. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. Only claims bundled using the NCCI will be accepted for encounter data submission. The Coding Policy Manual found on the CMS website can be utilized by MAOs and other entities as a general reference tool.

2.4.5 Minimum Data Elements

Minimum data elements are required to properly process and price encounters. MAOs and other entities must include at least the minimum data elements when submitting encounter data, including paper, 4010, and foreign provider generated encounters, as well atypical provider submissions. The EDS Minimum Data Elements and EDS Companion Guides provide details on the required elements.

www.csscoperations.com

2.4.6 Home Health Submission

EDS is not currently accepting Home Health encounter submissions from MAOs and other entities. CMS will provide further guidance on the submission of this data in the near future.

2.4.7 Part B Drug Data

Many drugs and biologics are further identified by the National Drug Code (NDC) assigned. NDC is a system created to identify drugs intended for human use. Originating from the Drug Listing Act of 1972, Section 510 requires the Food and Drug Administration (FDA) to list all current drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. The NDC codes, when available, must be submitted; however, it is not required for Part B drug data submission on the encounter.

MAOs and other entities may receive drug data from Pharmacy Benefit Managers (PBMs) in the National Council for Prescription Drug Programs NCPDP D.0 format, which is not compatible with the 837. Due to the incompatibility of the NCPDP D.0 format to the 837 format in the EDS, MAOs and other entities must only submit Part B drug data that can be processed through their claims processing system and submitted on the 837. Part B drug data received by the MAO or other entity on the NCPDP D.0 format must be excluded from encounter data submission. CMS is currently reviewing alternative options for the submission of Part B drug data collected from a PBM that is in the NCPDP D.0 format.

2.5 Encounter Data Monitoring

CMS will develop compliance requirements, which MAOs and other entities will hear more about in the future. CMS will also work with the industry to catch-up on the submission of 2012 data in the most expeditious way possible. Additionally, we will be monitoring individual submitters with regard to plan specific submission issues to address serious problems as they arise.

Areas of monitoring will include the following:

- Timeliness of submission
- Quantity (volume) of submission
- Quality of submission
- Accuracy of submission

2.5.1 Timeliness of Submission

The timely submission of encounter data refers to submitting encounter data within certain timeframes and deadlines. CMS has established timeliness compliance standards for the following types of data:

- Submission of full encounter data
- Submission of correct/replace or void/delete data
- Submission of chart review data

Table 2E below provides the timely filing guidelines for encounter data submissions.

TABLE 2E – TIMELY FILING GUIDELINES

Submission Type	Timely Filing Deadline
Full Encounter	13 months from the DOS Institutional – "Through" DOS Professional – Service Line DOS
Correct/Replace or Void/Delete Encounter	13 months from the DOS and not to exceed 30 days after the adjustment date
Chart Review Encounter	Within 25 months of the data collection period

2.5.1.1 Full Encounter Submission Timely Filing

MAOs and other entities must submit full encounters within 13 months from the date of service submitted on the encounter. The 13-month timely filing rule benefits MAOs and other entities by allowing an extra month beyond the FFS timely filing limit – which now requires submission within 12 months of the date of service (see section 6404 of the ACA). This allows more time for receiving and processing more accurate encounter data prior to transmitting data to CMS.

2.5.1.2 Correct/Replace and Void/Delete Submission Timely Filing

It may be necessary for MAOs and other entities to submit correct/replace or void/delete encounters to EDS to correct previously submitted and accepted encounters stored in EODS. MAOs and other entities must submit correct/replace or void/delete encounters within 13 months from the original date of service on the encounter stored in EODS and not to exceed 30 days after the adjustment date.

2.5.1.3 Chart Review Timely Filing

Chart reviews can be submitted within the 25 month data collection period. This requirement is aligned with the current data submission deadlines for RAPS processing. Table 2F provides the data collection period that MAOs and other entities must use for submission of chart review encounters.

TABLE 2F – CHART REVIEW TIMELY FILING

Dates of Service	Chart Review Submission Deadline
1/1/2011 – 12/31/2011	1/31/2013
1/1/2012 – 12/31/2012	1/31/2014
1/1/2012 – 12/31/2013	1/31/2015
1/1/2014 – 12/31/2014	1/31/2016

Chart review timely filing applies to the submission of additional diagnoses to a full encounter, deletion of diagnoses from a full encounter, and addition/deletion of diagnoses from a full encounter submitted on one (1) encounter as a result of a chart review.

2.5.1.4 Frequency of Submission

MAOs and other entities are required to submit data at the frequency specified according to a tiered scale determined by the number of Medicare enrollees per Contract ID. MAOs and other entities must adhere to

the minimum frequency standards established by the tiered scale, but are encouraged to submit encounter data more often. More frequent submission will help the EDS maintain its systematic capabilities to process encounter data. Table 2G provides the minimum frequency standards for encounter data submission based on the number of Medicare beneficiaries enrolled per contract.

TABLE 2G — TIERED DATA SUBMISSION FREQUENCY

Number of Medicare Enrollees	Minimum Submission Frequency
Greater than 100,000	Weekly
50,000 – 100,000	Bi-weekly
Less than 50,000	Monthly

Table 2G identifies minimum frequency standards for submission. MAOs and other entities may submit data as often as daily and should not delay the submission of data for any reason.

2.5.2 Quantity of Submission

EDS specifications require that the volume of encounters submitted to the system align with the number of enrollees per contract ID. Specific metrics include, but are not limited to, submission rates, proportions of claims in particular service categories, and overall volume of submission. It is MAOs and other entities' responsibility to ensure the volume of encounters submitted is appropriate in relation to the frequency standards established. CMS will confirm the anticipated volume annually and will run submission quantity analyses on a quarterly basis. CMS will also perform analyses on the quantity of encounters submitted to EDS against the volume of RAPS submissions for each Contract ID.

MAOs and other entities are strongly encouraged to evenly distribute the volume of encounters submitted according to the required frequency requirements.

2.5.3 Quality of Submission

Quality standards allow CMS to analyze encounter data submission to ensure that EDS collects accurate and complete data. Adherence to quality standards requires that MAOs and other entities collect and submit all encounter data in the appropriate ANSI V5010 X12 format. The quality of encounter data submitted is partially evidenced by the number of errors returned to the submitter and the number of duplicates submitted per Contract ID. CMS will develop error frequency benchmarks and will monitor resubmission and duplicate rates on a quarterly basis.

2.5.4 Accuracy of Submission

MAOs and other entities are responsible for the accuracy of all encounter data submitted and must ensure that every submission can be supported by an original source document (i.e. a medical record). MAOs and other entities must also attest that the data submitted is based on best knowledge, information, and belief and be accurate and truthful.

2.6 Use of Encounter Data

CMS is planning to use encounter data for determining the risk scores used in payment, calibrating the risk adjustment model, calculating Medicare Disproportionate Share Hospital (DSH) percentages, analyzing Medicare coverage , and conducting quality review and improvement activities. To support the calculation of risk scores during the transition from RAPS to EDS, the systems will run parallel until the transition to EDS is complete. MAOs and other entities must continue to submit RAPS and encounter data in parallel through 2013. Risk scores for payment year 2013, which will be based on 2012 dates of service, will be calculated using RAPS data.

2.7 Compliance

CMS will be using encounter data for a series of very important functions. It is therefore important that encounter data is timely, comprehensive, and accurate. CMS will be monitoring the submissions of encounter data as described in this module and will expand on the monitoring actions that will be taken. In addition, CMS is developing a compliance plan to ensure encounter data meets the required specifications. More information on the implementation of the compliance program will be shared at a later date.

2.8 Summary

In this module, new information regarding encounter data submission has been provided. CMS will continue to work with MAOs and other entities on the most efficient approaches for the submission of accurate, complete and timely encounter data; and plans should continue to raise questions and identify issues encountered in the process. MAOs and other entities should plan to submit data in parallel through both the RAPS and EDS through the end of 2013. All MAOs and other entities are encouraged to comply with the encounter data submission requirements in order optimize the encounter data collected.

MODULE 3 – PROFESSIONAL SUBMISSION

Purpose

Medicare Advantage Organizations (MAOs) and other entities must collect data from health care providers. The complete submission of all encounter data from these health care sources in the 5010 format is critical for accurate risk adjustment model recalibration, risk score calculation, and obtaining full beneficiary utilization. This module is designed to specify the data collection, submission, and processing principles for Professional encounter data in accordance with the CMS requirements.

Learning Objectives

At the completion of this module, participants will be able to:

- Demonstrate knowledge in interpreting Professional/Physician Supplier services.
- Identify the top Encounter Data Professional Processing and Pricing System (EDPPPS) error logic.
- Determine error prevention and resolution strategies.
- Apply the appropriate operational guidance for the processing of Professional encounters.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

3.1 Professional/Physician Supplier Services

Professional/Physician Supplier services may be performed in a home, office, institution, or at the scene of an accident. A patient's home, for this purpose, is anywhere the patient makes his or her residence, e.g., home for the aged, a nursing home, a relative's home.

Professional Services may be performed by any of the following providers who are legally authorized to practice in the State in which such function or action is performed:

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
- Certified Nurse Midwife
- Clinical Psychologist
- Clinical Social Worker
- Registered Dietitian
- Nutrition Professional

3.2 Professional/Physician Supplier Submission Format

Currently in FFS, Professional/Physician Supplier services are billed using Place of Service (POS) codes. In order to capture all necessary data, including POS codes, to accurately edit, process, and price Professional encounter data submissions, MAOs and other entities are required to submit encounter data in the HIPAA compliant standard Health Care Claims transaction for Professional data (currently using Implementation Guide (IG) ASC X12N 837/005010X222 with Errata for ASC X12N 837/005010X222A1), as defined in the Washington Publishing Company (WPC) Technical Report Type 3 (TR3) 5010 X12.

Washington Publishing Company
www.wpc-edi.com

3.2.1 837-P

The current 837-P TR3 is the foundation for encounter data submission. It provides detailed guidance on the appropriate structure and function of loops, segments, and data elements. Upon submission, the 837-P is processed through the Encounter Data Front-End System (EDFES) where translator and CEM level editing occur.

Several CEM edits currently active in the CMS CEM Edits Spreadsheet will be permanently deactivated in order to ensure that EDS syntactically correct encounters pass EDFES editing. Table 3A provides the current EDFES edits that are deactivated. The edit reference column provides the exact edit reference that will be deactivated. The edit description column provides the Claim Status Category Code (CSCC), the Claim Status Code (CSC), and the Entity Identifier Code (EIC), when applicable. The notes column provides a description of the edit reason. MAOs and other entities should reference the WPC website at www.wpc-edi.com for a complete listing of all CSCCs and CSCs.

TABLE 3A – 837-P PERMANENTLY DEACTIVATED CEM EDITS

Edit Reference	Edit Description	Edit Notes
X222.087.2010AA.NM109.030	CSCC A7: “Acknowledgement/Rejected for Invalid Information…” CSC 562: “Entity’s National Provider Identifier (NPI)” EIC 85: “Billing Provider”	2010AA.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109.
X222.087.2010AA.NM109.050	CSCC A8: “Acknowledgement/Rejected for relational field in error” CSC 496: “Submitter not approved for electronic claim submission on behalf of this entity” EIC 85: “Billing Provider”	2010AA.NM109 billing provider must be “associated” to the submitter (from a trading partner management perspective) in 1000A.NM109.
X222.091.2010AA.N301.070	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 503: "Entity's Street Address" EIC 85: “Billing Provider”	2010AA.N301 must not contain the following exact phrases (not case sensitive): "Post Office Box", "P.O. Box", "PO Box", "P O Box", "Lock Box", "Lock Bin".
X222.091.2010AA.N302.060	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 503: "Entity's Street Address" EIC: 85 Billing Provider	2010AA.N302 must not contain the following exact phrases (not case sensitive): "Post Office Box", "P.O. Box", "PO Box", "P O Box", "Lock Box", "Lock Bin".

TABLE 3A – 837-P PERMANENTLY DEACTIVATED CEM EDITS (CONTINUED)

Edit Reference	Edit Description	Edit Notes
X222.094.2010AA.REF02.050	CSCC A8: "Acknowledgement/Rejected for relational field in error" CSC 562: "Entity's National Provider Identifier (NPI)" CSC 128: "Entity's Tax ID" EIC 85: "Billing Provider"	2010AA.REF must be associated with the provider identified in 2010AA.NM109
X222.138.2010BB.REF.010	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 732: "Information submitted inconsistent with billing guidelines." CSC 560: "Entity's Additional/Secondary Identifier." EIC PR: "Payer"	Non-VA claims: 2010BB.REF with REF01 = "2U", "EI", "FY" or "NF" must not be present. VA claims: 2010BB.REF with REF01 = "EI", "FY" or "NF" must not be present.
X222.140.2010BB.REF02.075	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 496 "Submitter not approved for electronic claim submissions on behalf of this entity." EIC 85: "Billing Provider"	2010BB.REF02 billing provider must be "associated" to the submitter (from a trading partner management perspective) in 1000A.NM109.
X222.157.2300.CLM05-3.020	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 535: "Claim Frequency Code"	2300.CLM05-3 must be "1".
X222.196.2300.REF.010	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 732: "Information submitted inconsistent with billing guidelines." CSC 464: "Payer Assigned Claim Control Number."	2300.REF with REF01 = "F8" must not be present.
X222.262.2310B.NM109.030	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 562: "Entity's National Provider Identifier (NPI)" EIC 82: "Rendering Provider"	2310B.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109.
X222.351.2400.SV101-7.020	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 306: "Detailed description of service"	2400.SV101-7 must be present when 2400.SV101-2 is present on the table of procedure codes that require a description.
X222.430.2420A.NM109.030	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 562: "Entity's National Provider Identifier (NPI)" EIC 82 "Rendering Provider"	2420A.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109.

3.2.2 Minimum Data Elements

Based on research and MAO and other entity comments, the minimum data elements required in order to pass EDS translator and CEM level edits were developed. MAOs and other entities must include at least these minimum data elements when submitting encounter data, including paper generated, 4010, foreign provider, and chart review encounters.

The situational fields associated with these minimum data elements must be submitted if the situation is present. Loops, segments, and data elements with an asterisk ("*") denote the situational fields associated with the minimum data elements that occur commonly in encounter data submissions. **This list is not inclusive of all situational loops, segments, and data elements in the 837-P TR3.** MAOs and other entities must refer to the 837-P TR3 and CEM Edits Spreadsheet to determine the correct usage of situational fields. Table 3B provides the minimum file header and trailer level data elements.

TABLE 3B – HEADER AND TRAILER LEVEL MINIMUM DATA ELEMENTS

Reference	Reference Description
ISA01 – ISA16	Interchange Control Header
GS01 – GS08	Functional Group Header
ST01 – ST03	Transaction Set Header
BHT01 – BHT06	Beginning of Hierarchical Transaction
SE01 – SE02	Transaction Set Trailer
GE01 – GE02	Functional Group Trailer
IEA01 – IEA02	Interchange Control Trailer

Table 3C provides the minimum detail level data elements.

TABLE 3C – DETAIL LEVEL MINIMUM DATA ELEMENTS

Loop ID	Reference	Reference Description
LOOP ID 1000A – SUBMITTER INFORMATION		
1000A	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Organization Name/Last Name
	NM108	Identification Code Qualifier
	NM109	Submitter ID
	PER01	Contact Function Code
	PER02	Submitter Contact Name
	PER03	Communication Qualifier
	PER04	Communication Number
LOOP ID 1000B – RECEIVER INFORMATION		
1000B	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Organization Name
	NM108	Identification Code Qualifier
	NM109	Receiver Identifier
LOOP ID 2000A – BILLING PROVIDER HIERARCHICAL LEVEL		
2000A	HL01	Hierarchical ID Number
	HL03	Hierarchical Level Code
	HL04	Hierarchical Child Code
LOOP ID 2010AA – BILLING PROVIDER INFORMATION		
2010AA	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Organization Name/Last Name
	NM108	Identification Code Qualifier
	NM109	National Provider Identifier (NPI)
	N301	Billing Provider Street
	N401	Billing Provider City

TABLE 3C – DETAIL LEVEL MINIMUM DATA ELEMENTS (CONTINUED)

Loop ID	Reference	Reference Description
	N402	Billing Provider State
	N403	Billing Provider ZIP Code
	REF01	Reference Identification Qualifier
	REF02	Billing Provider Tax Identification Number
LOOP ID 2000B – SUBSCRIBER HIERARCHICAL LEVEL		
2000B	HL01	Hierarchical ID Number
	HL02	Hierarchical Parent ID Number
	HL03	Hierarchical Level Code
	HL04	Hierarchical Child Code
	SBR01	Payer Responsibility Sequence Number
	SBR02	Individual Relationship Code
	SBR03*	Subscriber Group or Policy Number
	SBR04*	Insured Group Number
	SBR05*	Insurance Type Code
	SBR09*	Claim Filing Indicator Code
LOOP ID 2010BA – SUBSCRIBER INFORMATION		
2010BA	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Subscriber Last Name
	NM104	Subscriber First Name
	NM105*	Subscriber Middle Name
	NM107*	Subscriber Name Suffix
	NM108	Identification Code Qualifier
	NM109	Subscriber HICN
	N301	Subscriber Street
	N401	Subscriber City
	N402	Subscriber State
	N403	Subscriber ZIP Code
	DMG01	Date Format Qualifier
	DMG02	Subscriber Date of Birth
	DMG03	Subscriber Gender
LOOP ID 2010BB – PAYER INFORMATION		
2010BB	NM101	Entity Identifier Code
	NM102	Entity Type Description
	NM103	Name Last or Organization
	NM108	Identification Code Qualifier
	NM109	Payer Identification (EDSCMS)
	N301	Payer Street
	N401	Payer City
	N402	Payer State
2010BB	N403	Payer ZIP Code
	REF01	Reference Identification Qualifier – Payer Identification Number
	REF02	Reference Identification – Payer Additional Identifier (Contract ID)
LOOP ID 2300 – CLAIM INFORMATION		
2300	CLM01	Claim Submitter's Identifier (Patient Control Number)
	CLM02	Monetary Amount
	CLM05-1	Facility Type Code
	CLM05-2	Facility Code Qualifier

TABLE 3C – DETAIL LEVEL MINIMUM DATA ELEMENTS (CONTINUED)

Loop ID	Reference	Reference Description
	CLM05-3	Claim Frequency Type Code
	CLM06	Provider or Supplier Signature Indicator
	CLM07	Assignment or Plan Participation Code
	CLM08	Benefits Assignment Certification Indicator
2300	CLM09	Release of Information Code
	CLM11-1*	Related Causes Code Indicator
	CLM11-2*	Related Causes Code
	DTP01*	Date Time Period Qualifier – Accident Date
	DTP02*	Date Time Period Format Qualifier – Accident Date
	DTP03*	Accident Date
	PWK01*	Report Type Code
	PWK02*	Attachment Transmission Code
	REF01*	Original Reference Number
	REF02*	Payer Claim Control Number
	HI01-1	Diagnosis Type Code Qualifier – Health Care Diagnosis Code
	HI01-2	Diagnosis Code
LOOP ID 2310E – AMBULANCE PICK-UP LOCATION		
2310E	NM101*	Identity Identifier Code – Ambulance Pick-Up Location
	NM102*	Entity Type Qualifier – Non-Person Entity
	N301*	Ambulance Pick-Up Address Line
	N401*	Ambulance Pick-Up City
	N402*	Ambulance Pick-Up State or Province
	N403*	Ambulance Pick-Up ZIP Code
LOOP ID 2310F – AMBULANCE DROP-OFF LOCATION		
2310F	NM101*	Identity Identifier Code – Ambulance Drop-Off Location
	NM102*	Entity Type Qualifier – Non-Person Entity
	N301*	Ambulance Drop-Off Address Line
	N401*	Ambulance Drop-Off City
	N402*	Ambulance Drop-Off State or Province
	N403*	Ambulance Drop-Off ZIP Code
LOOP ID 2320 – OTHER SUBSCRIBER INFORMATION		
2320	SBR01	Payer Responsibility Sequence Number
	SBR02	Individual Relationship Code
	SBR09	Claim Filing Indicator Code
	CAS01*	Claim Adjustment Group Code
	CAS02*	Claim Adjustment Reason Code
	CAS03*	Monetary Amount
	AMT01	Amount Qualifier Code
	AMT02	Payer Paid Amount
	OI03	Benefits Assignment Certification Indicator
2320	OI06	Release of Information Code
LOOP ID 2330A – OTHER SUBSCRIBER NAME		
2330A	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Subscriber Last Name
	NM108	Identification Code Qualifier
	NM109	Subscriber HICN
	N301	Subscriber Street

TABLE 3C – DETAIL LEVEL MINIMUM DATA ELEMENTS (CONTINUED)

Loop ID	Reference	Reference Description
	N401	Subscriber City
	N402	Subscriber State
	N403	Subscriber ZIP Code
LOOP ID 2330B – OTHER PAYER NAME		
2330B	NM101	Entity Identifier Code
	NM102	Entity Type Description
	NM103	Name Last or Organization
	NM108	Identification Code Qualifier
	NM109	Payer Identification
	N301	Payer Street
	N401	Payer City
	N402	Payer State
	N403	Payer ZIP Code
	REF01*	Reference Identification Qualifier – Signal code
	REF02*	Other Payer Claim Adjustment Indicator
LOOP ID 2400 – SERVICE LINE INFORMATION		
2400	LX01	Assigned Number
	DTP01	Date Time Qualifier - Service
	DTP02	Date Time Period Format Qualifier
	DTP03	Service Date
	SV101-1	Product/Service ID Qualifier
	SV101-2	Procedure Code
	SV101-3*	Procedure Modifier
	SV102	Monetary Amount
	SV103	Unit or Basis for Measurement Code
	SV104	Quantity
	SV107-1	Diagnosis Code Pointer
LOOP ID 2430 – SERVICE LINE ADJUDICATION INFORMATION		
2430	SVD01*	Identification Code – Other Payer Primary Identifier
	SVD02*	Monetary Amount – Service Line Paid Amount
	SVD03-1*	Product/Service ID Qualifier
	SVD03-2*	Procedure Code
	SVD03-3*	Procedure Modifiers
	SVD05*	Quantity
	DTP01*	Date Time Qualifier – Adjudication or Payment Date
	DTP02*	Date Time Period Format Qualifier
	DTP03*	Adjudication or Payment Date

3.2.3 Strategic National Implementation Process (SNIP) Types

The Workgroup for Electronic Data Interchange (WEDI) was established in 1991 to coordinate a group of leaders within the healthcare industry to identify practical strategies for reducing administrative costs in healthcare through the implementation of EDI. WEDI helped secure the passage of HIPAA in 1996 and was acknowledged as the facilitator of industry consensus on the implementation and fulfillment of the HIPAA mandate.

In 2003, WEDI proposed expansion of EDI testing to include seven (7) unique types. MAOs and other entities should not mistake the SNIP testing levels to mean these testing types are built on each other in some manner that

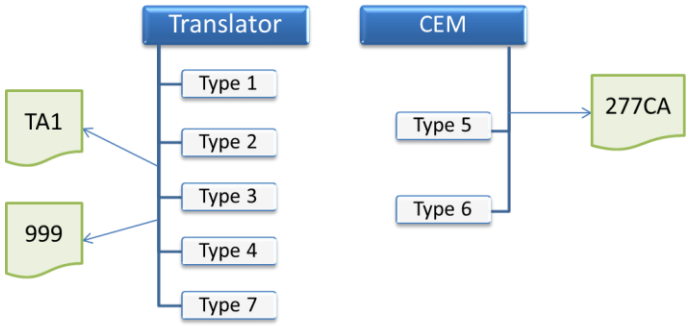
would allow testing to be stopped at a certain level. SNIP testing levels should be considered testing types, as they are not independent of each other, but are the group of edits CMS recommends to ensure HIPAA compliance. There are seven (7) SNIP types which, for encounter data purposes, occur in the EDFES translator and CEM. Table 3D provides the definition of the SNIP types and location within the EDS. Table 3D provides the SNIP types.

TABLE 3D – SNIP TYPES

SNIP Type	SNIP Type of Testing	SNIP Type Definition	SNIP Type EDS Location
Type 1	Integrity Testing	Tests for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 syntax and compliance with X12 rules.	Translator
Type 2	Requirement Testing	Tests for HIPAA IG specific requirements, such as repeat counts, used and not used codes, elements and segments, required or intra-segment situational data elements (non-medical code sets as laid out in the IG), and values noted by an X12 code list or table.	Translator
Type 3	Balancing Testing	Tests the transaction for balanced field totals, record or segment counts, financial balancing of claims, and balancing of summary fields.	Translator
Type 4	Situation Testing	Tests the specific inter-segment situations described in the HIPAA IGs such that: if 'A' occurs, then 'B' must be populated. This is considered to include the validation of situational fields given values or situations present elsewhere in the file.	Translator
Type 5	Code Set Testing	Tests for valid IG specific code set values.	CEM
Type 6	Line of Business Testing	Specialized testing required by certain product types/types of service such as chiropractic, ambulance, durable medical equipment, etc.	CEM
Type 7	Trading Partner-Specific Testing	Tests edits in the HIPAA IG that are unique and specific to a payer/receiver.	Translator

Figure 3A below illustrates the SNIP types and their link to the EDS.

Figure 3A – SNIP Types and the EDS



3.2.4 Encounter Data Balancing

To ensure encounter integrity, amounts reported in the 837-P must balance at three (3) different levels – the claim charge amounts, claim payment amounts, and service line levels. Encounters that do not balance at these levels will be rejected in the EDFES and returned to the submitter for resubmission.

3.2.4.1 Claim Level Charge Amount Balancing

The total claim charge amount reported in Loop 2300, CLM02 must balance to the sum of all service line charge amounts reported in Loop 2400, SV102.

Example

Green Health Plan received a claim from a provider that had a charge amount of 100.00. One (1) service provided was charged at 35.00 and the other service provided was charged at 65.00.

Claim Charge Amount	Loop 2300, CLM02	$100.00
Line 1 Charge Amount	Loop 2400, SV102	$35.00
Line 2 Charge Amount	Loop 2400, SV102	$65.00

When encounters are submitted contrary to this guidance, they will receive a front end edit, as described in Table 3E below.

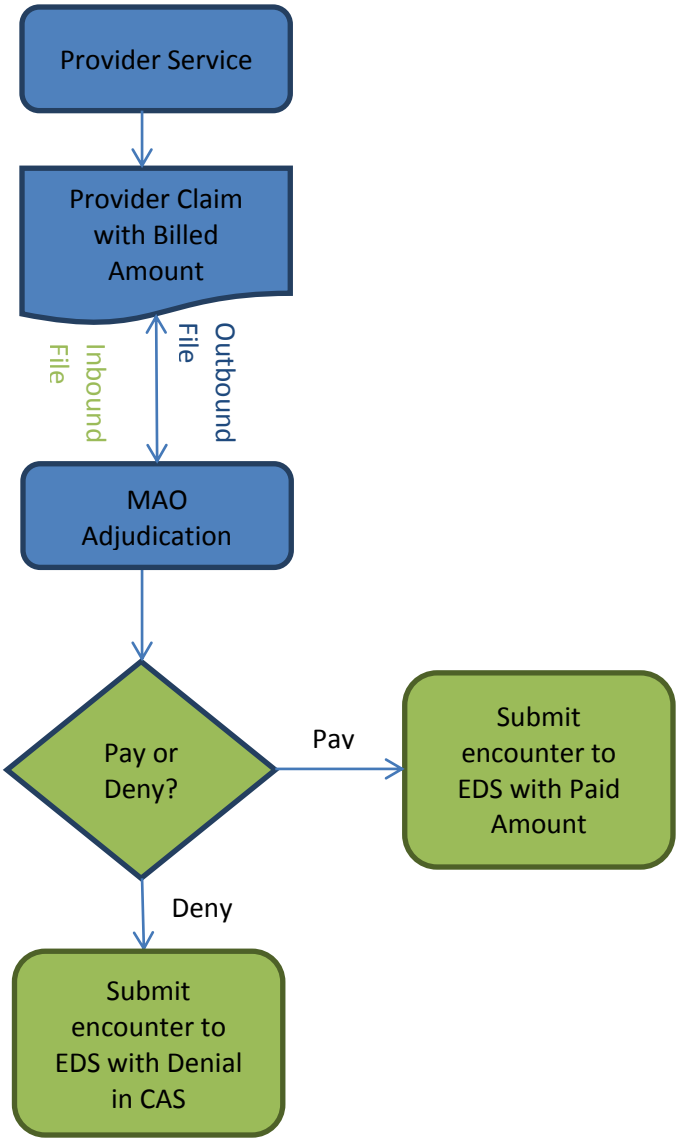
TABLE 3E – EDFES CLAIM LEVEL CHARGE AMOUNT BALANCING EDIT

EDIT REFERENCE	DATA ELEMENT	DISPOSITION/ERROR CODE	EDFES EDIT
X222.157.2300.CLM02.070	CLM02	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 178: "Submitted Charges"	2300.CLM02 must equal the sum of all 2400.SV102 amounts.

3.2.4.2 Claim Level Payer Paid Amount Balancing

All encounter data submissions must follow the Payer-to-Payer model. The provider originates the claim and sends the information to the MAO or other entity (Payer). The MAO or other entity then adjudicates the claim and sends the encounter to EDS (Payer). Figure 3B below provides the flow of data from the provider to EDS.

Figure 3B – Data Flow



All rejected lines must be extracted from the encounter prior to submission to the EDS. MAOs and other entities must return any encounters or encounter lines to the provider for correction. After receipt of corrected data, the MAO or other entity may submit an adjustment encounter to the EDS for processing.

For a given payer, the sum of all line level payment information (Loop 2430, SVD02) must balance to the claim level payment amount (Loop 2320, AMT02).

Also for a given payer, the claim level payment amount (Loop 2320, AMT02), plus any claim level adjustment amounts (Loop 2320, CAS), plus any line level adjustment amount (Loop 2430, CAS) must balance to the claim charge amount (Loop 2300, CLM02).

Line level payment information is reported in Loop 2430, SVD02. In order to ensure balancing, the MAO or other entity must identify the payer that the line payment belongs to, which is accomplished by the identifier populated in Loop 2430, SVD01. This identifier must match the identifier of the corresponding identifier populated in Loop 2330B, NM109.

Loop 2430, SVD01 (Line 1 Payer) = Loop 2330B, NM109 (Line 1 Payer)

Adjustments are reported in the CAS segments of Loop 2320 (claim level) and Loop 2430 (line level). When the adjustment amount is positive, the payment amount is decreased. When the adjustment amount is negative, the payment amount is increased.

For encounter data purposes, the first iteration of the COB loops (2320, 2330, and 2430) must always contain information pertaining to the MAO or other entity. The second and subsequent iterations of the COB loops may contain information pertaining to a true Coordination of Benefits (COB).

Example

Claim Charge	Loop 2300, CLM02	$100.00	Total Amount on Claim
Claim Payment	Loop 2320, AMT02	$80.00	Total Paid Amount
Claim Adjustment	Loop 2320, CAS03	$5.00	Amount Not Paid
Line 1 Charge	Loop 2400, SV102	$80.00	Charge Amount for Service Line
Line 1 Payment	Loop 2430, SVD02	$70.00	Amount Paid for Service Line
Line 1 Adjustment	Loop 2430, CAS03	$10.00	Amount Not Paid for Service Line
Line 2 Charge	Loop 2400, SV102	$20.00	Charge Amount for Service Line
Line 2 Payment	Loop 2430, SVD02	$15.00	Amount Paid for Service Line
Line 2 Adjustment	Loop 2430, CAS03	$5.00	Amount Not Paid for Service Line

Claim Payment = (Line 1 Payment + Line 2 Payment) – Claim Adjustment [80 = (70.00 + 15.00) – 5.00]

The second and subsequent iterations of the COB loops must summarize adjudication information at the COB level.

Example

Claim Charge	Loop 2300, CLM02	$100.00	Total Amount on Claim
Claim Payment	Loop 2320, AMT02	$80.00	Total Paid Amount
Claim Adjustment	Loop 2320, CAS03	$20.00	Amount Not Paid

Claim Charge = Claim Payment + Claim Adjustment [100 = 80.00 + 20.00]

When encounters are submitted contrary to this guidance, they will receive front-end edits, as described in Table 3F below.

TABLE 3F – EDFES CLAIM LEVEL PAYMENT AMOUNT BALANCING EDITS

Edit Disposition	Data Element	Edit Disposition/Error Code	EDFES Edit
X222.306.2320.AMT02.050	AMT02	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 596: "Non-covered Charge Amount" EIC: GB Other Insured	2320.AMT02 (with AMT01 = "A8") elements must = 2300.CLM02
X222.305.2320.AMT02.060	AMT02	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 672: "Other Payer's payment information is out of balance" CSC 286: Other payer's Explanation of Benefits/payment information	2320 AMT02 must = the sum of all existing 2430.SVD02 payer paid amounts (when the value in 2430.SVD01 is the same as the value in 2330B.NM109) minus the sum of all claim level adjustments (2320 CAS adjustment amounts) for the same payer.
X222.351.2400.SV102.060	SV102	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 400: "Claim is out of balance: CSC 583:"Line Item Charge Amount" CSC 643: "Service Line Paid Amount"	SV102 must = the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts.

3.2.4.3 Service Line Level Balancing

Line adjudication information, as populated in Loop 2430, is reported when the MAO or other entity (or true COB) has adjudicated the claim and there was service line payment and/or adjustments.

Line level balancing occurs for each individual line adjudication information loop. In order to balance, the sum of the line level adjustments amounts (Loop 2430, CAS) and line level payments (Loop 2430, SVD02) must balance to the charge amount for the associated line (Loop 2400, SV102). Although the TR3 allows for multiple payments to be reflected for a single service line, this has continued to fail in the CEM. As a result, MAOs and other entities should adhere to the guidance provided below.

- 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
- 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 – True COB Information
  - Loop 2330B — Other Payer Information
DTP*573 – Other Payer Adjudication Date

There is NO True COB Service Level Payment Amount information

Example

Claim Charge	Loop 2300, CLM02	$712.00
Claim Payment	Loop 2320, AMT02	$12.00
Claim Adjustment	Loop 2320, CAS03	$700.00
Line 1 Charge	Loop 2400, SV102	$712.00
Line 1 Payment	Loop 2430, SVD02	$700.00
Line 1 Adjustment	Loop 2430, CAS03	$12.00

(Line 1 Adjustment) + (Line 1 Payment) = Line 1 Charge [12.00 + 700.00 = 712.00]

When encounters are submitted contrary to this guidance, they will receive EDFES edits, as described in Table 3G below.

TABLE 3G – EDFES LINE LEVEL AMOUNT BALANCING EDITS

EDIT REFERENCE	DATA ELEMENT	DISPOSITION/ERROR CODE	EDFES EDIT
X222.351.2400.SV102.060	SV102	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 400: "Claim is out of balance: CSC 583:"Line Item Charge Amount" CSC 643: "Service Line Paid Amount"	SV102 must = the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts.

3.2.4.4 Capitated Submission

Due to the capitation payment structure, amount fields on claims submitted by capitated providers do not always have the accurate pricing information populated. For capitated or staff model arrangements submitting encounter data, MAOs and other entities must submit '0.00', only if billed and/or payment amount information is not available. If billed and/or payment information is available, it should be submitted as received from the provider.

In the instances where capitated and non-capitated service lines are submitted on one (1) claim, MAOs and other entities must populate Loop 2400, CN101='05' for each capitated service line.

MAOs and other entities must ensure that capitated provider encounters comply with all EDFES balancing edits.

Example

Best Health Plan has a capitated arrangement with Dr. Smith for only a portion of services Dr. Smith provides. In order for Best Health Plan to submit Dr. Smith's claim as an encounter to the EDS, Best Health Plan must submit an encounter using all applicable data elements and Loop 2400, CN101='05' for each capitated service line.

3.3 Place of Service (POS) Codes

POS codes are two (2)-digit codes used on Professional encounters to identify the setting in which a service was provided. This code set is required for use in transmitting electronic healthcare claims according to national standards established by HIPAA. The 837-P IG requires the use of POS codes from the National POS code set, which is currently maintained by CMS.

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

https://www.cms.gov/manuals/downloads/clm104c26.pdf

Table 3H provides POS codes from the National POS code set, which EDFES and EDPS utilize to process and price Professional encounter data.

TABLE 3H – POS CODES

POS Codes	POS Name	POS Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). Note that, for the purposes of receiving durable medical equipment (DME), a homeless shelter is considered the beneficiary's home.
06	Indian Health Service Provider-based Facility	A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-Based Facility	08 Tribal 638 Provider-Based Facility (January 1, 2003) A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. Special Considerations for Prison/Correctional Facility Settings (Code 09). The addition of Code 09 to the POS code set and Medicare claims processing reflects Medicare's compliance with HIPAA laws and regulations.

TABLE 3H – POS CODES (CONTINUED)

POS Codes	POS Name	POS Description
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services, including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation, such as a hotel, camp ground, hostel, cruise ship or resort, where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room-Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care, as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital.

TABLE 3H – POS CODES (CONTINUED)

POS Codes	POS Name	POS Description
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long term basis, which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance—Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHCs mental health services area, who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

TABLE 3H – POS CODES (CONTINUED)

POS Codes	POS Name	POS Description
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall, but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services, under the supervision of a physician, to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services, under the supervision of a physician, to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility, other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	State or Local Public Health Clinic	A facility maintained by either State or local health department that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically underserved area, that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

3.4 Professional Processing

The Encounter Data Professional Processing and Pricing System (EDPPPS) was developed to edit, process, and price managed care encounter data for use in the calibration of the risk adjustment model based on FFS-like pricing methodologies.

Professional encounters are submitted to the EDFES for translator and CEM level editing. Once encounters pass the EDFES edits, they are then transferred to the EDPPPS.

3.4.1 EDPPPS Edits

The EDPPPS contains edits that are applied to each encounter submission, which are organized in nine (9) different categories, including the following:

- Validation
- Provider
- Beneficiary
- Reference
- Limit
- Conflict
- Pricing
- Duplicate
- NCCI

The EDPPPS performs editing based on the following header level and line level information populated on the encounter:

- If at least one of the lines is accepted and there is no reject edit at the header level, then the encounter is accepted
- If all lines are rejected and there is no reject edit at the header level, then the encounter will be rejected
- If there is a reject edit at the header level, then the encounter will be rejected

There are two (2) edit dispositions that are generated on the header and line level: Informational and Reject. Informational edits indicated by an "I:" before the edit number will cause an informational flag to be placed on the encounter; however, the Informational edit will not cause processing and/or pricing to cease. Reject edits will cause an encounter to stop processing and/or pricing and the MAO or other entity must resubmit the encounter through the EDFES. The encounter must then pass translator and CEM level editing prior to the data being transferred to the EDPPPS for reprocessing. The EDPPPS edit message is provided on Encounter Data Processing System (EDPS) transaction reports to provide further information to the MAO or other entity of the specific reason the edit generated.

Table 3I below provides the complete list of EDPPPS edits to date.

TABLE 3I – EDPPPS EDITS

EDPPPS Edit#	EDPPPS Edit Category	EDPPPS Edit Description	EDPPPS Edit Error Message
00010	Validation	Reject	From Date of Service is Greater than TCN Date
00011	Validation	Reject	Claim Header Missing From Date of Service
00012	Validation	Reject	Date of Service Less Than 01.01.2012
00025	Validation	Reject	To Date of Service after Date of Claim Receipt
00065	Validation	Reject	Missing Pick up point ZIP Code
00265	Validation	Reject	Adjustment or Void ICN Not Found in History
00660	Validation	Reject	Codes Billed Together in Error
00699	Validation	Reject	Void Submission Must Match Original Encounter
00745	Validation	Reject	Anesthesia Service Without a Modifier
00755	Validation	Reject	Claim to be Voided is Already Voided
00760	Validation	Reject	Claim Adjustment is Already Adjusted or Adjustment is in Progress
00761	Validation	Reject	Unable to Void Due to Different Billing Provider on Void From Original
00762	Validation	Reject	Unable to Void Rejected Claim
01405	Provider	Reject	Sanctioned Provider
01415	Provider	Informational	Rendering Provider Not Eligible for Date of Service
02106	Beneficiary	Informational	Invalid Beneficiary Last Name

TABLE 3I – EDPPPS EDITS (CONTINUED)

EDPPPS Edit#	EDPPPS Edit Category	EDPPPS Edit Description	EDPPPS Edit Error Message
02110	Beneficiary	Reject	Beneficiary Health Insurance Carrier Number (HICN) Not on File
02112	Beneficiary	Reject	Date of Service is After Beneficiary Date of Death
02120	Beneficiary	Informational	Beneficiary Gender Mismatch
02125	Beneficiary	Reject	Beneficiary Date of Birth Mismatch
02240	Beneficiary	Reject	Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service
02255	Beneficiary	Reject	Beneficiary Not Part A Eligible for Date of Service
02256	Beneficiary	Reject	Beneficiary Not Part C Eligible for Date of Service
03015	Reference	Informational	DOS Spans Procedure Code Effective/End Date
03017	Reference	Informational	Diagnosis Not Covered for Reported Procedure
03101	Reference	Reject	Invalid Gender for Procedure Code
03102	Reference	Reject	Provider Type or Specialty Not Allowed to Bill Procedure
03340	Reference	Reject	Diagnosis Not Found on the Reference Table
16002	Pricing	Informational	Service Line Amount Adjusted for Multiple Technical Procedure
25000	NCCI	Informational	Correct Code Initiative Error
25001	NCCI	Informational	Medically Unlikely Error
98325	Duplicate	Reject	Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim

3.4.1.1 Top Beneficiary Errors

Beneficiary edits ensure that the correct beneficiary is associated with the submitted encounter. Accurate beneficiary data will ultimately impact the risk score calculation. The most common beneficiary edits generated on encounter data submissions are:

- 02110 – Beneficiary Health Insurance Carrier Number (HICN) Not on File
- 02125 – Beneficiary Date of Birth Mismatch
- 02240 – Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service
- 02255 – Beneficiary Not Part A Eligible for Date of Service
- 02106 – I: Invalid Beneficiary Last Name
- 02120 – I: Beneficiary Gender Mismatch

3.4.1.1.1 Edit 02110 – Beneficiary Health Insurance Carrier Number (HICN) Not on File

The EDPPPS rejects an encounter by displaying Error Code “02110” and Error Description “Beneficiary Health Insurance Carrier Number (HICN) Not on File” when the Beneficiary HICN field submitted on the encounter is blank or the HICN is not listed on the EDPS Beneficiary database tables.

3.4.1.1.1.1 Edit 02110 Prevention/Resolution Strategies

MAOs and other entities must reference MARx UI to determine that the HICN populated on the encounter is the correct HICN associated with the beneficiary and that the beneficiary is enrolled in their plan for the date of service provided on the encounter. If the HICN found in MARx for the beneficiary is identical to that provided on the encounter, MAOs and entities must contact CSSC Operations for further research.

If an MAO or other entity receives edit 02110, the rejected encounter must be corrected and resubmitted to the EDS with the accurate HICN.

3.4.1.1.2 Edit 02125 – Beneficiary Date of Birth Mismatch

The EDPPPS rejects an encounter by displaying Error Code "02125" and Error Description "Beneficiary Date of Birth Mismatch" when the Beneficiary Date of Birth received on the encounter does not match the Beneficiary Date of Birth maintained in the EDPS Beneficiary database tables for the submitted Beneficiary HICN. EDPS obtains daily feeds of the Medicare Beneficiary Database (MBD), which stores all beneficiary information.

3.4.1.1.2.1 Edit 02125 Prevention/Resolution Strategies

There are several steps that MAOs and other entities may take to rectify encounters that are rejected due to edit 02125.

- MAOs and other entities should contact their internal enrollment department to determine the beneficiary DOB provided on the enrollment transaction matches the beneficiary DOB populated on the encounter.
- If the beneficiary DOB matches the MAO or other entity's internal records, the MAO or other entity should verify that the beneficiary DOB populated on the encounter matches the beneficiary DOB in MARx UI. If there was an inputting error on the encounter causing an incorrect DOB (for example, transposed numbers), MAOs and other entities must resubmit the encounter with the correct DOB, as found in MARx UI.
- If the beneficiary DOB populated on the encounter is correct and the EDPS database is incorrect, MAOs and other entities must contact the beneficiary. The beneficiary must then contact the Social Security Administration to correct the stored DOB.
- If the HICN found in MARx for the beneficiary is identical to that provided on the encounter, MAOs and entities must contact CSSC Operations for further research.

3.4.1.1.3 Edit 02240 – Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service

The EDPPPS rejects an encounter by displaying Error Code "02240" and Error Description "Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service" when the following conditions are met:

- The Contract ID in the Beneficiary database record for the Beneficiary HICN submitted on the encounter matches the Contract ID submitted on the encounter, but the Contract ID effective dates are not within the From Date of Service or Through Date of Service **OR**
- The Contract ID submitted on the encounter for the Beneficiary HICN does not match the Contract ID on the Beneficiary database.

3.4.1.1.3.1 Edit 02240 Prevention/Resolution Strategies

Because edit 02240 may occur for two (2) different reasons, MAOs and other entities must determine if the encounter rejected because the beneficiary was not enrolled in their plan for the DOS or because the Contract ID submitted for the beneficiary HICN does not match the Contract ID in the EDPS beneficiary database.
Using information from the monthly membership report (MMR) and internal enrollment files, MAOs and other entities should be knowledgeable of the enrollment and eligibility of their beneficiaries. Establishing a systematic beneficiary enrollment tracking system will reduce the number of errors associated with this edit.

When an MAO or other entity receives this edit, the following steps should be taken:

- Ensure that the correct from date of service was entered on the service line.
- Check the from date of service against the enrollment dates to confirm that the beneficiary was enrolled with the MAO or other entity on or after the from date
- If the submitter determines that there are discrepancies in the data in CMS systems, contact CSSC
- If CSSC determines that EDPS beneficiary database requires updated MAO or other entity enrollment data, MAOs and other entities may resubmit after the beneficiary tables are updated and the MAO or other entity is notified by CSSC

3.4.1.1.4 Edit 02255 – Beneficiary Not Part A Eligible for Date of Service

The EDPPPS rejects an encounter by displaying Error Code "02255" and Error Description "Beneficiary Not Part A Eligible for Date of Service" when the following conditions are met:

- Beneficiary is not eligible for the encounter Date of Service based on eligibility data contained in the EDPS Beneficiary database
- Claim Date of Service is before the Beneficiary Part A entitlement date contained in the Beneficiary database
- Claim Date of service is after the Beneficiary Part A entitlement date contained in the Beneficiary database.

3.4.1.1.4.1 Edit 02255 Prevention/Resolution Strategies

MAOs and other entities must reference the MARx Eligibility Screen (M232) for the Part A start date and ensure the beneficiary was eligible during the date(s) of service submitted on the encounter.

3.4.1.1.5 Edit 02106 – I: Invalid Beneficiary Last Name

The EDPPPS displays (Informational)/Error Code "02106" and (Informational)/Error Description "Invalid Beneficiary Last Name" when the first five (5) positions of the Beneficiary Last Name submitted on the encounter are blank or do not match the first five (5) positions of the Last Name carried on the EDPS Beneficiary database tables for this HICN.

3.4.1.1.5.1 Edit 02106 Prevention/Resolution Strategies

When an MAO or other entity receives edit 02106, the following steps should be taken:

- Check internal enrollment records to verify the last name populated on the encounter matches the beneficiary's last name contained on the enrollment application.
- Check the beneficiary last name populated on the encounter against the beneficiary last name found in MARx UI.

Since this is an informational edit, MAOs and other entities are not required to resubmit the encounter; however, should ensure their system reflects accurate information.

3.4.1.1.6 Edit 02120 – I: Beneficiary Gender Mismatch

The EDPPPS displays (Informational)/Error Code "02120" and (Informational)/Error Description "Beneficiary Gender Mismatch" when the gender code submitted on the encounter does not match the gender on the EDPS Beneficiary database tables for the submitted Beneficiary HICN.

3.4.1.1.6.1 Edit 02120 Prevention/Resolution Strategies

MAOs and other entities must verify with the Social Security Administration the gender populated on the file. If the gender is incorrect, the beneficiary must coordinate with the Social Security Administration.

- Check internal enrollment records to verify the gender populated on the encounter matches the beneficiary's gender contained on the enrollment application.
- Check the beneficiary gender populated on the encounter against the beneficiary gender found in MARx UI.

Since this is an informational edit, MAOs and other entities are not required to resubmit the encounter; however, should ensure their system reflects accurate information.

3.4.1.2 Top Provider Errors

Provider edits ensure that Professional/Physician Supplier providers are valid and eligible to render the service(s) identified on encounter submission. The most common provider edits generated on encounter data submissions are:

- 01405 – Sanctioned Provider
- 01415 – I: Rendering Provider Not Eligible for Date of Service

3.4.1.2.1 Edit 01405 – Sanctioned Provider

The EDPPPS rejects an encounter by displaying Error Code "01405" and Error Description "Sanctioned Provider" when the Billing Provider has a Sanction code of '67' and the claim service line has a DOS which falls between the Sanction begin date and the Sanction end date.

3.4.1.2.1.1 Edit 01405 Prevention/Resolution Strategies

Sections 1128 A and B and 1162(e) of the Social Security Act give the Department of Health and Human Services (DHHS), through its Office of Inspector General (OIG), the authority to exclude certain individuals and entities from participation in the Medicare and State Medicaid health care programs. The Medicare Exclusion Database (MED), the CMS repository for OIG Sanction data, is distributed and updated monthly by CMS.

Monthly files are loaded, formatted, and provided by email to designated CMS personnel, Fiscal Intermediaries (FIs), Carriers, States (Medicaid), as well as any other organization that contracts with CMS. MAOs and other entities should be aware of and use the OIG's sanction list and must verify that a provider is not a sanctioned provider prior to adjudication of the claim and submission of the encounter to EDS.

The OIG Sanction List can be accessed on the OIG website at: http://oig.hhs.gov/exclusions/index.asp.

Encounters that generate edit 01045 must either be corrected to include a non-sanctioned provider, if the provider populated on the encounter was in error, or be considered as a rejected claim in the MAO or other entity's adjudication system.

Rejected claims cannot be submitted to EDS.

3.4.1.2.2 Edit 01415 – Rendering Provider Not Eligible for Date of Service

The EDPPPS continues the adjudication process of an encounter and displays (Informational)/Error Code "01415" and (Informational)/Error Description "Rendering Provider Not Eligible for Date of Service" when the Servicing Provider is on the Provider Master tables but is not eligible for the Claim Dates of Service based on the Provider eligibility dates on the Provider Master tables.

3.4.1.2.2.1 Edit 01415 Prevention/Resolution Strategies

MAOs and other entities must ensure that the correct NPI is populated on the encounter for the rendering provider.

3.4.1.3 Top Validation Errors

Validation edits are performed in order to allow the EDPPPS to verify that MAOs and other entities accurately report data to successfully process through the EDPPPS. If the data is not properly submitted by the MAO or other entity, edits will occur, preventing the encounter from transferring through the EDPPPS. The most common validation edits generated on encounter data submissions are:

- 00025 – To Date of Service After Date of Claim Receipt Date
- 00065 – Missing Pick-Up Point ZIP Code
- 00265 – Adjustment or Void ICN Not Found in History
- 00760 – Claim Adjustment is Already Adjusted or Adjustment is in Progress
- 00761 – Unable to Void Due to Different Billing Provider on Void from Original Adjustment
- 00762 – Unable to Void Rejected Claim

3.4.1.3.1 Edit 00025 – To Date of Service After Date of Claim Receipt

The EDPPPS rejects an encounter by displaying Error Code "00025" and Error Description "To Date of Service is after Date of Claim Receipt" when service line To Date of Service is greater than the receipt date portion of the ICN.

3.4.1.3.1.1 Edit 00025 Prevention/Resolution Strategies

MAOs and other entities must ensure that the DOS populated on the encounter is not after the date the encounter was submitted to the EDS. If an encounter rejects as a result of edit 00025, MAOs and other entities must obtain the correct DOS from the provider and resubmit the encounter with the correct data.

3.4.1.3.2 Edit 00065 – Missing Pick-Up Point ZIP Code

The EDPPPS rejects an encounter by displaying Error Code "00065" and Error Description "Missing Pick-Up Point ZIP Code" when the ambulance pick-up ZIP Code is not found on the encounter.

3.4.1.3.2.1 Edit 00065 Prevention/Resolution Strategies

Edit 00065 validates that the ZIP code populated on the encounter is valid. When submitting ambulance encounters, MAOs and other entities must ensure that the correct ZIP code is populated if it is available. If it is not

available, the ZIP code of the rendering provider or billing provider (if the rendering provider is the same as the Billing Provider) should be populated in Loop 2310E.

3.4.1.3.3 Edit 00265 – Adjustment or Void ICN Not Found in History

The EDPPPS rejects an encounter by displaying Error Code "00265" and Error Description "Adjustment or Void ICN Not Found in History" when the encounter is an adjustment or void (Claim Frequency = 7 or 8) and the former ICN is not found in EODS.

3.4.1.3.3.1 Edit 00265 Prevention/Resolution Strategies

MAOs and other entities must ensure the ICN provided on a correct/replace or void/delete encounter has an "accept" status on the 277CA. Encounters that have a reject status on the 277CA are not transmitted to the EDPS and therefore, no record of the ICN will be found in the EODS.

3.4.1.3.4 Edit 00760 – Claim Adjustment is Already Adjusted or Adjustment is in Progress

The EDPPPS rejects an encounter by displaying Error Code "00760" and Error Description "Claim Adjustment is Already Adjusted or Adjustment is in Progress" when the encounter is an adjustment or void (claim frequency = 7 or 8) and the original ICN indicated on the encounter is for an encounter that is currently in a status of adjusted or an adjustment is in progress in EODS.

3.4.1.3.4.1 Edit 00760 Prevention/Resolution Strategies

In order to ensure that this edit is not generated, MAOs and other entities must wait to receive the MAO-002 report reflecting a status of "accept" for the submitted correct/replace or void/delete encounter.

3.4.1.3.5 Edit 00761 – Unable to Void Due to Different Billing Provider on Void from Original

The EDPPPS rejects an encounter by displaying Error Code "00761" and Error Description "Unable to Void Due to Different Billing Provider on Void from Original" when the billing provider NPI populated on the void/delete encounters differs from the original encounter submission.

3.4.1.3.5.1 Edit 00761 Prevention/Resolution Strategies

MAOs and other entities must submit the exact same encounter as the previously submitted and accepted encounter, except that CLM05-3 must be changed to a value of '8'. Submission of the exact same encounter will ensure that the billing provider NPI is the same.

3.4.1.3.6 Edit 00762 – Unable to Void Rejected Claim

The EDPPPS rejects an encounter by displaying Error Code "00762" and Error Description "Unable to Void Rejected Claim" when the encounter is a void (Claim Frequency = 8) and the original ICN indicated on the encounter is for an encounter that is currently in a status of voided in EODS.

3.4.1.3.6.1 Edit 00762 Prevention/Resolution Strategies

Accepted and rejected encounters are stored in the EODS; however, only those encounters that have a status of accept are flagged as "active". If the ICN of a rejected ("inactive") encounter is populated on a void/delete encounter, the encounter will reject. MAOs and other entities must ensure that the ICN referenced on a void/delete encounter has a status of "accept" on the MAO-002 report. Although the 277CA may reflect an accept status for the ICN, this does not necessary indicate the encounter was completely accepted through the EDPS.

3.5 Special Considerations

The EDPPPS is structured to include FFS-like logic regarding submission, processing, and pricing; however, there are unique circumstances that require special considerations or modifications in order to allow encounters to successfully pass EDFES and EDPPPS edits. The special considerations include, but are not limited to, the following types of encounter data:

- Ambulance
- Part B Drug Data
- Default NPIs
- Atypical Provider
- Paper Claim
- 4010
- Chart Review
- Correct/Replace
- Void/Delete
- Proxy Claim Information

3.5.1 Ambulance

Ambulance services involve the assessment and administration of emergency care by medically trained personnel and transportation of patients within an appropriate, safe and monitored environment. CMS will collect ambulance data as part of the encounter data process.

3.5.1.1 Ambulance Submission

MAOs and other entities must submit Professional ambulance data on the 837-P. Loop 2310E (Ambulance Pick-Up Location) and 2310F (Ambulance Drop-Off Location) will be used to appropriately process and price ambulance data submissions for collection of encounter data.

If the true ambulance pick-up and drop-off locations are available from the provider, MAOs and other entities must include the address line(s), city, state, and ZIP code in Loops 2310E and 2310F. If the true ambulance pick-up and drop-off locations are not available from the provider, MAOs and other entities must abide by the following operational guidance:

- If the Rendering Provider is different than the Billing Provider, populate the Rendering Provider's complete address, including the address line(s), city, state, and ZIP code and populate this information in Loops 2310E and 2310F

- Use the Billing Provider's complete address, including the address line(s), city, state, and ZIP code and populate this information in Loops 2310E and 2310F

3.5.1.2 Ambulance Processing and Pricing Logic

The EDPPPS validates ambulance services data on submitted encounters against reference files in the EDPS database and prices encounter service lines. The EDPS databases contain the ZIP Code 5 to Carrier Locality Table, the ZIP Code 9 to Carrier Locality Table, and the Ambulance Fee Schedule Table.

When the EDPS receives an encounter, it reads the DOS, State Code, and the ZIP Codes from the Ambulance Pick-Up Location address (Loop 2310E) and Ambulance Drop-off Location Address (Loop 2310F) and processes encounters based on the ZIP code reference table and the ambulance fee schedule.

When the EDPPPS reads the Rural Indicator value from the ZIP Code file in the EDPS database along with the procedure code and DOS from the encounter service line, the EDPS then retrieves the Rural Payment Amount or Urban Payment Amount, listed on the Ambulance Fee Schedule in the EDPS database, to establish a Tentative Fee Schedule when the following conditions are met:

- If the Rural Indicator is "R" (Rural) and the procedure code is "A0425 – A0429" (Ground Ambulance), then the Tentative Fee Schedule equals the Rural Payment Amount.
- For procedure codes other than Ground Ambulance: If the Rural Indicator is "R" (Rural) or "B" (Super Rural) and the Rural Payment Amount for the Procedure Code data element is greater than zero, then the Tentative Fee Schedule equals the Rural Payment Amount.
- If the Rural Indicator is "R" (Rural) or "B" (Super Rural) and the Rural Payment Amount for the procedure code data element is zero, then the Tentative Fee Schedule equals the Urban Payment Amount.

The encounter is then stored in the EODS and the status of the encounter is returned on the MAO-002 report.

3.5.2 Part B Drug Data

MAOs and other entities must submit data on drugs or biologics that meet the Medicare Part A or Part B coverage requirements so that CMS can estimate the cost of these drugs and biologics.

Examples of drugs and biologics covered under Medicare Part B include:

- Drugs billed by physicians and typically provided in physicians' offices
- Drugs billed by pharmacy suppliers and administered through DME, such as respiratory drugs given through a nebulizer
- Drugs billed pharmacy suppliers and self-administered by the patient, such as immunosuppressive drugs and some oral anti-cancer drugs
- Drugs not self-administered and furnished incidental to a physician's service, such as prostate cancer drugs
- Certain cancer and anti-nausea drugs available in pill form
- Blood clotting factors
- Immunosuppressive drugs used following organ transplants
- Drugs or biologics administered by infusion or injection

Many drugs and biologics are further identified by the National Drug Code (NDC) assigned. NDC is a system created to identify drugs intended for human use. Originating from the Drug Listing Act of 1972, Section 510 requires the Food and Drug Administration (FDA) to list all current drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution.

The NDC is a unique, 11-digit, three (3) segment numeric identifier assigned to each medication. The segments identify the vendor, product, and trade package. The labeler code is the first four (4) or five (5) digits and is assigned by the FDA upon submission of a Labeler Code Request. Any firm that manufactures, repackages, or distributes a drug product is considered a labeler. The second segment, the product code, is three (3) or four (4) digits long and identifies a specific strength, dosage form, and formulation for a particular firm. The final segment, the package code, is one (1) or two (2) digits long and identifies package forms and sizes.

When a new drug is introduced, the FDA inputs the full NDC number and information into the Drug Registration and Listing System (DRLS). A registered establishment must update its drug listing data twice a year, in June and December, to identify drugs not previously listed or when a change occurs.

3.5.2.1 Part B Drug Data Submission

The NDC codes, when available, should be included in Loop 2410, data element LIN03 of the LIN segment with no separators in the 11-character data stream. If submitted, per the TR3, the quantity must be in Loop 2410, CTP04 and the unit of measure (UOM) code in Loop 2410, CTP05-1. The unit price must be populated in Loop 2410, CTP03. For compound drugs, a separate line should be used for each ingredient. Loop 2410, REF02 must have the same prescription number, or the same linkage number if provided without a prescription, for each ingredient of the compound to enable CMS to differentiate and link the ingredients to a single compound.

3.5.2.2 Part B Drug Data Processing and Pricing Logic

Encounters submitted in EDPPPS containing drug data are processed and priced based on the HCPCS code. Although the NDC may accurately identify the drug, the manufacturer, and the unit cost or price per unit to be paid, NDCs are not used in EDS pricing. MAOs and other entities may submit NDCs when available; however, NDCs are not required for EDS submission. If submitted on an encounter, the EDFES will perform syntax editing to ensure the value submitted is in the correct format. The EDFES edit that checks for NDC to proper HCPCS code association is deactivated. The NDC populated on the encounter will be stored in EODS and may be used for future analysis.

3.5.2.3 Part B Drug Data Processed through PBMs

MAOs and other entities may use Pharmaceutical Benefit Managers (PBMs) to collect Part B drug data. PBMs are third party administrators who oversee prescription drug programs. Key responsibilities include processing and payment of prescription drug encounters. PBMs are also responsible for developing and maintaining contracts with pharmacies and negotiating discounts and rebates with drug manufacturers. MAOs and other entities may receive drug data from PBMs in the National Council for Prescription Drug Programs NCPDP D.0 format.

Due to the incompatibility of the NCPDP D.0 format to the 837 format in the EDS, MAOs and other entities must only submit Part B drug data that can be processed through their medical claims processing system and submitted on the 837. Part B drug data received by the MAO or other entity on the NCPDP D.0 format must be excluded from encounter data submission. CMS is currently reviewing alternative options for the submission of Part B drug data collected from a PBM that is in the NCPDP D.0 format.

3.5.3 Default NPIs

HIPAA mandated that the Secretary of Health and Human Services (HHS) adopt a standard and unique health identifier for health care providers. On January 23, 2004, HHS published the Final Rule that adopts the National Provider Identifier (NPI) as the standard unique identifier for health care providers. The NPI is a ten (10)-position, intelligence-free unique numeric identifier and must be used in lieu of legacy provider identifiers.

Encounter data requires the use of a valid NPI for submission and processing. MAOs and other entities are responsible for ensuring that data collected for submission to the EDS derives from Medicare acceptable sources, as identified by an assigned NPI. The NPI is edited against the National Plan and Provider Enumeration System (NPPES) and the Provider Enrollment, Chain, and Ownership System (PECOS).

MAOs and other entities can use the NPI Registry, located on the NPPES website, to investigate and validate a provider's NPI. Information in the NPI Registry is updated daily and there is no fee to use the registry. Eligible providers may also apply for an NPI in this manner.

There may be instances, such as receipt of paper claim, atypical provider, and 4010 submissions from providers, in which MAOs and other entities are unable to obtain the provider's NPI information. As a result, CMS has temporarily established EDS default NPIs for submission of Institutional, Professional, and DME encounters only **when the provider has not been assigned an NPI**. MAOs and other entities are required to populate the true Employer Identification Number (EIN) of the provider when a default NPI is submitted.


Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information

Table 3J below provides the default NPI values by Payer ID:

TABLE 3J – DEFAULT 837-P NPI VALUE

SYSTEM	PAYER ID	DEFAULT NPI VALUE
Professional	80882	1999999984


MAOs and other entities must submit all encounter data using the EDS Minimum Data Elements

3.5.4 Atypical Provider

Providers who are not considered health care providers and do not provide health care services are referred to as "atypical service providers".

According to the Code of Federal Regulations (45 CFR 160.103), a health care provider is defined as a "provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills or is paid for health care in the normal course of business."

45 CFR 160.103 defines health care as "care, services, or supplies related to the health of an individual. Health care includes, but is not limited to:

- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription."

Both the provider and the service they provide must be evaluated to determine if a provider is considered to be "atypical." The following questions can be used as a guide for evaluation to determine if a provider meets the criteria of an atypical service provider:

- Is the provider within the health care provider definition according to the Code of Federal Regulations (45 CFR 160.103)?
  - If *yes*, then the provider is not considered an atypical service provider and is eligible to obtain an NPI.
  - If *not*, then continue to question 2:
- Does the provider deliver health care services as defined by the Code of Federal Regulations (45 CFR 160.103)?
  - If *yes*, then the provider is also not an atypical service provider and is eligible for a NPI.
  - If *not*, then the provider is considered an atypical service provider and is not eligible for a NPI.

The EDPS validates atypical provider service data on submitted encounters against provider NPI databases.

When the EDPPPS receives an encounter, it reads the atypical provider NPI and bypasses all other processing and pricing edits. The encounter is flagged, stored in the EODS, and the status of the encounter is returned on the MAO-002 report.

Diagnoses captured from atypical provider types (as notated by the default atypical provider NPI) will not be stored for risk adjustment calculation.

MAOs and other entities may submit a default Employer Identification Number (EIN) in Loop 2010BB, REF01=EI, REF02=199999998 for atypical provider submissions **only if the true EIN is not available**.

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information.

3.5.5 Paper Claim Submission

MAOs and other entities submitting encounters generated as a result of either a UB-04 or HCFA-1500 paper claim submission in which the provider's NPI was not provided may utilize the appropriate default NPI, as well as Loop 2300, PWK01='OZ', PWK02='AA'. Use of the PWK segment in coordination with the default NPI will allow the EDPPPS to flag the encounter appropriately for future analysis. Paper claim generated encounters will price according to the data provided on the encounter and the diagnoses will be eligible for risk adjustment.

It is important to note that failure to utilize the PWK segment appropriately will cause the encounter to be processed as an atypical provider submission, resulting in the encounter bypassing the pricing module and deeming the diagnoses ineligible for risk adjustment.

Example

Happy Health Plan received a paper claim from Dr. Smith, which did not contain an NPI. In order to convert the paper claim submission into an encounter, Happy Health Plan must include a Billing Provider NPI default value of 1999999984, and the required minimum data elements. In addition, Happy Health Plan must include Loop 2300, PWK01='OZ' and PWK02='AA'.

3.5.6 4010 Submission

MAOs and other entities submitting encounters generated as a result of a 4010 submission in which the provider's NPI was not provided may utilize the appropriate default NPI, as well as Loop 2300, PWK01='PY', PWK02='AA'. Use of PWK segment in coordination with the default NPI will allow the EDPPPS to flag the encounter appropriately for future analysis. 4010 generated encounters will price according to the data provided on the encounter and the diagnoses will be eligible for risk adjustment extraction.

It is important to note that failure to utilize the PWK segment appropriately will cause the encounter to be processed as an atypical provider submission, resulting in the encounter bypassing the pricing module and deeming the diagnoses ineligible for risk adjustment.

Example

Green Plan received a 4010 submission from Dr. Washington, which did not contain an NPI. In order to convert the 4010 submission in an encounter, Green Plan must include a Billing Provider NPI default value of 1999999984, and the required data elements. In addition, Green Plan must include Loop 2300, PWK01='PY' and PWK02='AA'.

3.5.7 Chart Reviews

Historically, chart reviews have been performed by MAOs and other entities for the purpose of obtaining diagnosis codes that were either not originally submitted by the provider or were submitted by the provider in error. Based on this information, CMS collects chart review data as a part of the encounter data process. All chart review encounter data must be from an appropriate provider "specialty," from an allowed provider type (inpatient, outpatient, physician), and within 25 months of the data collection period. Further, all diagnoses codes submitted through chart review must be based on a face-to-face visit and supported by a medical record.

Because not all chart reviews are able to be linked back to a previously adjudicated claim in the MAOs adjudication system, CMS allows for MAOs and other entities to submit chart review encounters that are linked to a previously submitted and accepted encounter (linked ICN) and chart review encounters that are not linked to a previously submitted and accepted encounter (unlinked ICN). All chart reviews, whether linked to an ICN or unlinked, must be able to be validated through the medical record.

The term "chart review" refers to all medical reviews

3.5.7.1 Chart Review Submission

MAOs and other entities are required to use the 837-P format to submit Professional encounters that are a result of chart reviews. MAOs and other entities can perform the following actions through a chart review encounter submission:

- Add specific diagnoses to full encounters
- Delete specific diagnoses from a full encounter
- Replace one chart review encounter with another chart review encounter
- Add and delete diagnoses on a single encounter

The chart review submission option must not be used to replace a full encounter.

To identify the data populated on the encounter is the result of a chart review, the PWK segment, PWK01='09', PWK02='AA' within the 2300 Loop must be used. Submission of the following elements will indicate the encounter is a result of a chart review:

- Report Type Code, PWK01='09'
- Attachment Transmission Code, PWK02='AA'
- Reference Identification Qualifier, REF01='F8'(if the chart review is linked to an ICN)
- Claim Original Reference Number, REF02=ICN of the previously accepted encounter (if the chart review is linked to an ICN)
- Claim Frequency Code, CLM05-3 = '1' for original

MAOs and other entities should refer to the 837-P Companion Guide for linked ICN and unlinked ICN chart review business cases

CMS has defined the minimum data elements required to submit any encounter data. In doing so, it is assumed that chart reviews will not always provide the minimum data elements, specifically the procedure code, and possibly the POS. MAOs and other entities may provide any valid procedure code and POS in order to pass translator and CEM level editing.

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information.

For chart review data that can be linked to an encounter but the encounter is in error (i.e., not yet accepted by EDS), MAOs and other entities must wait until the error is corrected and is accepted by EDS. If a claim has exceeded the 13-month timely filing rule and was not accepted by EDS, yet the chart review data can be linked to the claim, MAOs and other entities must submit the encounter as an unlinked chart review encounter. All chart review encounters must be submitted within 25 months of the beginning of the data collection period.

3.5.7.2 Chart Review – Addition of Specific Diagnoses

One function of a chart review submission is to add at least one (1) diagnosis code obtained through a medical record review/chart review. MAOs and other entities may use either the linked ICN or unlinked ICN method, pending if a claim was previously submitted and accepted in the EDPPPS. In order to add at least one (1) diagnosis code as a result of a chart review, MAOs and other entities must include the minimum data elements.

When an MAO or other entity submits a linked chart review encounter containing PWK01='09', PWK02='AA' in the 2300 loop because at least one (1) additional diagnosis code was found in the medical record, only the minimum data elements and the diagnosis code that was not included on the previously submitted and accepted encounter are permitted to be included on the chart review encounter. MAOs and other entities must include the following data as well as the minimum data elements required for all encounter data submissions:

- 2300 CLM05-3 = '1'= Original
- 2300 PWK01 = '09'
- 2300 PWK02 = 'AA'
- 2300 REF01 = 'F8'
- 2300 REF02 = ICN from accepted and stored encounter
- 2300 HI01-1 = 'BK' (first diagnosis code only)
- 2300 HI01-2 = **Added diagnosis code(s)**

Example

A-One Health Plan performed a quarterly medical record review at Health Care Associates and discovered that diagnosis 402.10 – Benign Hypertensive Heart Disease without Heart Failure was not included on the original encounter submission for Gwendolyn Nguyen. A-One Health Plan must submit a linked chart review, with Loop 2300 CLM05-3='1', PWK01='09', PWK02-'AA', REF01='F8', REF02 must include the original accepted ICN, HI01-1='BK', and HI01-2= 402.10 (the new diagnosis code). In addition, all required minimum data elements must be submitted.

3.5.7.3 Chart Review – Deletion of Specific Diagnoses

MAOs and other entities may need to delete diagnoses from a previously submitted and accepted encounter stored in EODS as a result of a chart review. While guidelines are established to accommodate deletion of specific diagnoses, it is critical to note that all minimum required data elements for the submission of 5010 encounter data must be submitted for linked and unlinked chart review deletion submissions. In order to delete diagnoses from an accepted encounter stored in EODS as a result of a chart review, MAOs and other entities must include the following data, as well as the minimum data elements required for all encounter data submissions:

- 2300 CLM05-3 = '1'= Original
- 2300 PWK01 = '09'
- 2300 PWK02 = 'AA'
- 2300 REF01 = 'F8'
- 2300 REF02 = ICN from accepted and stored encounter (for linked chart review)
- 2300 HI01-1 = 'BK' (first diagnosis code only)
- 2300 HI01-2 = **Deleted diagnosis code(s)**
- 2300 REF01 = 'EA'
- 2300 REF02 = '8' (Indicates the deletion of diagnosis code listed HI01-2)

Example

During a medical record review, Statewide Community Care is reconciling chart review data and finds that Dr. Aron Martinez has submitted diagnosis 429.3 - Cardiomegaly in error for patient, Mr. Ian Richards. Statewide Community Care must submit a linked chart review with Loop 2300 CLM05-3='1', PWK01='09', PWK02-'AA', REF01='F8', REF02 must include the original accepted ICN, HI01-1='BK', and HI01-2= 429.3 (the diagnosis being deleted), REF01='EA', REF02='8'. In addition, all required minimum data elements must be submitted.

3.5.7.4 Chart Review – Additions and Deletions of Specific Diagnoses on a Single Encounter

MAOs and other entities may need to add diagnoses, as well as delete diagnoses from a previously submitted and accepted encounter stored in EODS as a result of a chart review. In order to do so, MAOs and other entities must include the following data and the minimum data elements required for all encounter data submissions:

- 2300 CLM05-3 = '1'= Original
- 2300 PWK01 = '09'
- 2300 PWK02 = 'AA'
- 2300 REF01 = 'F8'
- 2300 REF02 = ICN from accepted and stored encounter (for linked chart review)
- 2300 HI01-1 = 'BK' (first diagnosis code only)
- 2300 HI01-2 = **Added diagnosis code(s)**
- 2300 REF01 = 'EA'
- 2300 REF02 = Deleted diagnosis code(s)

Example

Fresh Perspective Health Plan performed a random medical record review for Dr. Arlene Zynga and located a chart discrepancy for patient, Ms. Tracy Bennett. The diagnosis of 714.0 – Rheumatoid Arthritis was not valid for the service Dr. Zynga provided. Fresh Perspective Health Plan also noted in Ms. Bennett's medical record that diagnosis 403.90 – Kidney Disease due to Hypertension was omitted from the original encounter submission. Fresh Perspective Health Plan must submit a linked chart review with Loop 2300 CLM05-3='1', PWK01='09', PWK02='AA', REF01='F8', REF02 must include the original accepted ICN, HI01-1='BK', HI01-2=403.90 (the new diagnosis code), REF01='EA', REF02=714.0 (the deleted diagnosis code). In addition, all required minimum data elements must be submitted.

3.5.7.5 Chart Review – Correct/Replace a Chart Review Encounter with Another Chart Review Encounter

There may be instances in which MAOs and other entities submitted a chart review encounter in error, which necessitates that a correct/replace chart review encounter to be submitted. Correct/replace chart review encounters may only correct or replace other previously submitted and accepted chart review encounters and must not be submitted to correct or replace full encounters. MAOs and other entities must include the following data, as well as the minimum data elements required for all encounter data submissions:

- 2300 CLM05-3 = '7'= Correct/Replace
- 2300 PWK01 = '09'
- 2300 PWK02 = 'AA'
- 2300 REF01 = 'F8'
- 2300 REF02 = ICN from accepted and stored chart review encounter

Correct/replace submissions provide the final representation of the encounter; therefore, all correct information included on the original chart review must also be included on the correct/replace chart review submission. Upon EDFES and EDPPPS editing, the original chart review encounter will be flagged as "inactive" and the correct/replace chart review encounter will be flagged as the active record.

Example

Fit Health Plan performed a follow-up medical record review at Madagascar Internal Medicine due to discrepancies in encounter data submission. The representative found that the additional diagnoses provided for one of Dr. Madagascar's patients in the initial chart review were incorrect. Fit Health Plan must a chart review with Loop 2300 CLM05-3='7', PWK01='09', PWK02='AA', REF01='F8', and REF02 must include the original accepted ICN. In addition, all required minimum data elements must be submitted.

3.5.7.6 Chart Review Duplicate Logic

Once a chart review encounter passes through the EDPPPS, it is stored in an internal repository, the EODS. If another chart review encounter is submitted that matches specific values to another stored chart review encounter, it will be rejected and will be considered a duplicate. The chart review encounter will be returned to the submitter on the MAO-002 reports with error message 98325 – Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim, identifying it as a duplicate chart review encounter. Table 3K below provides the duplicate logic for linked ICN and unlinked ICN chart review encounters.

TABLE 3K – CHART REVIEW DUPLICATE LOGIC

Linked ICN Chart Review Duplicate Logic	Unlinked ICN Chart Review Duplicate Logic
Health Insurance Claim Number (HICN)	Health Insurance Claim Number (HICN)
Date of Service	Date of Service
Diagnosis Code	Diagnosis Code
Internal Control Number (ICN) From a Previously Stored Chart Review	

3.5.8 Correct/Replace

In order to correct/replace an encounter that has been previously accepted through the EDPPPS, MAOs and other entities may submit correct/replace encounters to the EDS. Correct/replace encounters will supersede previously accepted encounters.
Correct/replace encounters may be submitted for any modification to a previously accepted encounter, including but not limited to, billing or payment information, provider information, diagnosis codes, or procedure codes.

3.5.8.1 Correct/Replace Submission

In order to pass translator and CEM level edits, the correct/replace encounter must be submitted as the final encounter and include all applicable data. MAOs and other entities must indicate correct/replace encounters by populating Loop 2300, CLM05-3='7' and Loop 2300, REF01='F8' and REF02=ICN of the previously accepted encounter.

MAOs and other entities may reference the Correct/Replace business case in the 837-P Companion Guide for operational guidance

Example

Mary Jones went to Dr. Clark and was diagnosed with Diabetes without Complications Type II, Unspecified Not Uncontrolled (25000). Happy Health Plan received, processed, and adjudicated the claim from Dr. Clark and then submitted the encounter to EDS. Happy Health Plan received the 277CA associated with the file, which provided ICN 1567839847389, indicating it was accepted through the EDFES. The encounter was also accepted through the EDPPPS, as notated on the MAO-002 report as an accepted encounter. Two (2) months later, Happy Health Plan receives a claim correction from Dr. Clark to indicate that Mary Jones was actually diagnosed with Diabetes without Complications Type II, Unspecified Uncontrolled (25002). Happy Health Plan received, processed and adjudicated the corrected claim and submitted the encounter to EDS as a correct/replace by correcting the diagnosis code and using Loop 2300, CLM05-3='7' and REF01='F8', REF02= '1567839847389'.

3.5.8.2 Correct/Replace Processing and Pricing Logic

The EDPPPS processes correct/replace encounters by validating that the appropriate correct/replace indicators (CLM05-3='7') and REF01='F8', REF02=ICN are present on an encounter. When all indicator fields have valid values and match an encounter in EODS, the EDPPPS processes and prices the encounter with the information provided on the correct/replace encounter and flags the original encounter as "inactive" and the correct/replace encounter as "active".

There are several EDPPPS edits programmed in order to ensure that correct/replace encounters are processed and priced appropriately. The EDPPPS edits provided in Table 3L pertain specifically to correct/replace encounter data submissions.

TABLE 3L – EDPPPS CORRECT/REPLACE EDITS

EDPS Edit #	EDPS Edit Category	EDPS Edit Disposition	EDPS Edit Error Message
00265	Validation	Reject	Adjustment or Void ICN Not Found in History
00760	Validation	Reject	Claim Adjustment is Already Adjusted or Adjustment is in Progress

3.5.9 Void/Delete

In order to void/delete an encounter that has been previously accepted through the EDPPPS, MAOs and other entities may submit void/delete encounters to the EDS. Void/delete encounters will supersede previously accepted encounters.

A void/delete encounter is submitted when MAOs and other entities determine that a previously submitted and accepted encounter must be completely voided from the EDS.

3.5.9.1 Void/Delete Submission

The void/delete encounter must be submitted with the original encounter's information; however, MAOs and other entities must indicate void/delete by populating Loop 2300, CLM05-3='8' and Loop 2300, REF01='F8' and REF02=ICN of the previously accepted encounter.

Example

Dr. Baker submitted a claim to Best Health Plan. Best Health Plan received, processed and adjudicated the claim and submitted it as an encounter to EDS. The encounter was accepted through EDFES and received ICN 18932709879212 on the 277CA, and was accepted through the EDPS, as notated on the MAO-002 report. Three (3) weeks later, Dr. Baker contacts Best Health Plan to inform them the claim was mistakenly submitted and should not have been. Best Health Plan submits a void/delete encounter to EDS by populating Loop 2300, CLM05-3='8' and REF01='F8', REF02=' 18932709879212'.

MAOs and other entities may reference the Void/Delete business case provided in the 837-P Companion Guide for operational guidance

3.5.9.2 Void/Delete Processing and Pricing Logic

The EDPPPS processes void/delete encounters by validating that the appropriate void/delete indicators (CLM05-3='8') and REF01='F8', REF02=ICN are present on an encounter. When the indicator fields have valid values and match an encounter in EODS, the EDPPPS bypasses processing and pricing edits and flags the original encounter as "inactive".

There are several EDPPPS edits programmed in order to ensure that void/delete encounters are processed. The EDPPPS edits in Table 3M pertain specifically to void/delete encounter data submissions.

TABLE 3M – EDPS VOID/DELETE EDITS

EDPS Edit #	EDPS Edit Category	EDPS Edit Disposition	EDPS Edit Error Message
00265	Validation	Reject	Adjustment or Void ICN Not Found in History
00699	Validation	Reject	Void Submission Must Match Original Encounter
00755	Validation	Reject	Claim to be Voided is Already Voided
00761	Validation	Reject	Unable to Void Due to Different Billing Provider on Void from Original
00762	Validation	Reject	Unable to Void Rejected Claim

3.5.10 Proxy Data Information

All encounters submitted must match the provider's original claim after complete adjudication in the MAO or other entity's internal claims processing system. There are instances in which MAO or other entities must make modifications to the provider's original claim in order to successfully process and price through the EDPPPS. Some of these may include, but are not limited to, the following:

- Alteration of DOS from 2011 to 2012
- Anesthesia modifier
- Removal of rejected lines
- Medicaid service lines

MAOs and other entities must submit Loop 2300, NTE01='ADD' and NTE02 with the language provided below:

- DOS CLAIM CHANGE DUE TO 2011 DOS DURING EDS IMPLEMENTATION PERIOD
- MODIFIER CLAIM CHANGE DUE TO EDS ACCEPTABLE ANESTHESIA MODIFIERS
- REJECTED LINES CLAIM CHANGE DUE TO REJECTED LINE EXTRACTION
- MEDICAID CLAIM CHANGE DUE TO MEDICAID SERVICE LINE EXTRACTION

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information.

3.6 EDPPPS Duplicate Logic

Once an encounter passes through the EDPPPS, it is stored in the EODS. If a new encounter is submitted that matches specific values to another stored encounter, the encounter will be rejected and will be considered a duplicate encounter. The encounter will be returned to the submitter on the MAO-002 report with error message 98325 – Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim, identifying it as a duplicate encounter. The following values are the minimum values being used for matching encounters in the EODS:

- Beneficiary Demographic
  - Health Insurance Claim Number (HICN)
  - Last Name
- Date of Service
- Place of Service (2 digits)
- ***Type of Service – not submitted on the 837-P but derived from data captured***
- Procedure Code(s) and four (4) modifiers
- Rendering Provider NPI
- Paid Amount*

* The Paid Amount is the amount paid by the MAO or other entity and must be populated in Loop ID-2320, AMT02

3.7 Summary

During this module, submission, processing, and pricing requirements for Professional/Physician Supplier encounter data were provided. Participants were informed of the top EDPPPS beneficiary, provider, and validation edits, as well as prevention and resolution strategies to assist in successful submission of encounter data to the EDS. Special considerations for encounter data submissions were also identified and operational guidance was provided.

MODULE 4 – INSTITUTIONAL SUBMISSION

Purpose

CMS requires Medicare Advantage Organizations (MAOs) and other entities to submit all encounters, regardless of source of care. As a result, MAOs and other entities must understand the unique requirements for the collection, processing, and submission of Institutional encounter data. This module is designated to specify the data collection, submission, and processing principles for Institutional encounter data in accordance with the CMS requirements.

Learning Objectives

At the completion of this module, participants will be able to:

- Demonstrate knowledge in interpreting inpatient and outpatient Institutional services.
- Identify the top Encounter Data Institutional Processing and Pricing System (EDIPPS) error logic.
- Determine error prevention and resolution strategies.
- Apply the appropriate operational guidance for the processing of Institutional encounters.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

4.1 Institutional Services

Institutional services are the services performed in an inpatient or outpatient setting by an Institutional provider. Institutional services acceptable for encounter data may include services rendered in an inpatient hospital, outpatient hospital, and other clinic or facility settings.

4.2 Institutional Submission Format

Currently in FFS, Institutional services are billed using Type of Bill (TOB) and revenue codes. In order to capture all necessary data, including TOB codes and revenue codes, to accurately edit, process, and price Institutional encounter data submissions, MAOs and other entities are required to submit encounter data in the HIPAA compliant standard Health Care Claims transaction for Institutional data (currently using Implementation Guide (IG) ASC X12N 837/005010X223 with Errata for ASC X12N 837/005010X223A2), as defined in the Washington Publishing Company (WPC) Technical Report Type 3 (TR3) 5010 X12.

Washington Publishing Company - www.wpc-edi.com

4.2.1 837-I

The current 837-I TR3 is the foundation for encounter data submission. It provides detailed guidance on the appropriate structure and function of loops, segments, and data elements. Upon submission, the 837-I is processed through the Encounter Data Front-End System (EDFES) where translator and CEM level editing occur.

Several CEM edits active in the CMS CEM Edits Spreadsheet will be permanently deactivated in order to ensure syntactically correct encounters pass EDFES editing. Table 4A provides the current EDFES edits that are deactivated. The edit reference column provides the exact edit reference that will be deactivated. The edit description column provides the Claim Status Category Code (CSCC), the Claim Status Code (CSC) and the Entity Identifier Code (EIC), when applicable. The notes column provides a description of the edit reason. MAOs and other entities should reference the WPC website at www.wpc-edi.com for a complete listing of all CSCC and CSCs.

TABLE 4A – 837-I PERMANTENTLY DEACTIVED CEM EDITS

Edit Reference	Edit Description	Edit Notes
X223.084.2010AA.NM109.040	CSCC A8: “Acknowledgement/rejected for relational field in error” CSC 562: “Entity’s National Provider Identifier (NPI)” EIC 85: “Billing Provider”	Valid NPI Crosswalk must be available for this edit. 2010AA.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109.
X223.084.2010AA.NM109.050	CSCC A8: “Acknowledgement/rejected for relational field in error” CSC 496: “Submitter not approved for electronic claim submission on behalf of this entity”” EIC 85: “Billing Provider”	2010AA.NM109 billing provider must be “associated” to the submitter (from a trading partner management perspective) in 1000A.NM109.
X223.087.2010AA.N301.070	CSCC A7: “Acknowledgement/rejected for invalid information” CSC 503: “Entity’s Street Address” EIC 85: “Billing Provider”	2010AA.N301 must not contain the following exact phrases (not case sensitive): "Post Office Box", "P.O. BOX", "PO BOX", "LOCK BOX", "LOCK BIN", "P O BOX".
X223.090.2010AA.REF02.050	CSCC A8: “Acknowledgement/rejected for relational field in error” CSC 562: “Entity’s National Provider Identifier (NPI)” CSC 128: “Entity’s Tax ID” EIC 85: “Billing Provider”	Valid NPI Crosswalk must be available for this edit. 2010AA.REF must be associated with the provider identified in 2010AA.NM109.
X223.127.2010BB.REF.010	CSCC A7: “Acknowledgement/rejected for invalid information” CSC 732: “Information inconsistent with billing guidelines” CSC 560: “Entity’s Additional/Secondary Identifier” EIC PR: “Payer”	Non-VA claims: 2010BB.REF with REF01=”2U”, “EI”, “FY”, or “NF” must not be present. VA claims: 2010BB.REF with REF01=”EI”, “FY”, or “NF” must not be present.
X223.424.2400.SV202-7.025	CSCC A8: “Acknowledgement/rejected for relational field in error” CSC 306: Detailed description of service	2400.SV202-7 must be present when 2400.SV202-2 contains a non-specific procedure code.

4.2.2 Minimum Data Elements

Based on research and MAO and other entity comments, the minimum data elements required in order to pass EDS translator and CEM level edits were developed. MAOs and other entities must include at least these minimum data elements when submitting encounter data, including paper, 4010, foreign provider, and chart review encounters.

The situational fields associated with these minimum data elements must be submitted if the situation is present. Loops, segments, and data elements with an asterisk ("*") denote the situational fields associated with the minimum data elements that occur commonly in encounter data submissions. **This list is not inclusive of all situational loops, segments, and data elements in the 837-I TR3.** MAOs and other entities must refer to the 837-I TR3 and CEM edits spreadsheet to determine the correct usage of situational fields. Table 4B provides the minimum file header and trailer level data elements.

TABLE 4B – HEADER AND TRAILER LEVEL MINIMUM DATA ELEMENTS

Reference	Reference Description
ISA01 – ISA16	Interchange Control Header
GS01 – GS08	Functional Group Header
ST01 – ST03	Transaction Set Header
BHT01 – BHT06	Beginning of Hierarchical Transaction
SE01 – SE02	Transaction Set Trailer
GE01 – GE02	Functional Group Trailer
IEA01 – IEA02	Interchange Control Trailer

Table 4C provides the minimum detail level data elements.

TABLE 4C – DETAIL LEVEL MINIMUM DATA ELEMENTS

Loop ID	Reference	Reference Description
LOOP ID 1000A – SUBMITTER INFORMATION		
1000A	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Organization Name/Last Name
	NM108	Identification Code Qualifier
	NM109	Submitter ID
	PER01	Contact Function Code
	PER02	Submitter Contact Name
	PER03	Communication Qualifier
	PER04	Communication Number
LOOP ID 1000B – RECEIVER INFORMATION		
1000B	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Organization Name
	NM108	Identification Code Qualifier
	NM109	Receiver Identifier
LOOP ID 2000A – BILLING PROVIDER HIERARCHICAL LEVEL		
2000A	HL01	Hierarchical ID Number
	HL03	Hierarchical Level Code
	HL04	Hierarchical Child Code

TABLE 4C – DETAIL LEVEL MINIMUM DATA ELEMENTS (CONTINUED)

Loop ID	Reference	Reference Description
LOOP ID 2010AA – BILLING PROVIDER INFORMATION		
2010AA	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Organization Name/Last Name
	NM108	Identification Code Qualifier
	NM109	National Provider Identifier (NPI)
	N301	Billing Provider Street
	N401	Billing Provider City
	N402	Billing Provider State
	N403	Billing Provider ZIP Code
	REF01	Reference Identification Qualifier
	REF02	Billing Provider Tax Identification Number
LOOP ID 2000B – SUBSCRIBER HIERARCHICAL LEVEL		
2000B	HL01	Hierarchical ID Number
	HL02	Hierarchical Parent ID Number
	HL03	Hierarchical Level Code
	HL04	Hierarchical Child Code
	SBR01	Payer Responsibility Sequence Number
	SBR02	Individual Relationship Code
	SBR03*	Subscriber Group or Policy Number
	SBR04*	Insured Group Number
	SBR05*	Insurance Type Code
	SBR09*	Claim Filing Indicator Code
LOOP ID 2010BA – SUBSCRIBER INFORMATION		
2010BA	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Subscriber Last Name
	NM104	Subscriber First Name
	NM105*	Subscriber Middle Name
	NM107*	Subscriber Name Suffix
	NM108	Identification Code Qualifier
	NM109	Subscriber HICN
	N301	Subscriber Street
	N401	Subscriber City
	N402	Subscriber State
	N403	Subscriber ZIP Code
	DMG01	Date Format Qualifier
	DMG02	Subscriber Date of Birth
	DMG03	Subscriber Gender
LOOP ID 2010BB – PAYER INFORMATION		
2010BB	NM101	Entity Identifier Code
	NM102	Entity Type Description
	NM103	Name Last or Organization
	NM108	Identification Code Qualifier
	NM109	Payer Identification (EDSCMS)
	N301	Payer Street
	N401	Payer City
	N402	Payer State

TABLE 4C – DETAIL LEVEL MINIMUM DATA ELEMENTS (CONTINUED)

Loop ID	Reference	Reference Description
2010BB	N403	Payer ZIP Code
	REF01	Reference Identification Qualifier – Payer Identification Number
	REF02	Reference Identification – Payer Additional Identifier (Contract ID)
LOOP ID 2300 – CLAIM INFORMATION		
2300	CLM01	Claim Submitter's Identifier (Patient Control Number)
	CLM02	Monetary Amount
	CLM05-1	Facility Type Code
	CLM05-2	Facility Code Qualifier
	CLM05-3	Claim Frequency Type Code
	CLM07	Assignment or Plan Participation Code
	CLM08	Benefits Assignment Certification Indicator
	CLM09	Release of Information Code
	CLM11-1*	Related Causes Code Indicator
	CLM11-2*	Related Causes Code
	DTP01*	Date Time Qualifier – Discharge Hour
	DTP02*	Date Time Period Format Qualifier – Discharge Hour
	DTP03*	Date Time Period – Discharge Hour
	DTP01	Date Time Qualifier – Statement Date
	DTP02	Date Time Period Format Qualifier
	DTP03	Date Time Period
	DTP01*	Date Time Period Qualifier – Admission
	DTP02*	Date Time Period Qualifier
	DTP03*	Date Time Period
	PWK01*	Report Type Code
	PWK02*	Attachment Transmission Code
	CL101*	Admission Type Code – Institutional Claim Code
	CL102*	Admission Source Code
	CL103	Patient Status Code
	REF01*	Original Reference Number
	REF02*	Payer Claim Control Number
	HI01-1	Diagnosis Type Code Qualifier – Principal Diagnosis
	HI01-2	Diagnosis Code – Principal Diagnosis
	HI01-1*	Code List Qualifier Code – Occurrence Span Code
	HI01-2*	Industry Code – Occurrence Span Code
	HI01-3*	Date Time Period Format Qualifier
	HI01-4*	Date Time Period – Occurrence Span Code Date
	HI01-1*	Code List Qualifier Code – Occurrence Code
	HI01-2*	Industry Code – Occurrence Code
	HI01-1*	Code List Qualifier Code- Value Code
	HI01-2*	Industry Code – Value Code
	HI01-1*	Code List Qualifier Code – Condition Code
	HI01-2*	Industry Code – Condition Code
LOOP ID 2320 – OTHER SUBSCRIBER INFORMATION		
2320	SBR01	Payer Responsibility Sequence Number
	SBR02	Individual Relationship Code
	SBR09	Claim Filing Indicator Code
	CAS01*	Claim Adjustment Group Code
	CAS02*	Claim Adjustment Reason Code

TABLE 4C – DETAIL LEVEL MINIMUM DATA ELEMENTS (CONTINUED)

Loop ID	Reference	Reference Description
2320	CAS03*	Monetary Amount
	AMT01	Amount Qualifier Code
	AMT02	Payer Paid Amount
	OI03	Benefits Assignment Certification Indicator
	OI06	Release of Information Code
LOOP ID 2330A – OTHER SUBSCRIBER NAME		
2330A	NM101	Entity Identifier Code
	NM102	Entity Type Qualifier
	NM103	Subscriber Last Name
	NM108	Identification Code Qualifier
	NM109	Subscriber HICN
	N301	Subscriber Street
	N401	Subscriber City
	N402	Subscriber State
	N403	Subscriber ZIP Code
LOOP ID 2330B – OTHER PAYER NAME		
2330B	NM101	Entity Identifier Code
	NM102	Entity Type Description
	NM103	Name Last or Organization
	NM108	Identification Code Qualifier
	NM109	Payer Identification
	N301	Payer Street
	N401	Payer City
	N402	Payer State
	N403	Payer ZIP Code
	REF01*	Reference Identification Qualifier – Signal code
	REF02*	Other Payer Claim Adjustment Indicator
LOOP ID 2400 – SERVICE LINE INFORMATION		
2400	LX01	Assigned Number
	DTP01	Date Time Qualifier - Service
	DTP02	Date Time Period Format Qualifier
	DTP03	Service Date
	SV201	Service Line Revenue Code
	SV202-1*	Product or Service ID Qualifier
	SV202-2*	Procedure Code
	SV202-3*	Procedure Modifier
	SV203	Monetary Amount
	SV204	Unit or Basis for Measurement Code
	SV205	Quantity
	SV207*	Non-Covered Charge Amount
LOOP ID 2430 – SERVICE LINE ADJUDICATION INFORMATION		
2430	SVD01*	Identification Code – Other Payer Primary Identifier
	SVD02*	Monetary Amount – Service Line Paid Amount
	SVD03-1*	Product/Service ID Qualifier
	SVD03-2*	Procedure Code

4.3 Type of Bill (TOB)

The EDIPPS was developed to have similar processing characteristics as that of Fee-For-Service (FFS). Processing of submitted encounter data from Institutional sources of data will follow FFS methodologies according to the TOB and revenue code populated on the encounter. All bill types provided in subsections 4.3 below will be accepted for encounter data submission.

4.3.1 Hospital

MAOs and other entities are able to submit encounters for hospital inpatient (Medicare Parts A and Part B) and hospital outpatient services (Medicare Part B). In order for services to be covered under Medicare Part A or Part B, a hospital must furnish non-physician services to its inpatients directly or under arrangements. A non-physician service is one which does not meet the criteria defining Physicians' services specifically provided for in regulation 42 CFR 415.102.

4.3.1.1 Hospital Inpatient

Inpatient hospital services are defined in Title XVIII of the Social Security Act (the Act) and in the regulations (42 CFR 409.10) as services furnished to an inpatient of a participating hospital or Critical Access Hospital (CAH), or to an inpatient of a qualified hospital, such as the following:

- Bed and board
- Nursing services and other related services
- Use of hospital or CAH facilities
- Medical social services
- Certain other diagnostic or therapeutic services
- Medical or surgical services provided by certain interns or residents in-training
- Transportation services, including transport by ambulance

An inpatient Institutional service is provided by a hospital when a patient is admitted to the facility for purposes of receiving inpatient hospital services for at least one (1) overnight stay.

4.3.1.1.1 Hospital Inpatient – Part A

Beneficiaries covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services under Chapter 8, §10.1 "Hospital Providers of Extended Care Services." Medicare Part A covers the following types of services:

- A semi-private room (two to four beds in a room) or private room, when medically necessary or when in a hospital that only has one bed in each room
- All meals, including special diets
- Regular nursing services
- Costs of special care units such as intensive care units, coronary care units, etc.
- Certain lab tests included in the hospital bill and other diagnostic tests provided up to 72 hours prior to admission if related to reason for admission.
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- Operating and recovery room costs

- Rehabilitation services such as physical therapy, occupational therapy and speech pathology services
- Blood transfusions furnished by the hospital during the stay after beneficiary pays for first three unreplaced pints of blood
- Customary medical social services, including discharge
- Psychiatric Care
- Lifetime benefit of 190 days of inpatient care received in a participating psychiatric hospital
- Regular deductibles or coinsurance are required, based on benefit period
- Lifetime reserve days can be used for care received in a psychiatric hospital
- If beneficiary is an inpatient in a participating psychiatric hospital at the time Part A coverage begins, then the number of days of the beneficiary's first benefit period for which payment can be made under Part A will be reduced by the number of days he or she has already been hospitalized (not necessarily consecutively) in the psychiatric institution in the prior 150 days.

Table 4D provides the full list of hospital inpatient Part A sources of data and their associated TOB codes that are acceptable for encounter data submission.

TABLE 4D – HOSPITAL INPATIENT PART A/TOB

Encounter Data Facility Service	Type Of Bill
Inpatient Hospital	11X
Inpatient Rehabilitation Facility	11X
Inpatient Psychiatric Facility	11X
Long-Term Care Hospital	11X
Critical Access Hospital Inpatient/Swing Bed	11X, 18X
Skilled Nursing Facility Inpatient/Swing Bed	18X
Skilled Nursing Facility Inpatient – Part A	21X
Federally Qualified Health Center	77X

Example

Redwood Health Plan received a claim from Mercy Hospital for Mary Washington, who was admitted to Mercy on January 5, 2012 and discharged on February 28, 2012 due to pneumonia. Redwood Health Plan adjudicates the claim and submits the encounter with a TOB 11X, as well as the required minimum data elements.

4.3.1.1.2 Hospital Inpatient – Part B

In addition to submission of Hospital Inpatient – Part A services, MAOs and other entities are also able to submit encounters for services covered under Hospital Inpatient – Part B. Medicare Part B covers the following types of inpatient hospital services:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Screening mammography services
- Screening pap smears
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Colorectal screening
- Bone mass measurements

- Diabetes self-management
- Prostate screening
- Ambulance services
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision
- Epoetin Alfa (EPO)

Table 4E provides the full list of Hospital Inpatient – Part B sources of data and their associated TOB codes that are acceptable for encounter data submission.

TABLE 4E – HOSPITAL INPATIENT PART B/TOB

Encounter Data Facility Service	Type Of Bill
Hospital Inpatient – Part B	12X
Skilled Nursing Facility Inpatient – Part B	18X, 28X

4.3.1.2 Hospital Outpatient

A hospital outpatient is an individual who does not require an overnight or more than 24-hour stay in the hospital but is registered in the hospital records as an outpatient and receives services from the hospital. Medicare Part B covers both the diagnostic and therapeutic services furnished by a hospital to outpatients. Table 4F provides the full list of hospital outpatient sources of data and their associated TOB codes for collection of encounter data.

TABLE 4F – HOSPITAL OUTPATIENT/TOB

Encounter Data Facility Service	Type Of Bill
Hospital Outpatient	13X, 14X
Skilled Nursing Facility Outpatient	23X
Religious Non-Medical Health Care Institution	41X
Rural Health Clinic	71X
End-Stage Renal Disease Facility	72X
Outpatient Rehabilitation Facility (ORF/CORF)	74X, 75X
Community Mental Health Center	76X
Free Standing Clinic	77X
Ambulatory Surgical Center	83X
Critical Access Hospital Outpatient	85X

4.3.1.3 Critical Access Hospital

Under the Balanced Budget Act (BBA) of 1997, certain states were authorized to establish a State Medicare Rural Hospital Flexibility Program (Flex Program) under which specific facilities participating in Medicare were permitted to become Critical Access Hospitals (CAHs). A Medicare participating hospital must meet the following criteria to be considered as a CAH:

- Be located in a State that has established a State Medicare Rural Hospital Flexibility Program
- Be designated by the State as a CAH
- Be located in a rural area or an area that is treated as rural

- Be located either more than 35-miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, certified as a CAH based on State designation as a "necessary provider" of health care services to residents in the area
- Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units)
- Demonstrate compliance with the CAH CoPs found at 42 CFR Part 485 subpart F
- Furnish 24-hour emergency care services 7 days a week

Under the Social Security Act, specified small, rural hospitals are permitted to enter a swing bed agreement. Under this agreement, the hospital can use its beds, as needed, to provide acute or skilled nursing care to the patient. As defined by federal regulations, a swing bed hospital is a hospital or critical access hospital participating in Medicare that has approval to provide post-hospital skilled care. Beneficiaries must receive acute care at a hospital or critical access hospital (CAH) inpatient for a medically necessary stay of at least three (3) consecutive days in order to quality for coverage of skilled nursing services.

Table 4G provides the full list of CAH sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4G – CRITICAL ACCESS HOSPITAL/TOB

Encounter Data Facility Service	Type Of Bill
Critical Access Hospital/Swing Bed	11X, 18X
Critical Access Hospital	85X

4.3.2 Skilled Nursing Facility

A Skilled Nursing Facility (SNF) is a nursing facility with the staff and equipment to provide skilled nursing care and/or skilled rehabilitation services and other related health care services to Medicare beneficiaries who have been admitted to facilities.

Revenue code 0022 indicates that the encounter should be priced according to the SNF pricing methodologies and is required on all SNF encounters submitted to the EDS. This revenue code can be used as often as necessary on an encounter to indicate the changes to the beneficiaries' Health Insurance Prospective Payment System (HIPPS) rate code based on the reassessment period. The HIPPS rate consists of the three (3) character resource utilization group (RUG-III) code that is obtained from the grouper software program followed by a two (2) digit assessment indicator that specifies the type of assessment associated with the RUG code. The current RUG-III system consists of eight (8) major resident types:

- Rehabilitation plus extensive services
- Rehabilitation
- Extensive services
- Special care
- Clinically complex
- Impaired cognition
- Behavior programs
- Reduced Physical Function

Table 4H provides the full list of SNF sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4H – SKILLED NURSING FACILITY/TOB

Encounter Data Facility Service	Type Of Bill
SNF Inpatient – Part A	21X
SNF Inpatient – Part B	22X
SNF Outpatient	23X
SNF Swing Bed	28X

4.3.3 Home Health Agencies

Home Health Agencies (HHAs) provide care to homebound individuals who are ill or injured and require intermittent (part-time) skilled nursing services or skilled therapy services provided under a home health plan of care.

Medicare covers HHA services when the following criteria are met:

- The person to whom the services are provided is an eligible Medicare beneficiary
- The HHA that is providing the services to the beneficiary has a valid agreement to participate in the Medicare program
- The beneficiary qualifies for coverage of home health services, including the following:
  - Confined to the home
  - Under the care of a physician
  - Receiving services under a plan of care established and periodically reviewed by a physician
  - In need of skilled nursing care on an intermittent basis, physical therapy, or speech language pathology
  - Have a continued need for occupational therapy
- Medicare is the appropriate payer
- The services for which payment is claimed are not otherwise excluded from payment

The instrument/data collection tool used to collect and report performance data by HHAs is the Outcome and Assessment Information Set (OASIS). Since 1999, CMS has required Medicare-certified HHAs to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare with the exception of patients receiving pre- or postnatal services only. OASIS data is used to calculate several types of quality reports which are provided to HHAs to help guide quality and performance improvement efforts.

Data from the OASIS is used to develop the Health Insurance Prospective Payment System (HIPPS) codes based on clinical and functional status.


Home Health encounters are not currently required for encounter data submission


See also Section 2.4.6: Home Health Submission in the Policy, Monitoring, and Compliance Module.

Table 4I provides the full list of HHA sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4I – HOME HEALTH AGENCY/TOB

Encounter Data Facility Service	Type Of Bill
Home Health Inpatient – Part B	32X
Home Health Outpatient	33X
Home Health – Other	34X

4.3.4 Religious Non-Medical Health Care Institution

The Social Security Act provides for coverage of services furnished in a Medicare qualified religious nonmedical health care institution (RNHCI), when the beneficiary meets specific coverage conditions. In order to be considered a RNHCI, the following conditions must be met:

- Provide only nonmedical nursing items and services to patients who choose to rely solely on a religious method of healing and for whom the acceptance of medical services would be inconsistent with their religious beliefs
- Provide nonmedical items and services through nonmedical nursing personnel
- Provide nonmedical items and services to inpatients 24 hours a day
- Do not provide on the basis of its religious beliefs, through its personnel or otherwise, medical items and services for its patients
- Is not owned by or affiliated with a provider of medical treatment or services
- Have a utilization review plan

Table 4J provides the full list of religious nonmedical health care institution sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4J – RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION/TOB

Encounter Data Facility Service	Type Of Bill
Religious Non-Medical Health Care Institution	41x

4.3.5 Rural Health Clinic

Rural Health Clinics (RHCs) are clinics located in areas designated by the Census Bureau and the Secretary of the Department of Health and Human Services (DHHS) as medically underserved. To qualify as an RHC, a clinic must meet the following criteria:

- Be located in a non-urbanized area, as defined by the Census Bureau
- Be located in an area currently designated by the Health Resources and Services Administration as one of the following types of Federally designated or certified underserved areas:
  - Primary Care Geographic Health Professional Shortage Area (HPSA) under section 332(a)(1)(A) of the Public Health Service (PHS) Act
  - Primary Care Population Group HPSA under Section 332(a)(1)(B) of the PHS Act
  - Medically underserved area under Section 332(b)(3) of the PHS Act
  - Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act of 1989
- Directly furnish routine diagnostic and laboratory services

- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC
- Have available drugs and biologicals necessary for the treatment of emergencies
- Furnish onsite all of the following laboratory tests:
  - Chemical examination of urine by stick or tablet method or both
  - Hemoglobin or hematocrit
  - Blood sugar
  - Examination of stool specimens for occult blood
  - Pregnancy tests
  - Primary culturing for transmittal to a certified laboratory
- Have an annual program evaluation
- Not be a rehabilitation agency or facility that is primary for the treatment of mental disease
- Not be a Federally Qualified Health Center (FQHC)

Cost reports also play an integral role in payment to Independent and hospital-based RHCs in order to identify all incurred costs applicable to furnishing covered RHC services. Currently in FFS, at the end of the annual cost reporting period, RHCs submit a report that includes actual allowable costs and actual visits for RHC services for the reporting period and any other information that may be required.

For encounter data purposes, MAOs and other entities must not submit Cost Reports to the EDS.

Table 4K provides the full list of RHC sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4K – RURAL HEALTH CLINIC/TOB

Encounter Data Facility Service	Type Of Bill
Rural Health Clinic	71x

4.3.6 End-Stage Renal Disease Clinic

End-Stage Renal Disease (ESRD) clinics are facilities that are approved to provide at least one specific ESRD service. Such facilities include the following:

- Renal Transplantation Center – A hospital unit which is approved to furnish transplantation and other medical and surgical specialty services required for the care of the ESRD transplant patients, including inpatient dialysis furnished directly or under arrangement
- Renal Dialysis Center – a hospital unit which is approved to furnish diagnostic, therapeutic, and rehabilitative services required for the care of ESRD dialysis patients
- Renal Dialysis Facility – An independent unit that is approved to furnish dialysis services directly to ESRD patients
- Self-Dialysis Unit – A unit that is part of an approved renal transplantation center, renal dialysis center or renal dialysis facility, and provides self-dialysis services
- Special Purpose Renal Dialysis Facility – a renal dialysis facility that is approved to furnish dialysis at special locations on a short-term basis to a group of dialysis patients otherwise unable to obtain treatment

Table 4L provides the full list of ESRD clinic sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4L – ESRD CLINIC/TOB

Encounter Data Facility Service	Type Of Bill
ESRD Clinic	72x

4.3.7 Comprehensive Outpatient Rehabilitation Facility

The purpose of Comprehensive Outpatient Rehabilitation Facilities (CORFs) is to provide beneficiaries with multidisciplinary, coordinated and rehabilitation services at a single location. Section 1861(cc) of the Social Security Act specifies that no service may be covered as a CORF service if it would not be covered as an inpatient hospital service if provided to a hospital patient.

The following are considered "core" services that CORFs provide:

- Physician services
- Physical therapy services
- Social and/or psychological services

In addition to the core services, CORF may also provide any or all of the following rehabilitation services:

- Occupational therapy
- Speech – Language pathology
- Respiratory therapy
- Prosthetic and orthotic devices
- Nursing

Table 4M provides the full list of CORF sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4M – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY/TOB

Encounter Data Facility Service	Type Of Bill
CORF Clinic	75x

4.3.8 Community Mental Health Center

A Community Mental Health Center (CMHC) provides services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility. The core services provided by a CMHC are:

- 24 hour-a-day emergency care services
- Day treatment or other partial hospitalization services or psychosocial rehabilitation services

- Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission

Table 4N provides the full list of CMHC sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4N – COMMUNITY MENTAL HEALTH CENTER/TOB

Encounter Data Facility Service	Type Of Bill
Community Mental Health Center	76x

4.3.9 Federally Qualified Health Center

Federally Qualified Health Centers (FQHCs) provide services that are similar to those provided by RHCs, but also include preventative primary services. The following includes preventive primary services that may be provided by FQHCs:

- Medical social services
- Nutritional assessment and referral
- Preventive health education
- Children's eye and ear examinations
- Prenatal and post-partum care
- Prenatal services
- Well child care, including periodic screenings
- Immunizations
- Voluntary family planning services
- Blood pressure measurement
- Weight measurement
- Physical examination targeted risk
- Visual acuity screening
- Hearing screening
- Cholesterol screening
- Stool testing for occult blood
- Dipstick urinalysis
- Risk assessment and initial counseling regarding risks

Table 4O provides the full list of FQHC sources of data and the associated TOB codes that are acceptable for encounter data submission.

TABLE 4O – FEDERALLY QUALIFIED HEALTH CENTER

Encounter Data Facility Service	Type Of Bill
Federally Qualified Health Center	77x

4.4 Institutional Processing Logic

The Encounter Data Institutional Processing and Pricing System (EDIPPS) was developed to edit, process, and price managed care encounter data for use in the calibration of the risk adjustment model based on FFS-like pricing methodologies.

Institutional encounters are submitted to the EDFES for translator and CEM level editing. Once encounters pass the EDFES edits, they are then transferred to the EDIPPS.

4.4.1 EDIPPS Edits

The EDIPPS contains edits that are applied to each encounter submission, which are organized in nine (9) different categories, including the following:

- Validation
- Provider
- Beneficiary
- Reference
- Limit
- Conflict
- Pricing
- NCCI
- Duplicate

The Professional Submission module provides detailed system header and line level logic, which is also applicable to the EDIPPS.

Table 4P below provides the complete list of EDIPPS edits to date.

TABLE 4P – EDIPPS EDITS

EDIPPS Edit #	EDIPPS Edit Category	EDIPPS Edit Disposition	EDIPPS Edit Error Message
00010	Validation	Reject	From Date Of Service Is Greater Than TCN Date
00011	Validation	Reject	From or To Date Of Service Missing in the Claim – Header or Line
00012	Validation	Reject	Date Of Service Is Less Than 01-01-2012
00025	Validation	Reject	To Date Of Service Is After Date Of Claim Receipt
00265	Validation	Reject	Adjustment Or Void ICN Not Found In History
00699	Validation	Reject	Void Submission Must Match Original Encounter
00761	Validation	Reject	Unable To Void Due To Different Billing Provider On Void From Original
01405	Provider	Reject	Sanctioned Provider
01415	Provider	Informational	Rendering Provider Not Eligible For Date Of Service
02106	Beneficiary	Informational	Invalid Beneficiary Last Name
02110	Beneficiary	Reject	Beneficiary Health Insurance Carrier Number (HICN) Not On File
02112	Beneficiary	Reject	Date Of Service Is After Beneficiary Date Of Death
02120	Beneficiary	Informational	Beneficiary Gender Mismatch
02125	Beneficiary	Reject	Beneficiary Date Of Birth Mismatch

TABLE 4P – EDIPPS EDITS (CONTINUED)

EDIPPS Edit #	EDIPPS Edit Category	EDIPPS Edit Disposition	EDIPPS Edit Error Message
02240	Beneficiary	Reject	Beneficiary Not Enrolled In Medicare Advantage Organization For Date Of Service
02255	Beneficiary	Reject	Beneficiary Not Part A Eligible For Date Of Service
02256	Beneficiary	Reject	Beneficiary Not Part C Eligible For Date Of Service
03015	Reference	Reject	DOS Spans Procedure Code Effective/End Date
03022	Pricing	Reject	Invalid Case Mix Group For Inpatient Rehabilitation Facility Claim
03101	Reference	Reject	Invalid Gender For Procedure Code
03102	Pricing	Reject	Provider Type Or Specialty Not Allowed To Bill For Procedure
17085	Validation	Reject	Inpatient/SNF Same Day Transfer Must Have Condition Code 40
17100	Validation	Reject	Type Of Bill - Home Health Claim Missing Date Of Service
17257	Validation	Informational	Revenue - Revenue Code 910 Not Allowed
17285	Validation	Reject	Billed Lines Require Charges (Few Exceptions)
17295	Conflict	Reject	Inpatient Claim Missing Revenue Code Or Outpatient Claim Missing Either Revenue Code Or HCPCS Code
17310	Validation	Reject	Surgical Revenue Code 036X Requires Surgical Procedure Code
17330	Reference	Reject	Adjustment Not Allowed For A RAP
17404	Validation	Reject	Procedure - HCPCS Code Cannot Be Duplicated And Max Unit Of 1 Per Visit
17407	Validation	Reject	Procedure - HCPCS Modifier Without HCPCS Code
17590	Validation	Reject	Value Code - Code 5 Not Present Or Conflicts With Dollar Amount
17595	Validation	Reject	Value Code - Code 5 And Revenue Codes Not Allowed
17735	Validation	Reject	Modifier - Not Within Effective Date
18010	Reference	Informational	Age Conflict With Diagnosis
18012	Reference	Informational	Gender – Inconsistency With Diagnosis
18018	Reference	Informational	Gender - Inconsistency With Procedure Code
18120	Reference	Reject	ICD-9 Diagnosis Code Error
18121	Reference	Reject	ICD-9 Procedure Code Error
18130	Reference	Reject	Diagnosis - Principal Diagnosis Code Is A Duplicate
18135	Reference	Reject	Diagnosis - Principal Diagnosis Code Is A Manifestation Code
18140	Reference	Reject	Diagnosis - Principal Diagnosis Is An E-Code
18145	Reference	Reject	Diagnosis - Unacceptable Code
18260	Reference	Reject	Revenue - Code Not Recognized
18265	Reference	Informational	Revenue - Diagnosis Code V70.7 Required
18270	Validation	Informational	Revenue Code and HCPCS Code Required On Outpatient
18495	Validation	Reject	Procedure - Invalid Digit
18500	Conflict	Informational	Procedure - Multiple Codes For The Same Service
18540	Reference	Informational	Procedure – Service Unit Out Of Range On Same Claim
18705	Validation	Reject	Discharge Status Is Invalid
18710	Validation	Reject	POA Indicator - Missing Or Invalid
18730	Reference	Reject	Modifier - Invalid Format
18905	Validation	Reject	Age Is 0 Or Exceeds 124
20035	Validation	Reject	Outpatient Claim Requires Date Of Service For Revenue Code 57X
20270	Validation	Reject	Admit From And Thru Dates Are Same; Day Count Does Not Equal 1
20450	Validation	Reject	Attending Physician is Sanctioned

TABLE 4P – EDIPPS EDITS (CONTINUED)

EDIPPS Edit #	EDIPPS Edit Category	EDIPPS Edit Disposition	EDIPPS Edit Error Message
20455	Validation	Informational	Operating Provider Is Sanctioned
20500	Conflict	Reject	Valid Service Date For Revenue Code Billed
20505	Conflict	Reject	Accurate Ambulance HCPCS and Revenue Code Required
20510	Conflict	Reject	Revenue Code 0540 Requires Specific HCPCS Codes
20520	Validation	Reject	Invalid Ambulance Pickup Location
20530	Validation	Reject	ZIP Code Cannot Be 0 or Blank For Ambulance Pickup
20835	Pricing	Reject	Service Line Date Of Service Must Be Valid And Within Header Date of Service
20980	Pricing	Informational	Provider Not Eligible To Bill TOB 12X or 22X
21925	Pricing	Reject	Conditions For Swing Bed SNF PPS Claim Are Not Met
21950	Pricing	Reject	Line Level DOS Is Required For Outpatient Claim
25000	NCCI	Informational	Correct Code Initiative Error
98325	Duplicate	Reject	Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim

4.4.1.1 Top Beneficiary Edits

Beneficiary edits ensure that the correct beneficiary is associated with the submitted encounter. Accurate beneficiary data will ultimately impact the risk score calculation. The beneficiary edits identified in Module 3 – Professional Submission are also applicable for Institutional submissions and utilize the same editing processes to correct errors with population of Beneficiary data. The most common beneficiary edits generated are:

- 02110 – Beneficiary Health Insurance Carrier Number (HICN) Not On File
- 02112 – Date of Service is After Beneficiary Date of Death
- 02125 – Beneficiary Date of Birth Mismatch
- 02240 – Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service
- 02255 – Beneficiary Not Part A Eligible for the Date of Service

Example

Mary Jackson was admitted to NC Hospital for chest pain. During her inpatient stay at NC Hospital, Mary Jackson expired on January 12, 2012. NC Hospital submitted a claim to North Carolina Health Plan for Mary Jackson's inpatient services and included a Date of Service of January 19, 2012. North Carolina Health Plan adjudicates the claim, converts it to an outbound encounter and submits it to EDS. The encounter successfully processes through the EDFES and a 277CA is returned with an ICN of 19847582821. North Carolina Health Plan then receives an MAO-002 report indicating that encounter ICN 19847582821 was rejected due to edit "02112 – Date of Service is After Beneficiary Date of Death". North Carolina Health Plan verifies the date of death against their internal enrollment file, which states that Mary Jackson expired on February 3, 2012. North Carolina Health instructs Ms. Jackson to contact the Social Security Administration (SSA) to verify and discovers that Ms. Jackson's date of death in the SSA's records is January 12, 2012. In order to resolve the matter, North Carolina Health Plan must coordinate with the provider to ensure the DOS provided on the encounter is correct and is prior to the date of death, since SSA's records provide the correct source of verification.

4.4.1.2 Top Provider Edits

Provider edits ensure that Institutional providers are valid and eligible to render the service(s) identified on encounter submission. The provider edits identified in Module 3 – Professional Submission are also applicable for Institutional submissions and utilize the same editing processes to identify errors with population of provider data.

- 01405 – Sanctioned Provider
- 03102 – Provider Type or Specialty Not Allowed to Bill for Procedure

Example

Paul Brown is admitted to Old Dominion Regional Hospital due to extreme abdominal pain. It is determined that an x-ray is required. Dr. Rogers performs an abdominal x-ray (CPT code 70422). The claim for Paul Brown is submitted to Greenville Health Plan and actually includes a procedure code for cheiloplasty (CPT code 40702) instead of the x-ray service performed. Greenville Health Plan adjudicates the claim, converts it to an encounter and submits it to EDS. The encounter passes EDFES edits and a 277CA is generated with an associated ICN of 832748392859. An MAO-002 report is returned to Greenville Health Plan, and the encounter ICN 832748392859 is reflected with a reject status due to edit "03102 – Provider Type or Specialty Not Allowed to Bill Procedure", as a Radiologist cannot bill for

4.4.1.3 Top Validation Edits

Validation edits are performed to allow the EDIPPS to verify that MAOs and other entities accurately report data to successfully process through the EDIPPS. If the data is not properly submitted by the MAO or other entity, edits will occur, preventing the encounter from transferring through the EDIPPS. The most common validation edits generated on encounter data submissions are:

- 17590 – Value Code – Code 05 Not Present Or Conflicts With Dollar Amount
- 17285 – Billed Lines Require Charges (Few Exceptions)
- 17310 – Surgical Revenue Code 036X Requires Surgical Procedure Code
- 20505 – Accurate Ambulance HCPCS and Revenue Code Required

4.4.1.3.1 Edit 17590 – Value Code – Code 05 Not Present Or Conflicts With Dollar Amount

The EDIPPS rejects encounters and displays Error Code "17590" and Error Description "Value code - code 05 conflicts with dollar amount" when the following condition is met:

An error exists if one of the following is true:

- Value code 05 is not present.
- Value code 05 is present with a dollar amount less than the sum of revenue codes = 960, 962, 963, 964, 969, 970-989, and 98X.

This edit is bypassed if any of the following is true:

- TOB = 85X
- OPPS bill types

- TOB = 34X with vaccine, antigen, splint, or cast HCPCS payable under OPPS
- TOB = 75X with vaccine HCPCS payable under OPPS
- Non-OPPS bill types with condition code 07 and an antigen, splint, or cast HCPCS payable under OPPS guidelines

4.4.1.3.1.1 Edit 17590 Prevention/Resolution Strategies

MAOs and other entities must ensure that when submitting a value code and HI01-1 = 'BE' and HI01-2 = '05' (Professional Component Included in Charges and Also Billed Separately to Carrier), that the value code dollar amount is more than the sum of revenue codes 960, 962, 963, 964, 969, 970-989, and 98X.

4.4.1.3.2 Edit 17285 – Billed Lines Require Charges (Few Exceptions)

The EDIPPS rejects encounters and displays Error Code "17285" and Error Description "Billed Lines Require Charges (Few Exceptions)" when the following conditions are met:

- A charge is not required when Revenue and HCPCS codes are present on capitated claim
- A capitated encounter is defined as when there exists the following value (Loop 2300, CN101=05.)

4.4.1.3.2.1 Edit 17285 Prevention/Resolution Strategies

MAOs and other entities must ensure that all non-capitated encounters submitted include billed lines greater than 0.00. If the encounter is submitted with a billed amount of 0.00, then there must be an associated capitated encounter indicator in Loop 2300, CN101='05'.

4.4.1.3.3 Edit 17310 – Surgical Revenue Code 036X Requires Surgical Procedure Code

The EDIPPS rejects encounters and displays Error Code "17310" and Error Description "Surgical Revenue Code 036X Requires Surgical Procedure Code" when the following conditions are met:

- TOBs 11X, 18X, 21X are present on the encounter
- Revenue code 036X is present, but a surgical procedure code and a procedure code date are not on the encounter.

This edit will be bypassed when diagnosis V641, V642, or V643 is populated on the encounter. These diagnosis codes indicate that surgery was cancelled.

4.4.1.4.3.1 Edit 17310 Prevention/Resolution Strategies

When submitting encounters for surgical services, MAOs and other entities must ensure that for revenue code 036X and TOBs 11X, 18X, and 21X, that a surgical procedure code and procedure code date are also provided on the encounter.

4.4.1.3.4 Edit 20505 - Accurate Ambulance HCPCS and Revenue Code Required

The EDIPPS rejects encounters and displays Error Code "20505" and Error Description "Accurate Ambulance HCPCS and Revenue Code Required" when the following conditions are met:

- For TOBs 12X, 13X, 22X, 23X, 83X or 85X when Revenue Code 0540 (Ambulance) is present and the submitted HCPCS code does not equal A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433 OR A0434 and a HCPCS mileage code is not present
- Or units do not equal 1

4.4.1.3.4.1 Edit 20505 Prevention/Resolution Strategies

When submitting encounters for ambulance services using TOBs 12X, 13X, 22X, 23X, 83X or 85X and Revenue Code 0540, the HCPCS codes must include at least one of the following: A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433 OR A0434 and an appropriate mileage HCPCS code. The encounter must also reflect units of 1.

4.5 Special Considerations

The EDIPPS is structured to include FFS-like logic regarding submission, processing, and pricing; however, there are unique circumstances that require special consideration or modifications in order to allow encounters to successfully pass EDFES and EDIPPS edits. The special considerations include, but are not limited to, the following types of encounter data:

- Ambulance
- Capitated
- Default NPIs
- Atypical
- Paper Claim
- 4010
- Chart Review
- Correct/Replace
- Void/Delete
- Proxy Claim Information

4.5.1 Ambulance

MAOs and other entities must submit Institutional ambulance data on the 837-I. The ambulance Pick-Up ZIP Code will be used to appropriately process and price ambulance data submissions for collection of encounter data. In order to populate ambulance encounters, MAOs and other entities must include the appropriate ambulance revenue code(s), associated HCPCS codes, the required minimum data elements and the following:

- HI01-1 = ‘BE’ (Value Qualifier)
- HI01-2 = ‘A0’ (Value Code)
- HI01-5 = ZIP Code + 4, when available (Value Code Amount)
  - First eight (8) digits of the ZIP Code +4 should be populated to the left of the decimal
  - Last digit of the ZIP Code +4 should be populated to the right of the decimal

Example

USA Health Plan received a claim from United Hospital for ambulance services provided to Gloria Jones, which includes revenue code 0540, and one (1) unit of HCPCS code 0425 and one (1) unit of HCPCs code 0427, as well as the Pick Up ZIP Code of 34568999.9 provided in the value code amount field.

If ambulance procedure codes with QL modifiers (patient pronounced dead after ambulance called) are submitted to EDS, the ambulance pick-up ZIP code is not required to be populated in the value code fields.

Example

Spangle Health Plan received a claim from Cox Hospital for ambulance services for Jennifer Rodriguez, who expired after a fatal car crash and prior to the ambulance arrival. The claim reported included procedure code A0429, which is for ambulance services, basic life support (BLS), emergency transport with a QL modifier (Patient pronounced dead after ambulance called). Because ambulance services were not completed, Spangle Health Plan submitted the encounter without populating HI01-1='BE', HI01-2='A0', and HI01-5 = ZIP Code + 4.

4.5.2 Capitated

Capitated providers are physicians or other health care providers that provide services based on a contracted rate for each member assigned, referred to as a "per-member-per-month" (PMPM) rate, regardless of the number or nature of services provided. Capitated and staff model arrangements must populate and submit valid CPT/HCPCS codes on the 5010, as this is necessary for accurate encounter data pricing.

4.5.2.1 Capitated Submission

Due to the capitated payment structure, amount fields on claims submitted by capitated providers do not always have the accurate pricing information populated. For capitated or staff model arrangements submitting encounter data, MAOs and other entities must submit '0.00', only if no amount information is available. If billed and/or payment information is available, it should be submitted as is.

Capitated submission may only be populated on the claim level. MAOs and other entities must populate Loop 2300, CN101='05' for each capitated encounter submission.

MAOs and other entities must ensure that capitated provider encounters comply with all EDFES balancing edits.

Example

Best Health Plan has a capitated arrangement with Mercy Hospital. In order for Best Health Plan to submit Mercy Hospital's claim as an encounter to the EDS, Best Health Plan must submit an encounter using all applicable data elements and Loop 2300, CN101='05'.

4.5.3 Default NPIs

Section 2.4.2 of the Policy, Monitoring, and Compliance Module and Section 3.5.3 of the Professional Submission Module provide detailed information on the purpose and use of default NPIs for encounter data.

Table 4Q below provides the default NPI value by Payer ID:

TABLE 4Q – DEFAULT 837-I NPI VALUE

SYSTEM	PAYER ID	DEFAULT NPI VALUE
Institutional	80881	1999999976

4.5.4 Atypical Provider

Section 3.5.4 of the Professional Submission Module provides detailed information on the purpose and use of atypical provider generated encounters.

MAOs and other entities may submit a default Employer Identification Number (EIN) in Loop 2010BB, REF01=EI, REF02= 199999999 for atypical provider submissions **only if the true EIN is not available**.

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information.

Example

Your Health Plan received an invoice from Jamie Smith for massage therapy services provided in the hospital and her EIN is provided on the invoice. Jamie Smith meets the requirements to be considered an atypical provider. Your Health Plan converts the invoice to an encounter. Because Jamie Smith does not have an NPI, Your Health Plan inputs the default NPI value of 1999999976.

976 and the EIN provided on the invoice.

4.5.5 Paper Claim Submission

Section 3.5.5 of the Professional Submission Module provides detailed information on the use of paper claim generated encounters.

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information.

Example

Happy Health Plan received a paper claim from USA Hospital, which did not contain an NPI. In order to convert the paper claim submission into an encounter, Happy Health Plan must include a Billing Provider NPI default value of 1999999976, and the required minimum data elements. In addition, Happy Health Plan must include Loop 2300, PWK01='OZ' and PWK02='AA'.

4.5.6 4010 Submission

Section 3.5.6 of the Professional Submission Module provides detailed information on the use of 4010 generated encounters. Also, please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for more on proxy claim information.

Example

Green Plan received a 4010 submission from Georgia Hospital, which did not contain an NPI. In order to convert the 4010 submission into an encounter, Green Plan must include a Billing Provider NPI default value of1999999976, and the required minimum data elements. In addition, Green Plan must include Loop 2300, PWK01='PY' and PWK02='AA'.

4.5.7 Chart Reviews

Section 3.5.7 of the Professional Submission Module provides detailed information on the purpose and use of chart review submissions.

The term "chart review" refers to all medical reviews

4.5.7.1 Chart Review Submission

Institutional chart review submission and processing logic follows the same guidelines used for professional chart review submissions. MAOs and other entities are required to use the 837-I format to submit Institutional encounters that are a result of chart reviews. MAOs and other entities can perform the following actions through a chart review encounter submission:

- Add specific diagnoses to full encounters
- Delete specific diagnoses from a full encounter
- Replace one chart review encounter with another chart review encounter
- Add and delete diagnoses on a single encounter

EXERCISE 1

A-One Health Plan performed a quarterly medical record review at Virginia Mountain Hospital and discovered that diagnosis 402.10 – Benign Hypertensive Heart Disease without Heart Failure was not included on the original encounter submission (ICN 37293848292) for Gwendolyn Nguyen. A-One Health Plan must submit a linked chart review, with Loop 2300 CLM05-3='1', PWK01='09', PWK02-'AA', REF01='F8', REF02 must include the original accepted ICN, HI01-1='BK', and HI01-2= 402.10 (the new diagnosis code). In addition, all required minimum data elements must be submitted.

Using the scenario provided above, populate Table 4R with the loops, segments, and data elements required for the addition of diagnoses as a result of an Institutional chart review submissions.

TABLE 4R – CHART REVIEW ADDITION ELEMENTS

Loop	Data Element	Required Value
2300	CLM05-3	1
2300	PWK01	
2300	PWK02	
2300	REF01	
2300	REF02	
2300	HI01-1	
2300	HI01-2	

EXERCISE 2

During a medical record review, Statewide Community Care is reconciling chart review data and finds that California Beach Hospital has submitted diagnosis 429.3 - Cardiomegaly in error for patient, Mr. Ian Richards. Statewide Community Care must submit a linked chart review with Loop 2300 CLM05-3='1', PWK01='09', PWK02-'AA', REF01='F8', REF02 must include the original accepted ICN (72739283929), HI01-1='BK', and HI01-2= 429.3 (the diagnosis being deleted), REF01='EA', REF02='8'. In addition, all required minimum data elements must be submitted.

Using the scenario provided above, populate Table 4S with the loops, segments, and data elements required for the deletion of diagnoses as a result of an Institutional chart review submissions.

TABLE 4S – CHART REVIEW DELETION ELEMENTS

Loop	Data Element	Required Value
2300	CLM05-3	1
2300	PWK01	
2300	PWK02	
2300	REF01	
2300	REF02	
2300	HI01-1	
2300	HI01-2	
2300	REF01	
2300	REF02	

EXERCISE 3

Fresh Perspective Health Plan performed a random medical record review for New York Hospital and located a chart discrepancy for patient, Ms. Tracy Bennett. The diagnosis of 714.0 – Rheumatoid Arthritis was not valid for the service Dr. Zynga provided. Fresh Perspective Health Plan also noted in Ms. Bennett's medical record that diagnosis 403.90 – Kidney Disease due to Hypertension was omitted from the original encounter submission. Fresh Perspective Health Plan must submit a linked chart review with Loop 2300 CLM05-3='1', PWK01='09', PWK02='AA', REF01='F8', REF02 must include the original accepted ICN (09230293020), HI01-1='BK', HI01-2=403.90 (the new diagnosis code), REF01='EA', REF02=714.0 (the deleted diagnosis code). In addition, all required minimum data elements must be submitted.

Using the scenario provided above, populate Table 4T with the loops, segments, and data elements required for the addition and deletion of diagnoses provided on a single encounter as a result of an Institutional chart review submissions.

TABLE 4T – CHART REVIEW ADDITION AND DELETION ON A SINGLE ENCOUNTER ELEMENTS

Loop	Data Element	Required Value
2300	CLM05-3	1
2300	PWK01	
2300	PWK02	
2300	REF01	
2300	REF02	
2300	HI01-1	
2300	HI01-2	
2300	REF01	
2300	REF02	

EXERCISE 4

Fit Health Plan performed a follow-up medical record review at Madagascar Regional Hospital due to discrepancies in encounter data submission. The representative found that the additional diagnoses provided for one of Dr. Madagascar's patients in the initial chart review were incorrect. Fit Health Plan must submit a chart review with Loop 2300 CLM05-3='7', PWK01='09', PWK02='AA', REF01='F8', and REF02 must include the original accepted ICN (26328373087). In addition, all required minimum data elements must be submitted.

Using the scenario provided above, populate Table 4U with the loops, segments, and data elements required for the correction of a chart review encounter with another chart review encounter submission.

TABLE 4U – CHART REVIEW CORRECT/REPLACE ELEMENTS

Loop	Data Element	Required Value
2300	CLM05-3	7
2300	PWK01	
2300	PWK02	
2300	REF01	
2300	REF02	

4.5.7.2 Chart Review Duplicate Logic

Institutional chart review duplicate logic follows the same guidelines used for Professional chart review duplicate logic. Table 4V below provides the duplicate logic for linked ICN and unlinked ICN chart review encounters.

TABLE 4V – CHART REVIEW DUPLICATE LOGIC

Linked ICN Chart Review Duplicate Logic	Unlinked ICN Chart Review Duplicate Logic
Health Insurance Claim Number (HICN)	Health Insurance Claim Number (HICN)
Date of Service	Date of Service
Diagnosis Code	Diagnosis Code
Internal Control Number (ICN) From Previously Accepted Encounter	

Example

Rohring Community Health performed a chart review and determined that diagnosis code 38500 was not included on the original encounter submission for Tiffany Smith, ICN 4829383588, with a DOS of January 28, 2012. Rohring Community Health submitted a chart review to add the diagnosis code to the originally submitted encounter. The chart review was accepted through the EDIPPS and an MAO-002 report was generated and returned to Rohring Community Health. Six (6) months later, Rohring Community Health hired Riverview Medical Consultants to perform their standard semi-annual medical record review. Riverview Medical Consultants performed a medical record review and determined that diagnosis code 38500 was not included for Tiffany Smith, for ICN 4829383588, with a DOS of January 28, 2012. Rohring Community Health submits a chart review encounter to add diagnosis code 38500 for Tiffany Smith for a DOS of January 28, 2012 for ICN 4829383588. The EDIPPS reads the linked chart review, recognizes that it as a duplicate linked chart review, and an MAO-002 report is returned with edit 98325.

4.5.8 Correct/Replace

Section 3.5.8 of the Professional Submission Module provides detailed information on the purpose and use of correct/replace encounters. The same submission and processing logic applies to Institutional correct/replace submissions.

MAOs and other entities may reference the Correct/Replace business case in the EDS Companion Guides for operational guidance

Example

Mary Jones went to Vermont Regional Medical Center and was diagnosed with Diabetes without Complications Type II, Unspecified Not Uncontrolled (25000). Happy Health Plan received, processed and adjudicated the claim from Vermont Regional Medical Center and then submitted the encounter to EDS. Happy Health Plan received the 277CA associated with the file, which provided ICN 1567839847389, indicating it was accepted through the EDFES. The encounter was also accepted through the EDIPPS, as notated on the MAO-002 report as an accepted encounter. Two (2) months later, Happy Health Plan receives a claim correction from Vermont Regional Medical Center to indicate the Mary Jones was actually diagnosed with Diabetes without Complications Type II, Unspecified Uncontrolled (25002). Happy Health Plan received, processed and adjudicated the correct claim and submitted the encounter to EDS as a correct/replace by correcting the diagnosis code and using Loop 2300, CLM05-3=’7’ and REF01=’F8’, REF02= ‘1567839847389’

4.5.9 Void/Delete

Section 3.5.9 of the Professional Submission Module provides detailed information on the purpose and use of void/delete encounters. The same submission and processing logic applies to Institutional void/delete submissions.

Example

Baker Hospital submitted a claim to Best Health Plan. Best Health Plan received, processed and adjudicated the claim and submitted it as an encounter to EDS. The encounter was accepted through EDFES and received ICN 18932709879212 on the 277CA, and was accepted through the EDIPPS, as notated on the MAO-002 report. Three (3) weeks later, Baker Hospital contacts Best Health Plan to inform them the claim was mistakenly submitted and should not have been. Best Health Plan submits a void/delete encounter to EDS by populating Loop 2300, CLM05-3='8' and REF01='F8', REF02='18932709879212'.

MAOs and other entities may reference the Void/Delete business case provided in the EDS Companion Guides for operational guidance

4.5.10 Proxy Claim Information

Please see Section 2.4.2 of the Policy, Monitoring, and Compliance Module for more on proxy claim information. Section 3.5.10 of the Professional Submission Module provides detailed information on the purpose and use of proxy claim information. The same submission and processing logic applies to Institutional modified encounters.

Example

Valley Regional Hospital submitted a claim to State Health Plan which contained four (4) service lines. Three (3) of the service lines contained valid HCPCS; however, one (1) service line included a HCPCS that contained eight (8) characters and was not processable by State Health Plan's claims processing system, therefore was deemed "rejected" by EDS definitions. State Health Plan extracted the rejected line from the claim in order to submit the encounter. The encounter submitted by State Health Plan must include all relevant claims data meeting the minimum data elements requirement as well as Loop 2300, NTE01='ADD', and NTE02='REJECTED LINES CLAIM CHANGE DUE TO REJECTED LINE EXTRACTION'.

4.6 EDIPPS Duplicate Logic

Once an encounter passes through the EDIPPS, it is stored in an internal repository, the EODS. If a new encounter is submitted that matches specific values to another stored encounter, the encounter will be rejected and will be considered a duplicate encounter. The encounter will be returned to the submitter on the MAO-002 report with error message 98325 – Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim, identifying it as a duplicate encounter.

The following values are the minimum values being used for matching encounters in the EODS:

- Beneficiary Demographic
  - Health Insurance Claim Number (HICN)
  - Last Name
- Date of Service
- Type of Bill (TOB)
- Revenue Code(s)
- Procedure Code(s)
- Billing Provider NPI
- Paid Amount*

*** The Paid Amount is the amount paid by the MAO or other entity and must be populated in Loop ID-2320, AMT02.**

4.7 Summary

During this module, submission, processing, and pricing requirements for Institutional encounter data were provided. Acceptable Types of Bills and an explanation of the services associated were detailed. Participants were informed of the top EDIPPS beneficiary, provider, and validation edits, as well as prevention and resolution strategies to assist in successful submission of encounter data into the EDS. Special considerations for encounter data specific submissions were also identified and operational guidance was provided.

MODULE 5 – DURABLE MEDICAL EQUIPMENT (DME) SUBMISSION

Purpose

MAOs and other entities are required to submit encounters for all Durable Medical Equipment (DME) related services, regardless of the source of data. As a result, MAOs and other entities must understand the special requirements for the collection, processing, and submission of DME services to the Encounter Data System (EDS). This module is designated to specify the data collection, submission, and processing principles for DME encounter data in accordance with the CMS requirements.

Learning Objectives

At the completion of this module, participants will be able to:

- Demonstrate knowledge in interpreting DME Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier services.
- Understand the DMEPOS Supplier submission process requirements.
- Identify DMEPOS Supplier processing and pricing logic.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

5.1 DME Services

There are currently two (2) types of DME submissions that are acceptable for encounter data: DME services that are incident to a provider and DMEPOS Supplier services. A provider of service may include an institution or physician. A supplier is an entity other than a provider that furnishes health care services under Medicare. A provider of supplies that enrolls as a DMEPOS Supplier is considered a DMEPOS Supplier for encounter data submission.

DMEPOS Supplier Guidelines –
http://www.cms.gov/MedicareProviderSupEnroll/Downloads/DMEPOSSupplierStandards.pdf

DMEPOS supplies must be submitted on a separate 837-P; and are medical or other health services and equipment that meet the following definitions:

- Can withstand repeated use
- Primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an illness or injury
- Appropriate for use in the home

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

Parenteral and Enteral Nutrition (PEN), and related accessories and supplies, are covered under the Medicare program as a prosthetic device. All PEN services furnished are considered as a DME Supplier claim. If a provider provides PEN items, the provider must qualify for and receive a supplier number and bill as a supplier.

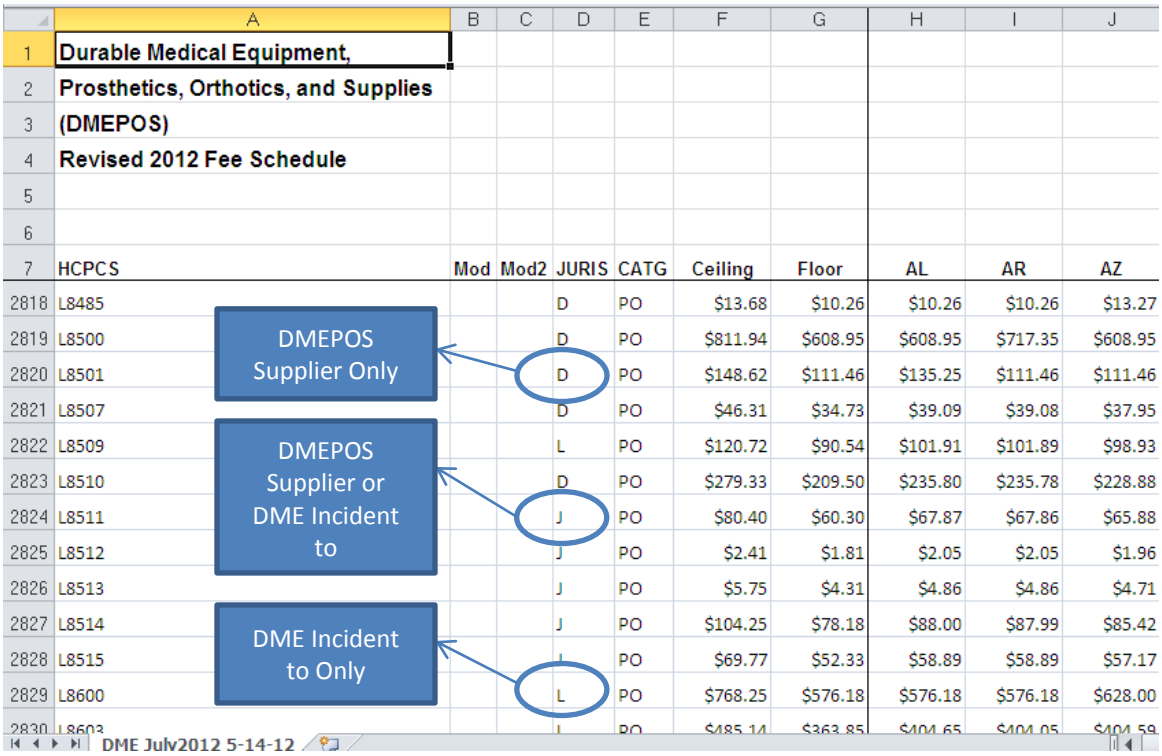
DME incident to provider and DMEPOS Supplier determination is made by the NPI for the provider or supplier and the associated HCPCS code. HCPCS codes found on the DMEPOS Fee Schedule are categorized in the "JURIS" column as the following:

- "D" = DMEPOS Supplier HCPCS code only
- "J" = DMEPOS Supplier HCPCS code or DME incident to HCPCS code
- "L" = DME incident to HCPCS code only

DMEPOS Fee Schedule HCPCS Codes
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule-Items/DME12_C.html.
Tip: Select DME12_C.zip file and select the DME2012 Jul.xls file.

Figure 5A below provides an excerpt from the DMEPOS Fee Schedule HCPCS Codes documentation.

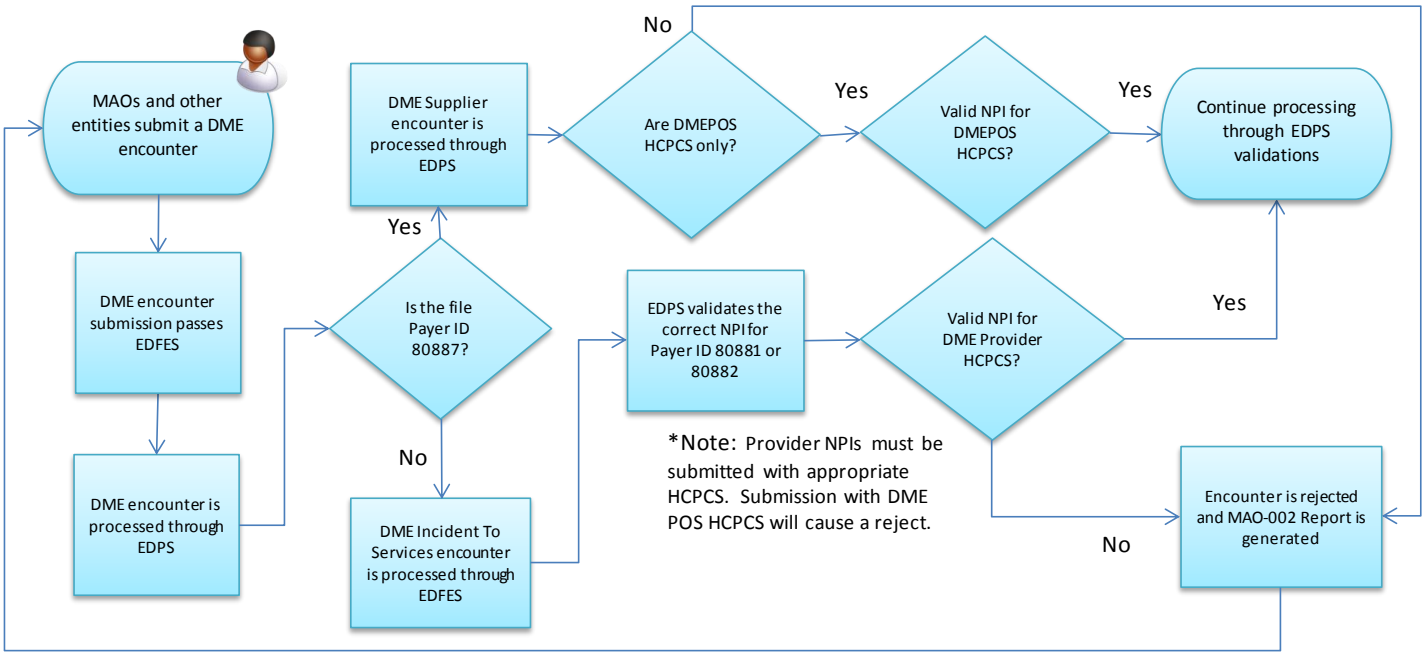
Figure 5A – DMEPOS Fee Schedule HCPCS Codes



	HCPCS	Mod	Mod2	JURIS	CATG	Ceiling	Floor	AL	AR	AZ
2818	L8485			D	PO	$13.68	$10.26	$10.26	$10.26	$13.27
2819	L8500			D	PO	$811.94	$608.95	$608.95	$717.35	$608.95
2820	L8501			D	PO	$148.62	$111.46	$135.25	$111.46	$111.46
2821	L8507			D	PO	$46.31	$34.73	$39.09	$39.08	$37.95
2822	L8509			L	PO	$120.72	$90.54	$101.91	$101.89	$98.93
2823	L8510			D	PO	$279.33	$209.50	$235.80	$235.78	$228.88
2824	L8511			J	PO	$80.40	$60.30	$67.87	$67.86	$65.88
2825	L8512			J	PO	$2.41	$1.81	$2.05	$2.05	$1.96
2826	L8513			J	PO	$5.75	$4.31	$4.86	$4.86	$4.71
2827	L8514			J	PO	$104.25	$78.18	$88.00	$87.99	$85.42
2828	L8515			J	PO	$69.77	$52.33	$58.89	$58.89	$57.17
2829	L8600			L	PO	$768.25	$576.18	$576.18	$576.18	$628.00
2830	L8603			J	PO	$485.14	$363.85	$404.65	$404.05	$404.59

Figure 5B provides the processing flow of DME data through the EDS.

Figure 5B – DME Processing Data Flow



5.1.1 DME Incident to Submission

If the DME service is incident to a physician or institutional service, it must be submitted on the 837-P or 837-I, as outlined in Module 3 (Professional Submission) and Module 4 (Institutional Submission) using the appropriate Payer ID of 80881 for DME encounters that are incident to an institutional service or Payer ID 80882 for DME encounters that are incident to a professional service. The DME product/service would be populated as a service provided by the provider/physician or institution. Claims for implanted DME, implanted prosthetic devices, replacement parts, accessories, and supplies for the implanted DME when considered "incident to" a health care provider are part of the provider/physician's or institution's encounter.

The provider's NPI populated on the encounter must be for a provider/physician or institution and not for a DMEPOS Supplier. If a DMEPOS Supplier NPI is populated with a Payer ID of 80881 or 80882, the encounter will be rejected.

Table 5A below provides a sample of DME incident to HCPCS codes that are acceptable for encounter data submission. The DME incident to HCPCS codes provided are not inclusive of all codes that are identified on the DMEPOS Fee Schedule with a DME HCPCS code identifier of "L" or "J". MAOs and other entities must submit a physician or institutional provider NPI when submitting DME incident to HCPCS codes with a Payer ID of 80881 or 80882.

TABLE 5A – DME INCIDENT TO HCPCS CODES

DME HCPCS Code	DME HCPCS Code Identifier	HCPCS Code Description
A7043	L	Vacuum drainage bottle/tubing
L8511	J	Indwelling tracheotomy insert
L8515	J	Gel cap app device for tracheotomy
L8614	L	Cochlear device

Example

Yellow Health Plan submitted an encounter using a provider NPI for a DME Supplier, Med Emporium, Supplier, a Payer ID of 80881 (Institutional), and a HCPCS code with a HCPCS code identifier of "D" on the DMEPOS Fee Schedule. The encounter will not be accepted through EDS, as the Payer ID is incorrect for the HCPCS code and provider NPI processed on the encounter.

Example

Sally Jane goes to Dr. Jones and as a result of the visit, Dr. Jones provides Sally Jane with crutches. Dr. Jones submits a claim to Yellow Health Plan for Sally Jane's crutches. In order to submit the encounter to EDS, Yellow Health Plan must provide a Payer ID of 80882 to indicate the service was incident to a professional service provided and include a DME HCPCS code with a code identifier of either "J" or "L" on the DMEPOS Fee Schedule.

5.1.2 DMEPOS Supplier Submission

If a DMEPOS claim is as a result of a DMEPOS Supplier service provided to the beneficiary, MAOs and other entities must indicate it as such by populating the following values, along with all other relevant claims data:

- ISA08 (Interchange Receiver ID) = 80887
- GS03 (Application Receiver's Code) = 80887
- Loop 1000B, NM109 (Receiver's Identifier) = 80887
- Loop 2010BB, NM109 (Payer's Identifier) = 80887

If an encounter is submitted with Payer ID 80887, then a DMEPOS Supplier NPI must be submitted, as well as DMEPOS HCPCS codes identified as "D" or "J" on the DMEPOS Fee Schedule. If a non-DME Supplier NPI is provided with a Payer ID of 80887, the encounter will be rejected. Table 5B below provides samples of DMEPOS Supplier HCPCS codes acceptable for encounter data submission. The DMEPOS Supplier HCPCS codes provided are not inclusive of all codes that are identified on the DMEPOS Fee schedule with a DME HCPCS code identifier of "D" or "J".

TABLE 5B – DME INCIDENT TO HCPCS CODES

HCPSC Code	DME HCPCS Code Identifier	HCPCS Code Description
A4216	D	Sterile water/saline, 10 ml
A4616	D	Tubing (oxygen) per foot
A6241	J	Hydrocolloid dressing, would filler, dry form, sterile, per gram
K0040	D	Adjustable angle footplate

Medicare DMEPOS Specific Program Transmittals
http://www.cms.gov/DMEPOSFeeSched/DMEPOSTrans/list.asp

Medicare Claims Processing Manual, Chapter 20
http://www.cms.gov/manuals/downloads/clm104c20.pdf

Example

ABC Health Plan submitted an encounter using a Billing Provider NPI for Dr. Brown, the Payer ID of 80887 (DME Supplier), and a HCPCS code for a powered wheelchair. The encounter will not be accepted through EDS, as the Payer ID is incorrect for the HCPCS code and Billing Provider NPI processed on the encounter.

Example

Happy Health Plan received a claim from Med Health Store, with an NPI categorized as a DMEPOS Supplier, and an associated HCPCS code for a DMEPOS supplier service. In order to submit the encounter to EDS, Happy Health Plan must include the minimum data elements, including Med Health Store's NPI, the DMEPOS Supplier HCPCS code and the Payer ID 80887.

5.1.2.1 DMEPOS Supplier Supplemental Forms

Due to EDS' current structure, DME supplemental forms, such as a Certificate of Medical Necessity or Oxygen Certification must not be submitted either by fax, mail, or electronically to the EDS. MAOs and other entities must indicate on the encounter that the appropriate forms are available and can be retrieved, if necessary, for auditing purposes. In order to do so, the following loop, segment, and data elements must be populated for each DME supplier service line along with all other relevant claims data:

- Loop 2400, PWK01='CT' (Certificate)
- Loop 2400, PWK02='NS' (Not Specified)

Example

American Health Plan received a claim from a DME supplier for oxygen services accompanied by an Oxygen Certification form. In order to submit the encounter to CMS, American Health Plan must include at least the minimum data elements, as well as Loop 2400, PWK01='CT' and PWK02='NS' to indicate that the required form will not be submitted with the file but is available upon request.

5.1.2.2 DMEPOS CEM Edits

Several CEM edits currently active in the FFS CEM edits spreadsheet will be permanently deactivated in order to ensure syntactically correct encounters pass 837-P DME Supplier EDFES editing. The CEM edits spreadsheet includes two (2) columns: Proposed 5010A1 Edits Part B and Proposed 5010A1 Edits CEDI. The Proposed 5010A1 Edits CEDI apply to DMEPOS Supplier services and must be referenced for DMEPOS Supplier encounter submissions and EDFES report reconciliation. There are specific edits programmed for DMEPOS Supplier encounters, which are included in the Proposed 5010A1 Edits CEDI column and for DME incident to services, which

are included in the Proposed 5010A1 Edits Part B column. Figure 5C displays the CEM Edits spreadsheet, which includes an excerpt of the Proposed 5010A1 Edits Part B and Proposed 5010A1 Edits CEDI edits.

Figure 5C – DMEPOS CEM Edits

Loop	Loop Repeat	5010A1 Values	TA1/ 999/ 277CA	Accept/Reject	Disposition / Error Code	Proposed 5010A1 Edits Part B	Proposed 5010A1 Edits CEDI
2400			999	R	IK304 = I9: "Implementation Dependent "Not Used" Segment Present"	2400.PWK must not be present when 2400.PWK01 = CT and 2400.PWK02 = AB, AD, AF, AG, or NS.	
			999	R	IK304 = I6: "Implementation Dependent Segment Missing"		2400.PWK with PWK01 = "CT" must be present when 2400.CR3 is present.
			999	R	IK304 = 5: "Segment Exceeds Maximum Use"		Only one iteration of 2400.PWK with PWK01 = "CT" is allowed.

Example

Mercy Health Plan received an EDFES acknowledgement report for a DMEPOS Supplier encounter because Loop 2400, PWK01='CT' was not provided on the encounter, even though Loop 2400, CR3 was populated. Mercy Health Plan references the CMS CEM Edits spreadsheet and notices that there is not an edit in the Proposed 5010A1 Edits Part B column but is in the Proposed 5010A1 Edits CEDI column. Mercy Health Plan must reference the Proposed 5010A1 Edits CEDI column for the correct DME Supplier report reconciliation.

Table 5C provides the current 837-P DMEPOS supplier EDFES edits (Proposed 5010A1 Edits CEDI) that are deactivated. The edit reference column provides the exact edit reference that will be deactivated. The edit description column provides the Claim Status Category Code (CSCC), the Claim Status Code (CSC), and the Entity Identifier Code (EIC), when applicable. The notes column provides a description of the edit reason. MAOs and other entities should reference the WPC website at www.wpc-edi.com for a complete listing of all CSCC, CSC, and EICs.

TABLE 5C – 837-P (DME SUPPLIER) PERMANTENTLY DEACTIVED CEM EDITS

Edit Reference	Edit Description	Edit Notes
X222.494.2440.FRM.010	IK304 = I6: "Implementation Dependent Segment Missing"	If 2440.LQ is present, 2440.FRM must be present.
X222.494.2440.FRM.025	CSCC A8: "Acknowledgement / Rejected for relational field in error." CSC 21: "Missing or invalid information." CSC 699: "Question/Response from Supporting Documentation Form"	If 2440.LQ = "484.03", occurrences of 2440.FRM with FRM01 = ("1A" or "1B") and FRM01 = "1C" and FRM01 = "05" are required.
X222.494.2440.FRM.035	CSCC A8: "Acknowledgement / Rejected for relational field in error." CSC 21: "Missing or invalid information." CSC 699: "Question/Response from Supporting Documentation Form"	If 2440.LQ = "484.03" and 2440.FRM01 = "1A" and FRM05 >= 55.5 and <= 59.4, occurrences of 2440.FRM with FRM01 = "07", "08" and "09" are required.
X222.494.2440.FRM.045	CSCC A8: "Acknowledgement / Rejected for relational field in error." CSC 21: "Missing or invalid information." CSC 699: "Question/Response from Supporting Documentation Form"	If 2440.LQ = "484.03" and 2440.FRM01 = "1B" and FRM05 >= 88.5 and <=89.4, occurrences of 2440.FRM with FRM01 = "07", "08" and "09" are required.

TABLE 5C – 837-P (DME SUPPLIER) PERMANTENTLY DEACTIVED CEM EDITS (CONTINUED)

Edit Reference	Edit Description	Edit Notes
X222.494.2440.FRM.050	IK304 = I6: "Implementation Dependent Segment Missing"	If 2400.PWK with PWK01 = "CT" is present, 2440.FRM must be present.
X222.494.2440.FRM.060	IK304 = 5: "Segment Exceeds Maximum Use"	Only 99 iterations of 2440.FRM are allowed.
X222.494.2440.FRM01.010	IK403 = 1: "Required Data Element Missing"	2440.FRM01 must be present.
X222.494.2440.FRM01.020	IK403 = 5: "Data Element Too Long"	2440.FRM01 must be valid for the value in 2440.LQ02.
X222.494.2440.FRM01.025	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 512: "Length invalid for receiver's application system" CSC 699: "Question/Response from Supporting Documentation Form."	
X222.494.2440.FRM01.030	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 699: "Question/Response from Supporting Documentation Form."	If 2440.LQ02='484.03' and 2440.FRM01='05' is present and the value in FRM03 is > '4', an occurrence of FRM01 with the value of '6A' or '6B' is required.
X222.494.2440.FRM01.040	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 699: "Question/Response from Supporting Documentation Form."	If 2440.LQ02='484.03' and 2440.FRM01='6A' or '6B', an occurrence of FRM01 with the value of '6C' is required.
X222.494.2440.FRM01.050	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 699: "Question/Response from Supporting Documentation Form."	If 2440.LQ02='484.03' and 2440.FRM01='6C', an occurrence of FRM01 with the value of '6A' or '6B' is required.
X222.494.2440.FRM02.010	IK403 = 7: "Invalid Code Value"	2440.FRM02 must be valid values.
X222.494.2440.FRM02.020	IK403 = 2: "Conditional Required Data Element Missing"	If 2440.FRM03 and 2440.FRM04 and 2440. FRM05 are not present, 2440.FRM02 must be present.
X222.494.2440.FRM02.035	CSCC A8: "Acknowledgement / Rejected for relational field in error." CSC 21: "Missing or invalid information." CSC 699: "Question/Response from Supporting Documentation Form"	If 2440.LQ02 = '484.03" and 2440 FRM with FRM01 = "04", "07", "08" or "09" is present, then 2440.FRM02 must be present.
X222.494.2440.FRM03.010	IK403 = 6: "Invalid Character in Data Element"	2440.FRM03 must contain at least one non-space character.
X222.494.2440.FRM03.020	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 699: "Question/Response from Supporting Documentation Form."	2440.FRM03 must be present if 2440.LQ02 = "04.04" and 2440.FRM01 = "07B", "09B", "10B" or "10C".
X222.494.2440.FRM03.030	"CSCC A7: ""Acknowledgement /Rejected for Invalid Information…"" CSC 699: ""Question/Response from Supporting Documentation Form.""""	2440.FRM03 must be present if 2440.LQ02 = "06.03" and FRM01 = "02" or "03".
X222.494.2440.FRM03.040	"CSCC A7: ""Acknowledgement /Rejected for Invalid Information…"" CSC 699: ""Question/Response from Supporting Documentation Form.""""	2440.FRM03 must be present if 2440.LQ02 = "09.03" and FRM01 = "01", "01A", "01B", "01C", "02", "02A", "02B", "02C", "03" or "04".

TABLE 5C – 837-P (DME SUPPLIER) PERMANTENTLY DEACTIVED CEM EDITS (CONTINUED)

Edit Reference	Edit Description	Edit Notes
X222.494.2440.FRM03.050	"CSCC A7: ""Acknowledgement /Rejected for Invalid Information…"" CSC 699: ""Question/Response from Supporting Documentation Form.""""	2440.FRM03 must be present if 2440.LQ02 = "10.03" and FRM01 = "03", "03A", "03B", "04", "04A", "04B", "05", "06", "08A", "08C", "08D", "08F", "08G" or "09".
X222.494.2440.FRM03.070	IK403 = 5: "Data Element Too Long"	2440.FRM03 must be 1 - 50 characters.
X222.494.2440.FRM03.080	"CSCC A7: ""Acknowledgement /Rejected for Invalid Information…"" CSC 512: ""Length invalid for receiver's application system"" CSC 699: ""Question/Response from Supporting Documentation Form.""""	
X222.494.2440.FRM03.090	IK403 = 6: "Invalid Character in Data Element"	2440.FRM03 must be populated with accepted AN characters.
X222.494.2440.FRM03.110	IK403 = 2: "Conditional Required Data Element Missing"	If 2440.FRM02 and 2440.FRM04 and 2440. FRM05 are not present, 2440.FRM03 must be present.
X222.494.2440.FRM03.125	"CSCC A8: ""Acknowledgement / Rejected for relational field in error."" CSC 21: ""Missing or invalid information."" CSC 699: ""Question/Response from Supporting Documentation Form"""	If 2440.LQ02 = '484.03" and 2440 FRM with FRM01 = "1A", "1B", "02", "03" or "05" is present, then 2440.FRM03 must be present.
X222.494.2440.FRM04.010	IK403 = 8: "Invalid Date"	2440.FRM04 must be a valid date in the format of CCYYMMDD.
X222.494.2440.FRM04.020	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 510: "Future date" CSC 699: "Question/Response from Supporting Documentation Form."	2440.FRM04 must not be a future date.
X222.494.2440.FRM04.030	IK403 = 2: "Conditional Required Data Element Missing"	If 2440.FRM02 and 2440.FRM03 and 2440. FRM05 are not present, 2440.FRM04 must be present.
X222.494.2440.FRM04.045	CSCC A8: "Acknowledgement / Rejected for relational field in error." CSC 21: "Missing or invalid information." CSC 699: "Question/Response from Supporting Documentation Form"	If 2440.LQ02 = '484.03" and 2440 FRM with FRM01 = "1C" is present, then 2440.FRM04 must be present.
X222.494.2440.FRM05.010	IK403 = 6: "Invalid Character in Data Element"	2440.FRM05 must be numeric.
X222.494.2440.FRM05.020	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 699: "Question/Response from Supporting Documentation Form."	2440.FRM05 must be present if 2440.LQ02 = "10.03" and FRM01 = "08B", "08E" or "08H".
X222.494.2440.FRM05.030	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 699: "Question/Response from Supporting Documentation Form."	2440.FRM05 must be >= 0 and <= 100.0.
X222.494.2440.FRM05.040	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 697: "Too many decimal positions"	2440.FRM05 is limited to 0 or 1 decimal positions.

TABLE 5C – 837-P (DME SUPPLIER) PERMANTENTLY DEACTIVED CEM EDITS (CONTINUED)

Edit Reference	Edit Description	Edit Notes
X222.494.2440.FRM05.050	IK403 = 2: "Conditional Required Data Element Missing"	If 2440.FRM02 and 2440.FRM03 and 2440. FRM04 are not present, 2440.FRM05 must be present.

5.2 DMEPOS Supplier End-to-End Testing

837-P (DMEPOS Supplier) end-to-end testing helps to ensure EDS functionality based on specifically designed test cases, as identified in Table 5D. It also allows MAOs and other entities to confirm that the EDS operational guidance has been properly programmed in their systems.

MAOs and other entities must be EDFES certified in order to submit end-to-end test cases for DMEPOS Supplier encounter data, and must achieve a 95% acceptance rate on all required test cases and receive notification of certification for DMEPOS Supplier end-to-end testing in order to submit production data.

TABLE 5D – 837-P (DMEPOS SUPPLIER) TEST CASES

Test Case File #	Test Case/Script Title	Test Case/Script Identifier	Test Case #
1	New MA Member	Beneficiary Eligibility	TC01
1	DMEPOS	Data Validation	TC03
1	Purchased DME	Pricing	TC04
1	Capped Rental	Pricing	TC05
1	Oxygen	Pricing	TC06
2	Incident to Services	Data Validation	DMETC02
3	Duplicate	Processing	TC07

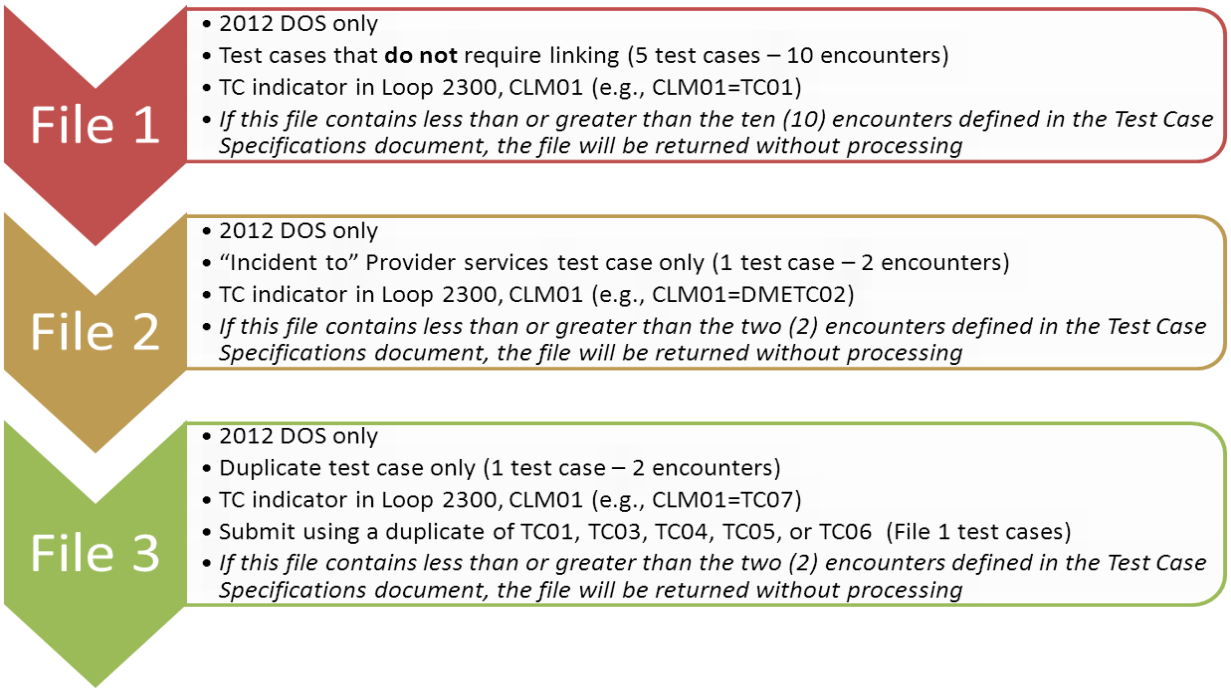
DMETC02 – Incident to Services must include Payer ID 80881 or 80882, a DME Supplier NPI, and DMEPOS HCPCS codes with a "JURIS" identifier of "D" on the DMEPOS Fee Schedule HCPCS Code.

The 837-P DMEPOS encounter test cases must be submitted in **three** (**3**) files:

- File 1 includes all unlinked test cases, 2 each, with unique ICNs:
  - TC01
  - TC03
  - TC04
  - TC05
  - TC06 (total of 10 encounters)
- File 2 includes only DMETC02 with a Payer ID of '80881' or '80882' (2 encounters)
- File 3 includes only TC07 (2 encounters) using the DME Payer ID '80887', and should only be a duplicate of one of the test cases in TC01, TC03, TC04, TC05, and TC06.

All test cases included in File 1 and File 2 must be completely accepted as indicated on the MAO-002 report before File 3 is submitted. File 1 and File 2 may be submitted at the same time or within the same day. File 3 can only be submitted once MAO-002 reports have been received for File 1 and File 2. MAOs and other entities must receive a 95% acceptance rate to be deemed certified for end-to-end testing. Figure 5D below provides the DMEPOS Supplier testing requirements.

Figure 5D – 837-P (DMEPOS Supplier) Testing Requirements



MAOs and other entities will receive a certification notification when MAO-002 reports reflect 95% of all test cases successfully completed end-to-end testing. Certification per Submitter ID will be dependent upon successful completion of end-to-end testing based on DME supplier test cases.

5.3 Encounter Data DME Processing and Pricing Logic (EDDPPS)

As provided in Module 3, Professional Submission, one of the goals of encounter data is to ensure accurate payment to MAOs and other entities. In support of this effort for DME submissions, CMS developed the EDDPPS to edit, process, and price managed care encounter data to use in the calibration of the risk adjustment model.

The EDDPPS is structured to edit, process, and price DMEPOS Supplier encounters based on FFS pricing methodologies.

5.3.1 EDDPPS Edits

The EDDPPS contains edits that are applied to each encounter submission, which are organized in four (4) different categories, including the following:

- Validation
- Beneficiary
- Reference
- Duplicate

The Professional Submission module provides detailed system header and line level logic, which is also applicable to the EDDPPS.

Table 5E below provides the complete list of EDDPPS edits to date.

TABLE 5E – EDDPPS EDITS

EDDPPS Edit#	EDDPPS Edit Category	EDDPPS Edit Disposition	EDDPPS Edit Error Message
00010	Validation	Reject	From Date of Service is Greater than TCN Date
00011	Validation	Reject	From or To Date Of Service Missing in the Claim – Header or Line
00012	Validation	Reject	Date of Service Less Than 01.01.2012
00025	Validation	Reject	To Date Of Service Is After Date Of Claim Receipt
00265	Validation	Reject	Adjustment or Void ICN Not Found in History
00699	Validation	Reject	Void Submission Must Match Original Encounter
00761	Validation	Reject	Unable to Void Due to Different Billing Provider on Void From Original
02106	Beneficiary	Informational	Invalid Beneficiary Last Name
02110	Beneficiary	Reject	Beneficiary Health Insurance Carrier Number (HICN) Not on File
02112	Beneficiary	Reject	Beneficiary Date of Death is After the From Date of Service on Encounter Submitted
02120	Beneficiary	Informational	Beneficiary Gender Mismatch
02125	Beneficiary	Reject	Beneficiary Date of Birth Mismatch
02240	Beneficiary	Reject	Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service
02255	Beneficiary	Reject	Beneficiary Not Part A Eligible for Date of Service
02256	Beneficiary	Reject	Beneficiary Not Part C Eligible for Date of Service
03015	Reference	Informational	DOS Spans Procedure Code Effective/End Date
03101	Validation	Reject	Invalid Gender for Procedure Code
30055	Validation	Reject	Duplicate Within Claim - Suppliers are Equal
30135	Reference	Informational	Diagnosis - Gender Mismatch
30261	Validation	Informational	Referring Physician NPI is Required
30262	Validation	Informational	Invalid Modifier
31000	Validation	Informational	Certain HCPCS Codes Require LT or RT Modifiers
31100	Validation	Informational	Invalid Diagnosis Codes For Procedure Codes
31105	Validation	Informational	Modifier AY and AX Combination is Invalid
98325	Duplicate	Reject	Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim

Example

Medical Supply Company submitted a claim to Lamb Health Plan, which included two (2) service lines. Both service lines were for a breast prosthesis, mastectomy bra, unilateral for the same beneficiary on the same date of service using the exact same HCPCS code (L8001) with modifier LT (left side). Lamb Health Plan adjudicated the claim, accepted all service lines, converted the claim to an encounter, and submitted it to EDS. The encounter passed EDFES edits, but once processed through the EDDPPS, was rejected due to edit 30055 – Duplicate Within Claim – Suppliers are Equal. The exact same beneficiary demographic data, procedure code(s), modifier(s), POS, DMEPOS Supplier NPI, and paid amounts cannot be submitted relating to more than one (1) service line within an encounter. Lamb Health Plan must contact Medical Supply Company to correct the encounter and resubmit with the appropriate data.

5.4 Special Considerations

The EDDPPS is structured to include FFS-like logic regarding submission, processing, and pricing; however, there are unique circumstances that require special consideration or modifications in order to allow encounters to successfully pass EDFES and EDDPPS edits. The special considerations include, but are not limited to, the following types of encounter data:

- Default NPIs
- Atypical

5.4.1 Default NPIs

Section 3.5.3 of the Professional Submission Module provides detailed information on the purpose and use of default NPIs for encounter data.

Table 5F below provides the default NPI value by Payer ID:

TABLE 5F – DEFAULT 837-P (DMEPOS) NPI VALUE

SYSTEM	PAYER ID	DEFAULT NPI VALUE
DME	80887	1999999992

MAOs and other entities must submit all encounter data using the EDS Minimum Data Elements.

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information.

5.4.2 Atypical Provider

Section 3.5.4 of the Professional Submission Module provides detailed information on the purpose and use of atypical provider generated encounters.

MAOs and other entities may submit a default Employer Identification Number (EIN) in Loop 2010BB, REF01=EI, REF02= 199999999 for atypical provider submissions **only if the true EIN is not available**.

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for instructions on submitting proxy claim information.

5.5 Duplicate Logic

Once an encounter passes through the EDDPPS, it is stored in the EODS. If a new encounter is submitted that matches specific values to another stored encounter, the encounter will be rejected and will be considered a duplicate encounter. The encounter will be returned to the submitter on MAO-002 report with the error message 98325 – Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim, identifying it as a duplicate encounter. The DMEPOS Supplier duplicate data elements are identical to the Professional/Physician Supplier duplicate data elements, and are the minimum values being used for matching encounters in the EODS:

- Beneficiary Demographic
  - Health Insurance Claim Number (HICN)
  - Last Name
- Date of Service
- Place of Service (2 digits)
- ***Type of Service – not submitted on the 837-P but derived from data captured***
- Procedure Code(s) and four (4) modifiers
- Rendering Provider NPI
- Paid Amount*

* The Paid Amount is the amount paid by the MAO or other entity and must be populated in Loop ID-2320, AMT02

5.6 Summary

During this module, submission, processing, and pricing requirements for DMEPOS incident to provider and DME Supplier encounter data were provided. Acceptable DME incident to provider and DMEPOS Supplier services were detailed.

MODULE 6 – EDFES ACKNOWLEDGEMENT REPORTS

Purpose

Once Medicare Advantage Organizations (MAOs) and other entities submit encounter data to the Encounter Data Front-End System (EDFES), CMS sends acknowledgement reports to allow MAOs and other entities to understand the disposition of data submitted. This module provides best practices for reviewing the acknowledgement reports and reconciling data.

Learning Objectives

At the completion of this module, participants will be able to:

- Identify key elements of the TA1, 999, and 277CA acknowledgement reports.
- Interpret the TA1, 999, and 277CA acknowledgements reports.
- Map the acknowledgement reports back to the 837X file.

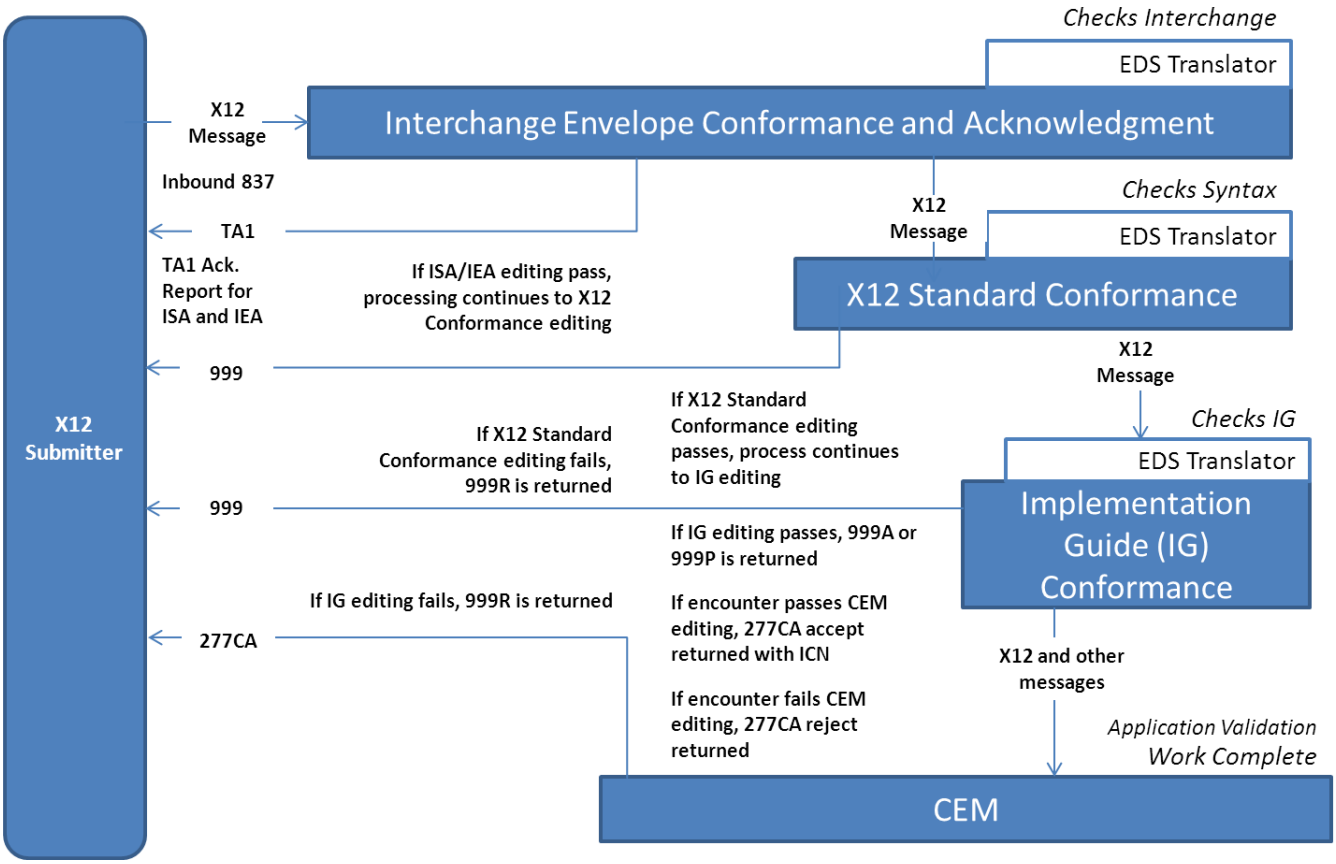
ICON KEY	
Definition	
Example	
Reminder	
Resource	

6.1 Acknowledgement Reports Overview

After MAOs and other entities submit data, the EDFES performs format and integrity checks on the file at the Electronic Data Interchange (EDI) translator and Common Edits and Enhancements Module (CEM) levels. The EDI translator will perform all X12 syntax edits and CMS selected HIPAA Implementation Guide (IG) edits, and output the TA1 and 999 acknowledgement reports. The CEM will perform Medicare and CMS selected IG edits. An Internal Control Number (ICN) will be assigned for accepted encounters. A 277CA will be generated for each accepted or rejected file and the flat file containing all accepted encounters will be forwarded to the Encounter Data Processing System (EDPS).

Figure 6A below illustrates the flow of data for edit processing.

Figure 6A – Encounter Data Front-End System Edits and Flow



6.2 Acknowledgement Report File Naming Convention

EDFES acknowledgement reports are sent to MAOs and other entities within 48 hours of submission.

The naming conventions for EDFES acknowledgement reports were developed to allow MAOs and other entities the ability to identify reports distributed. Table 6A provides testing acknowledgement reports file naming convention.

TABLE 6A – TESTING ACKNOWLEDGEMENT REPORTS FILE NAMING CONVENTION

Report Type	Gentran Mailbox	FTP Mailbox – Text	FTP Mailbox - Zipped
EDFES	T.xxxxx.EDS_RESPONSE.pn	RSPxxxxx.RSP.REJECTED_ID	RSPxxxxx.RSP.REJECTED_ID
EDFES	T.xxxxx.EDS_REJT_IC_ISAIEA.pn	X12xxxxx.X12.TMMDDCCYYHHMMS	X12xxxxx.X12.TMMDDCCYYHHMMS
EDFES	T.xxxxx.EDS_REJT_FUNCT_TRANS.pn	999xxxxx.RSP	999xxxxx.RSP
EDFES	T.xxxxx.EDS_ACCPT_FUNCT_TRANS.pn	999xxxxx.RSP	999xxxxx.RSP
EDFES	T.xxxxx.EDS_RESP_CLAIM_NUM.pn	RSPxxxxx.RSP_277CA	RSPxxxxx.RSP_277CA

Table 6B below provides the production reports file naming convention.

TABLE 6B – PRODUCTION ACKNOWLEDGEMENT REPORTS FILE NAMING CONVENTION

Report Type	Gentran Mailbox	FTP Mailbox – Text	FTP Mailbox - Zipped
EDFES	P.xxxxx.EDS_RESPONSE.pn	RSPxxxxx.RSP.REJECTED_ID	RSPxxxxx.RSP.REJECTED_ID
EDFES	P.xxxxx.EDS_REJT_IC_ISAIEA.pn	X12xxxxx.X12.TMMDDCCYYHHMMS	X12xxxxx.X12.TMMDDCCYYHHMMS
EDFES	P.xxxxx.EDS_REJT_FUNCT_TRANS.pn	999xxxxx.RSP	999xxxxx.RSP
EDFES	P.xxxxx.EDS_ACCPT_FUNCT_TRANS.pn	999xxxxx.RSP	999xxxxx.RSP
EDFES	P.xxxxx.EDS_RESP_CLAIM_NUM.pn	RSPxxxxx.RSP_277CA	RSPxxxxx.RSP_277CA

Note: There is a limit of 20 characters on the description of the file. The description starts after "RPT" or "ZIP".

Table 6C provides a description of the file name components, which will assist MAOs and other entities in identifying the report type.

TABLE 6C – TESTING AND PRODUCTION ACKNOWLEDGEMENT REPORTS FILE NAME COMPONENT DESCRIPTION

File Name Component	Description
RSPxxxxx	The type of data 'RSP' and a sequential number assigned by the RISC 'xxxxx'
X12xxxxx	The type of data 'X12' and a sequential number assigned by the RISC 'xxxxx'
TMMDDCCYYHHMMS	The Date and Time stamp the file was processed by the RISC
999xxxxx	The type of data '999' and a sequential number assigned by the RISC 'xxxxx'
RPTxxxxx	The type of data 'RPT' and a sequential number assigned by the RISC 'xxxxx'
RPT/ZIP	Determines if the file is a plain text 'RPT' or compressed 'ZIP'
XXXXXXX	Seven (7) characters available to be used as a short description of the contents of the file
RPT/FILE	Identifies if the file is a formatted report 'RPT' or a flat file 'FILE' layout

6.3 TA1 Acknowledgement Report

The purpose of the TA1 acknowledgement report is to provide the status of a received Interchange header (ISA) and trailer (IEA) after being processed by the translator. The translator analyzes the Interchange control structure for inconsistencies and/or incorrect data.

The TA1 Interchange acknowledgement report is used to inform MAOs and other entities of their Interchange status. The TA1 acknowledgement report is generated and returned within 48 hours, notifying the sender of problems that were encountered within the Interchange control structure.

A TA1 acknowledgement report may be returned in two (2) situations:

- If requested in the ISA14 of the 837 transaction
- If the transaction is rejected. For EDS processing, a TA1 is produced only when there is a rejection.

The TA1 acknowledgement report represents translator Interchange level syntax editing as follows:

- The EDFES edits the ISA and IEA segments for consistency with the data they contain

- Errors found in this stage will cause the entire X12 Interchange to be rejected with no further processing

When a TA1 acknowledgement report is received, this indicates that there are programming issues within the MAO or other entities' systems. The entire ISA/IEA Interchange (837X file) must be resubmitted after corrections are made.

6.3.1 TA1 Acknowledgement Reports Responses

The CMS CEM Edits Spreadsheet provides TA1 responses, which correlate to the ISA/IEA Interchange. Table 6D lists three (3) TA1 edit examples from the spreadsheet. The "Proposed 5010A1 Edits Part B" column notes the reason for the failure. For example, edit X222.C3..ISA08.020, ISA08 (Interchange Receiver ID) contains the error and was rejected at the TA1 level because the value in ISA08 was either more or less than 15 characters.

📖 http://www.cms.gov/Medicare/Billing/MFFS5010D0/Technical-Documentation.html

TABLE 6D – TA1 EDIT EXAMPLES FROM CMS CEM EDITS SPREADSHEET

Edit Reference	Segment or Element	Description	TA1/ 999/ 277CA	Accept/ Reject	Disposition / Error Code	Proposed 5010A1 Edits Part B
X222.C3..ISA06.010	ISA06	Interchange Sender ID	TA1	Reject	TA105: 006 "Invalid Interchange Sender ID".	ISA06 must be present.
X222.C3..ISA08.020	ISA08	Interchange Receiver ID	TA1	Reject	TA105: 008 "Invalid Interchange Receiver ID".	ISA08 must be 15 characters.
X222.C3..ISA13.050	ISA13	Interchange Control Number	TA1	Reject	TA105: 018 "Invalid Interchange Control Number Value".	ISA13 must be unsigned.

The TA1 is a single segment and is unique in that it is transmitted without the GS/GE envelope structure.

The Interchange Control Number, Interchange date and time are identical to those that were present in the 837X file. This provides the capability to associate the TA1 with the transmitted Interchange. The TA104, Interchange Acknowledgement code, indicates the status of the Interchange control structure.

MAOs and other entities should be able to map the value in the 837X ISA13 data element (Interchange Control Number), to the value in the TA101 data element in the TA1 Acknowledgement, as provided below.

- ISA*00* *00* *ZZ*ENH9999 *ZZ*80882 *120430*1144*^*00501*200000031*1*P*:~
  - The ISA13 data element has a value of "200000031"

The first segment of the TA1 acknowledgement report includes:

- TA1*200000031*120425*1217*R*024~
  - The TA01 data element has a value of "200000031"

Table 6E provides the key TA1 acknowledgement report segments and its description in order to interpret the TA1 report generated and distributed to the MAO or other entity.

TABLE 6E – TA1 KEY SEGMENTS

Segment	Description

TA1 – Interchange Acknowledgement	This segment provides the status of processing a received Interchange header and trailer
	• TA101 – Interchange Control Number
	• TA102 – Interchange Date
	• TA103 – Interchange Time
	• TA104 – Interchange Acknowledgement Code
	  • A = The transmitted Interchange control structure header and trailer have been received and have no errors
	  • R = The transmitted Interchange control structure header and trailer are rejected because of errors
	• TA105 – Interchange Note Code
	  • 001 = The Interchange Control Number in the header and trailer do not match.
	  • 002 = This standard as noted in the control standard identifiers not supported.
	  • 003 = This version of the controls is not supported.
	  • 004 = The segment terminator is invalid.
	  • 005 = Invalid Interchange ID qualifier for sender.
	  • 006 = Invalid Interchange Sender ID.
	  • 007 = Invalid Interchange ID qualifier for receiver.
	  • 008 = Invalid Interchange receiver ID.
	  • 009 = Unknown Interchange receiver ID.
	  • 010 = Invalid authorization information qualifier value
	  • 011 = Invalid authorization information value.
	  • 012 = Invalid security information qualifier value.
	  • 013 = Invalid security information value.
	  • 014 = Invalid Interchange date value.
	  • 015 = Invalid Interchange time value.
	  • 016 = Invalid Interchange standards identifier value.
	  • 017 = Invalid Interchange standards identifier value.
	  • 018 = Invalid Interchange Control Number value.
	  • 019 = Invalid acknowledgement requested value.
	  • 020 = Invalid test indicator value.
	  • 021 = Invalid number of included groups value.
	  • 022 = Invalid control structure.
	  • 023 = Improper (premature) end of file (transmission).
	  • 024 = Invalid Interchange content (e.g., invalid GS Segment).
	  • 026 = Invalid Data Element Separator.
	  • 027 = Invalid component element separator.
	  • 028 = Invalid delivery date in deferred delivery request.
	  • 029 = Invalid delivery time in deferred delivery request.
	  • 030 = Invalid delivery time code in deferred delivery request.
	  • 031 = Invalid grade of service code.

6.3.2 Interpreting the TA1 Acknowledgement Report

The string provided in Figure 6B below is a TA1 acknowledgement report. This string will allow MAOs and other entities to identify the Interchange error.

Figure 6B – TA1 Acknowledgement Report Example

```
1 ISA*00*       *00*       *ZZ*80881       *ZZ*ENC9999       *110916*1632*^*00501*000000003*0*T*:~
2 TA1*000000003*110825*1217*R*001~
3 IEA*0*000000003~
```

Based on the data string provided above, the file with an Interchange Control Number of 000000003 was rejected because the Interchange header (ISA) and trailer (IEA) control numbers do not match.

Table 6F below provides a more detailed analysis of the TA1 segment.

TABLE 6F – TA1 ACKNOWLEDGEMENT REPORT EXAMPLE

Line Number	Data Element	Description
2	TA1	Segment Identifier, Interchange Acknowledgement
	000000003	Interchange Control Number, value from the ISA13 segment of the 837 being reported
	110825	Interchange date
	1217	Interchange time
	R	Interchange Acknowledgement Code, R = Rejected
	001	Interchange Note Code, 001 = Interchange Control Number in the Header and Trailer Do Not Match. The value from the Header is used in the acknowledgement.

6.3.3 Reconciling the TA1 Acknowledgement

The following are resolution steps for error 001, provided in data element TA105:

1. Locate the error on the TA1 Acknowledgement - **TA105 = 001**
2. Look in the appropriate edit spread sheet (837-I or 837-P) – **837-I CMS CEM Edits Spreadsheet**
3. Locate the error on the edit spreadsheet
4. Access the 837 file with the Interchange Control Number of 000000003
   a. View the value populated in the following data elements (they must be identical):
      1) ISA13
      2) IEA02
5. Correct the value populated in ISA13 and IEA02, by populating both data elements with an identical unused value (not used within 12 months)
6. Resubmit the 837 file

6.4 999 Acknowledgement Report

After the Interchange passes the TA1 edits, the next stage of editing is to perform translator level edits of the Functional Group header and trailer (GS/GE) and Transaction Set header and trailer (ST/SE). Errors found on the 999 are compliance errors identified in the TR3 (Implementation Guide). The 999 also reflects technical problems that must be addressed in the software that prepared the EDI 837X file.

The 999 acknowledgement report is generated for every file submission and is used to inform MAOs and other entities of the processing status of the Functional Group and Transaction Sets included in the file.

The 999 transaction set is designed to report on the adherence to IG level edits and CMS standard syntax errors as depicted in the CMS CEM Edits Spreadsheet. Three (3) possible acknowledgement values are:

- "A" – Accepted
- "P" – Partially Accepted, At Least One Transaction Set Was Rejected
- "R" – Rejected

Receipt of the 999A acknowledgement report indicates that the file is accepted and will continue processing. A 999P acknowledgement report indicates that the file was partially accepted and that at least one (1) transaction set was rejected. The 999R acknowledgement report notifies MAOs and other entities that the functional group(s) rejected and the file will not continue for processing. When the 999R or 999P acknowledgement report is received, MAOs and other entities must correct and resubmit the file.

6.4.1 999 Acknowledgement Report Responses

The CMS CEM Edits Spreadsheet provides 999 failure reasons. Table 6G provides one (1) 999 edit example from the spreadsheet, "Proposed 5010A1 Edits Part B" and the associated reason for the failure.

The "Accept/Reject" Column is populated with one of the following values:

- R – The Transaction Set (ST-SE) is rejected back to the submitter.

Disposition/Error Code IK502: 6 for edit reference X222.070..ST.010 noted in Table 6G indicates if received, the 837X file was sent without a Transaction Set Header (ST). MAOs and other entities must ensure there is a ST segment (Transaction Set header) as per the TR3 and EDS 837-P and 837-I Companion Guides.

TABLE 6G – SAMPLE 999 CMS CEM EDITS SPREADSHEET

Edit Reference	Segment or Element	Description	TA1/ 999/ 277CA	Accept/ Reject	Disposition / Error Code	Proposed 5010A1 Edits Part B
X222.070..ST.010	ST	TRANSACTION SET HEADER	999	R	IK502: 6 "Missing or Invalid Transaction Set Identifier".	ST must be present.

6.4.2 Reading the 999 Acknowledgement

The 999 acknowledgement report is composed of segments that report information on the 837X file received. Segments such as the IK3 error identification are present only when there is a need to report a segment error. The CTX context segment appears after the IK3 segment to describe the context within the segment. The IK4 data element segment is present when there is a need to report an error at the data element level and if required, there is a CTX context segment after the IK4 to describe the context within the segment. The IK5 and AK9 segments are always present, noting the transaction set and and/or the functional group's accept or reject status.

MAOs and other entities should be able to map the value in the 837X ST02 data element (Transaction Set Control Number), to the value in the 999 Acknowledgement AK202 data element (Transaction Set Control Number), as provided below.

- ST*837*000000135*005010X222A1~
  - The ST02 data element has a value of "000000135"

The 999 acknowledgement report returned includes the following AK2 segment:

- AK2*837*000000135*005010X222A1~
  - The AK202 data element has a value of 000000135

Table 6H below provides the key 999 acknowledgement report segments and their associated description.

TABLE 6H – 999 ACKNOWLEDGEMENT REPORT KEY SEGMENTS

Segment	Description
AK1- Functional Group Response Header	This segment responds to the functional group information received on the 837X file • AK101 - Functional Identifier Code • HC – Health Care Claim (837) • AK102 - Group Control Number (837X GS06 value) • AK103 - Version/Release/Industry Identifier Code
AK2 - Transaction Set Response Header	This segment starts the acknowledgement of a transaction set • AK201 - Transaction Set Identifier Code • 837 – Health Care Claim • AK202 - Transaction Set Control Number (837X ST02 value) • AK203 - Implementation Convention Reference

TABLE 6H – 999 ACKNOWLEDGEMENT REPORT KEY SEGMENTS (CONTINUED)

Segment	Description

IK3 - Error Identification
(Represents the Segment in Error)
	This segment reports segment errors related to this AK2 Loop
	• IK301 – This data element is the two or three byte segment ID that contains the error, (example "ST" or "SBR")
	• IK302 – This data element contains the sequential position of the segment ID identified in IK301. The transaction set header is count one, example:
	  • In the received 837X, the CAS segment was the 37th segment from the ST segment
	• IK303 – Loop identifier
	• IK304 – Segment Syntax Error Code (This data element describes the type of error encountered)
	  • 1 = Unrecognized segment ID
	  • 2 = Unexpected segment
	  • 3 = Required segment missing
	  • 4 = Loop occurs over maximum times
	  • 5 = Segment exceeds maximum use
	  • 6 = Segment not in defined transaction set
	  • 7 = Segment not in proper sequence
	  • 8 = Segment has data element errors
	  • I4 = Implementation "Not Used" segment present
	  • I6 = Implementation dependent segment missing
	  • I7 = Implementation loop occurs under minimum times
	  • I8 = Implementation segment below minimum use
	  • I9 = Implementation dependent "Not Used" segment present

CTX - Segment Context
(related to IK3)
	This is the segment context, used to identify the 837X segment data that triggered the error (related to this AK2)
	• CTX01 – Context Identification
	  • CTX01-1 – Context Reference – value "SITUATIONAL TRIGGER", will be displayed, to identify the situational segment and loop that caused the situation to be required
	• CTX02 – Segment ID Code, Code defining the segment ID of the data segment in error
	• CTX03 – Segment Position in Transaction Set, the numerical count position of this data segment from the start of the transaction set
	• CTX04 - Loop Identifier Code, the loop ID number for this data element
	• CTX05 - Position in Segment, code indicating the relative position of the data element or composite data structure in error
	  • CTX05-1 - Element Position in Segment
	  • CTX05-2 - Component Data Element Position in Composite
	  • CTX05-3 - Repeating Data Element Position
	• CTX06 – Reference in Segment
	  • CTX06-1- Data Element Reference Number
	  • CTX06-2- Data Element Reference Number

CTX - Business Unit Identifier (related to IK3)	This is the business unit identifier segment, used to identify the 837X segment data that triggered the error (related to this AK2) • CTX01 – Context Identification • CTX01-1 – Context Reference – value "CLM01", will be displayed, to identify the business unit in CTX01-1 (Claim/Encounter Identifier Number)

TABLE 6H – 999 ACKNOWLEDGEMENT REPORT KEY SEGMENTS (CONTINUED)

Segment	Description

IK4 – TR3 Data Element Note
(Represent the Data Element in Error, related to the segment (noted in the IK3 loop)
	This segment reports data element and composite errors in the 837X (related to this AK2)
	
	This segment is required when the error described in IK3 applies to a data element, and the location of the data element containing the error can be identified by CMS.
	• IK401 - Position in Segment, This is a composite data element, indicating there is sub data element under this data element
	  • IK401-1 – Data element position in the segment, example:
	  ▪ REF02 structure says "REF" is the segment and "REF02" is the 2nd data element within the segment
	  • IK401-2 – Component Data Element Position, in Composite, This data element identifies within the composite structure where the error occurs (Situational filed)
	  • IK401-3 – Repeating Data Element Position, This data element identifies the specific repetition of a data element that is in error (Situational filed)
	• IK402 – TR3 Data Element Reference Number, reference number used to locate the data element in the Data Element Dictionary (Situational field, Palmetto currently not populating)
	• IK403 - Implementation Data Element Syntax error code:
	  • 1 = Required data element missing
	  • 2 = Conditional required data element missing
	  • 3 = Too many data elements
	  • 4 = Data element too short
	  • 5 = Data element too long
	  • 6 = Invalid character in data element
	  • 7 = Invalid code value
	  • 8 = Invalid date
	  • 9 = Invalid time
	  • 10 = Exclusion condition violated
	  • 12 = Too many repetitions
	  • 13 = Too many components
	  • I6 = Code value not used in Implementation
	  • I9 = Implementation dependent data element missing
	  • I10 = Implementation "Not Used" data element present
	  • I11= Implementation too few repetitions
	  • I12 = Implementation pattern match failure
	  • I13 = Implementation dependent "Not Used" data element present
	• IK404 - Copy of Bad Data Element, This is a copy of the data element in error

TABLE 6H – 999 ACKNOWLEDGEMENT REPORT KEY SEGMENTS (CONTINUED)

Segment	Description

CTX - Element Context
(related to IK4)
	This is the element context used to identify the 837X segment data that triggered the Error (related to this AK2)
	• CTX01 – Context Identification
	  ○ CTX01-1 – Context Reference – value "SITUATIONAL TRIGGER", will be displayed, to identify the situational segment and loop that caused the situation to be required
	• CTX02 – Segment ID Code, Code defining the segment ID of the data segment in error
	• CTX03 – Segment Position in Transaction Set, the numerical count position of this data segment from the start of the transaction set
	• CTX04 - Loop Identifier Code, the loop ID number for this data element
	• CTX05 - Position in Segment, code indicating the relative position of the data element or composite data structure in error
	  • CTX05-1 - Element Position in Segment
	  • CTX05-2 - Component Data Element Position in Composite
	  • CTX05-3 - Repeating Data Element Position
	• CTX06 – Reference in Segment
	  • CTX06-1- Data Element Reference Number
	  • CTX06-2- Data Element Reference Number

IK5 - Transaction Set Response Trailer	This segment acknowledges the acceptance or rejection of a transaction and report errors.
	Transaction Set Response Trailer
	• IK501 - Transaction Set Acknowledgement Code
	  • A – Accepted
	  • P – Partially Accepted, at least one transaction set was rejected
	  • R – Rejected
	• IK502 - Transaction Set Syntax Error Code
	  • 1 = Transaction set not supported
	  • 2 = Transaction set trailer missing
	  • 3 = Transaction set control number in header and trailer do not match
	  • 4 = Number of included segments does not match actual count
	  • 5 = One or more segments in error
	  • 6 = Missing or invalid transaction set identifier
	  • 7 = Missing or invalid transaction set control number
	  • 18 = Transaction set not in functional group
	  • 19 = Invalid transaction set implementation convention reference
	  • I5 = Implementation One or More Segments in Error
	  • I6 = Implementation convention not supported

TABLE 6H – 999 ACKNOWLEDGEMENT REPORT KEY SEGMENTS (CONTINUED)

Segment	Description

AK9 - Functional Group Response Trailer	This segment acknowledges the acceptance or rejection of a functional group and reports the number of transaction sets originally included, received, and accepted.
	• AK901 - Functional Group Acknowledgement Code
	  • A – Accepted
	  • P – Partially Accepted, at least one transaction set was rejected
	  • R – Rejected
	• AK902 - Number of Transaction Sets Included
	• AK903 - Number of Received Transaction Sets
	• AK904 - Number of Accepted Transaction Sets

6.4.3 Interpreting the 999A Functional Group with One Transaction Set Accepted

The string provided below in Figure 6C is an example of a 999A acknowledgement report. This string will allow MAOs and other entities to identify the Functional Group and the Transaction Set header and trailer information.

Figure 6C – 999A Acknowledgement Report Example

```
1  ISA*00*       *00*       *ZZ*80882       *ZZ*ENC9999      *120410*0802*^*00501*003125081*0*T*:~
2  GS*FA*80882*ENC9999*20120410*08021518*3112795*X*005010X231A1~
3  ST*999*112795001*005010X231A1~
4  AK1*HC*135*005010X222A1~
5  AK2*837*000000135*005010X222A1~
6  IK5*A~
7  AK9*A*1*1*1~
8  SE*6*112795001~
9  GE*1*3112795~
10 IEA*1*003125081~
```

An 837 file with a functional group control number of 135 was submitted containing one (1) transaction set with a control number of 000000135. Both the functional group and transaction set passed 999 editing and were accepted. Table 6I below provides a more detailed analysis of the 999A functional group and transaction set.

TABLE 6I - 999A ACKNOWLEDGEMENT REPORT – FUNCTIONAL GROUP AND TRANSACTION

Data String Line	Data Element	Description
4	AK1	999 Segment Identifier
	HC	Healthcare Claims Functional Identifier Code
	135	837 Functional Group Control Number (GS06)
	005010X222A1	TR3 Guide ID Health Care Claim: Professional
5	AK2	999 segment Identifier
	837	Health Care Claim
	000000135	837 Transaction Set Response Header Segment ID (ST02)
	005010X222A1	TR3 Guide ID Health Care Claim: Professional

TABLE 6I - 999A ACKNOWLEDGEMENT REPORT – FUNCTIONAL GROUP AND TRANSACTION (CONTINUED)

Data String Line	Data Element	Description
6	IK5	999 segment Identifier, Transaction Set Response Trailer
	A	Accept The "A" in the IK5 segment indicates there were no errors in the Transaction Set
	AK9	999 Segment Identifier, Functional Group Response Trailer
	A	Acknowledgement Code The "A" in the AK9 segment indicates there were no errors in the Functional Group
	1	Number of Transaction Sets Included
	1	Number of Received Transaction Sets
	1	Number of Accepted Transaction Sets

6.4.4 Interpreting the 999A Functional Group with Multiple Transaction Sets Accepted

The string provided in Figure 6D below is an example of a 999A acknowledgement report. In this string, MAOs and other entities will be able to identify the Functional Group header and trailer and the five (5) transaction sets

Figure 6D - 999A Acknowledgement Report Example

```
ISA*00*       *00*       *ZZ*80882       *ZZ*ENC9999      *120405*1507*^*00501*003029653*0*T*:~
GS*FA*80882*ENC9999*20120405*15072373*3017357*X*005010X231A1~
ST*999*17357001*005010X231A1~
AK1*HC*22*005010X222A1~
AK2*837*0001*005010X222A1~
IK5*A~
AK2*837*0002*005010X222A1~
IK5*A~
AK2*837*0003*005010X222A1~
IK5*A~
AK2*837*0004*005010X222A1~
IK5*A~
AK2*837*0005*005010X222A1~
IK5*A~
AK9*A*5*5*5~
SE*80*17357001~
GE*1*3017357~
IEA*1*003029653~
```

Note: The circled data elements represent the ST/SE Control numbers.

An 837 file with a functional group control number of 22 was submitted containing five (5) transaction sets (ST/SE). The first transaction set has a control number of 0001, the second 0002, the third 0003, the fourth

0004, and the fifth 0005. The functional group and all five (5) transaction sets passed 999 editing and were accepted.

6.4.5 Interpreting the 999R Rejected Transaction Set

The string below provided in Figure 6E is a sample of a 999R acknowledgement report, which includes two (2) different transaction sets. MAOs and other entities will be able to identify the transaction set, segment, data element, and encounter in which the error occurred.

Figure 6E – 999R Acknowledgement Report Example

```
1  ISA*00*       *00*       *ZZ*80882       *ZZ*ENC9999      *120406*0804*^*00501*003038950*0*T*:~
2  GS*FA*80882*ENC9999*20120406*08043574*3026654*X*005010X231A1~
3  ST*999*26654001*005010X231A1~
4  AK1*HC*133*005010X222A1~
5  AK2*837*000000133*005010X222A1~
6  IK3*SBR*689*2430*7~
7  CTX*CLM01:2012020399900522TC11~
8  IK3*AMT*698*2320*8~
9  CTX*CLM01:2012020399900522TC11~
10 IK4*2**7*000000000021~
11 IK3*SBR*735*2430*7~
12 CTX*CLM01:2012030799900224TC11~
13 IK3*AMT*744*2320*8~
14 CTX*CLM01:2012030799900224TC11~
15 IK4*2**7*000000000015~
16 IK5*R*I5~
17 AK2*837*000020860*005010X222A1~
18 IK3*SVD*31*2430*8~
19 CTX*CLM01:P2752560~
20 IK4*1**2*H9999~
21 CTX*SITUATIONAL TRIGGER***2330~
22 IK5*R*I5~
23 AK9*R*2*1*0~
24 SE*16*26654001~
25 GE*1*3026654~
26 IEA*1*003038950~
```

In the 999R response example listed above, there are two (2) transaction sets. The first transaction set illustrates four (4) errors reported, effecting two (2) different encounters (2012020399900522TC11 and 2012030799900224TC11). The second transaction set illustrates one (1) error reported, effecting one (1) encounter P2752560.

- Transaction Set 000000133, rejected transaction
  - Encounter Identifier Number 2012020399900522TC11, 2430 Loop, SBR segment is not in the proper sequence. The 2430 Loop, SBR segment found in the 689th location from the “ST” segment on the 837X file
  - Encounter Identifier Number 2012020399900522TC11, 2320 Loop, AMT segment has data element errors. The 2320 Loop, AMT segment found in the 698th location from the “ST” segment on the 837X file

  - Data element AMT02 has an invalid code value
  - The code value for the AMT02 is found in data element AMT01, the value should be "D" not "000000000021
- Encounter Identifier Number 2012030799900224TC11, 2430 Loop, SBR segment is not in the proper sequence. The 2430 Loop, SBR segment found in the 735th location from the "ST" segment on the 837X file
- Encounter Identifier Number 2012030799900224TC11, 2320 Loop, AMT segment has data element errors. The 2320 Loop, AMT segment found in the 744th location from the "ST" segment on the 837X file
  - Data element AMT02 has an invalid code value
  - The code value for the AMT02 data element is found in data element AMT01, the value should be "D" not "000000000021

- Transaction Set 000020860, rejected transaction
  - Encounter Identifier Number P2752560, 2430 Loop, SVD segment has data element errors. The 2430 Loop, SVD segment found in the 31st location from the "ST" segment on the 837X file
    - Data element SVD01 has a conditional required data element that is missing
      - Loop that is triggering this error was Loop 2330
        - TR3 rule 2430.SVD01 must = 2330B.NM109 (for the same payer)

Table 6J below provides a more detailed analysis of the rejected Transaction Sets.

TABLE 6J – 999R REJECTED TRANSACTION SET EXAMPLE

Data String Line	Data Element	Description
6	IK3	999 segment Identifier, Error Identification
	SBR	ID of segment containing the syntax error (SBR segment)
	689	Position of the segment in error relative to the start of the transaction set (SBR is the 689th segment from the "ST" segment which is counted as 1)
7	CTX	999 segment Identifier, Segment Context
	CLM01:2012020399900522TC11	Context Identification Context Name: Context Reference Number
8	IK3	999 segment Identifier, Error Identification
	AMT	ID of segment containing the syntax error (AMT segment)
	698	Position of the segment in error relative to the start of the transaction set (AMT is the 698th segment from the "ST" segment which is counted as 1)
	2320	Loop identifier Code
	8	Syntax Error Code, 8 = Segment has data element errors
9	CTX	999 segment Identifier, Segment Context
	CLM01:2012020399900522TC11	Context Identification Context Name: Context Reference Number
10	IK4	999 segment Identifier, TR3 Data Element Note
	2	Position of the element in error inside of the segment IK301(AMT) + IK401(2) = (AMT02)
	7	Syntax error code, 7 = Invalid code value
	000000000021	Copy of Data Element in error
11	IK3	999 segment Identifier, Error Identification
	SBR	ID of segment containing the syntax error (SBR segment)

TABLE 6J – 999R REJECTED TRANSACTION SET EXAMPLE (CONTINUED)

Data String Line	Data Element	Description
	735	Position of the segment in error relative to the start of the transaction set (SBR is the 735th segment from the "ST" segment which is counted as 1)
	2430	Loop identifier Code
	7	Syntax Error Code, 7 = Segment not in proper sequence
12	CTX	999 segment Identifier, Segment Context
	CLM01:2012030799900224TC11	Context Identification Context Name: Context Reference Number
13	IK3	999 segment Identifier, Error Identification
	AMT	ID of segment containing the syntax error (AMT segment)
	744	Position of the segment in error relative to the start of the transaction set (AMT is the 744th segment from the "ST" segment which is counted as 1)
	2320	Loop identifier Code
	8	Syntax Error Code, 8 = Segment has data element errors
14	CTX	999 segment Identifier, Segment Context
	CLM01:2012030799900224TC11	Context Identification Context Name: Context Reference Number
15	IK4	999 segment Identifier, TR3 Data Element Note
	2	Position of the element in error inside of the segment IK301(AMT) + IK401(2) = (AMT02)
	7	Syntax error code, 7 = Invalid code value
	000000000015	Copy of Data Element in error
16	IK5	999 segment Identifier, Transaction Set Response Trailer
	R	Acknowledgement Code R = rejected
	I5	Transaction Set Syntax Error Code I5 = Implementation One or More Segments in Error
17	IK3	999 segment Identifier, Error Identification
	SVD	ID of segment containing the syntax error (SVD segment)
	31	Position of the segment in error relative to the start of the transaction set (SBR is the 31st segment from the "ST" segment which is counted as 1)
	2430	Loop identifier Code
	8	Syntax Error Code, 8 = Segment has data element errors
19	CTX	999 segment Identifier, Segment Context
	CLM01:P2752560	Context Identification Context Name: Context Reference Number
20	IK4	999 segment Identifier, TR3 Data Element Note
	1	Position of the element in error inside of the segment IK301(SVD) + IK401(1) = (SVD01)
	2	Syntax error code, 2 = Conditional required data element missing
	H9999	Copy of Data Element in error
21	CTX	999 segment Identifier, Segment Context
	SITUATIONAL TRIGGER	Context Identification
	2330	Loop Identifier Code, the loop ID number for this data element
23	AK9	999 Segment Identifier, Functional Group Response Trailer
	R	Acknowledgement Code R = rejected
	2	Number of Transaction Sets Included
	2	Number of Received Transaction Sets
	0	Number of Accepted Transaction Sets

6.4.6 999R Reject Transaction Set Resolution Steps

In order to properly reconcile the 999R acknowledgement report, MAOs and other entities must follow the guidance provided below:

1. Locate errors for transaction set **000000133 (4 errors in transaction set)**
   a. Look at the data string for encounter **2012020399900522TC11**
      1) 1St error for this encounter, **IK304 = 7**
      2) Access the CMS CEM Edits Spreadsheet
      3) Access the WPC 999 TR3
      4) Look up error IK304 = 7 to obtain dispositions
         a) Error IK304 = 7 was not found on the CMS CEM Edits Spreadsheet
            Error IK304 = 7 was found in the 999 TR3 = "**Segment Not in Proper Sequence**"
      5) Move the 2430 Loop, SBR segment to the correct sequence/location in the data string
      6) 2nd error set for encounter 2012020399900522TC11, combination **IK304 = 8** and **IK403 = 7**
         b) Error IK304 = 8 was not found on the CMS CEM Edits Spreadsheet
            Error IK304 = 8 was found in the 999 TR3 = "**Segment has data element errors**"
         c) Error IK403 = 7 was found on the CMS CEM Edits Spreadsheet = "**Invalid Code Value**"
            Excerpt from CMS CEM Edits Spreadsheet:

X222.305.2320.AMT01.020	**AMT01**	**999**	**R**	**IK403 = 7: "Invalid Code Value"**
2320.AMT01 must be "D".				

      7) Look at the value in Loop 2320, data element AMT01
         a) Correct the value in AMT01, it must be "D" Error
   b. Look at the data string for encounter **2012030799900224TC11**
      1) 1St error for this encounter, **IK304 = 7**
      2) Access the CMS CEM Edits Spreadsheet
      3) Access the WPC 999 TR3
      4) Look up error IK304 = 7 to obtain dispositions
         a) Error IK304 = 7 was not found on the CMS CEM Edits Spreadsheet
         b) Error IK304 = 7 was found in the 999 TR3 = "**Segment Not in Proper Sequence**"
      5) Move the 2430 Loop, SBR segment to the correct sequence
      6) 2nd error set for encounter 2012030799900224TC11, combination **IK304 = 8** and **IK403 = 7**
         a) Error IK304 = 8 was not found on the CMS CEM Edits Spreadsheet
            Error IK304 = 8 was found in the 999 TR3 = "**Segment has data element errors**"
         b) Error IK403 = 7 was found on the CMS CEM Edits Spreadsheet = "**Invalid Code Value**"
            Excerpt from CMS CEM Edits Spreadsheet:

X222.305.2320.AMT01.020	**AMT01**	**999**	**R**	**IK403 = 7: "Invalid Code Value"**
2320.AMT01 must be "D".				

      7) Look at the vale in Loop 2320, data element AMT01
         a) Correct the value in AMT01, it must be "D" Error
      8) After all encounters in the transaction set are corrected, resubmit the transaction set

2. Locate errors for transaction set **000020860 (1 error in transaction set)**
   a. Look at the data string for encounter **P2752560**
      1) 1St error for this encounter, **combination IK304 = 8 and IK403 = I12**
      2) Access the CMS CEM Edits Spreadsheet

3) Access the WPC 999 TR3
4) Look up error IK304 = 8 to obtain dispositions
   a) Error IK304 = 8 was not found on the CMS CEM Edits Spreadsheet
      Error IK304 = 8 was found in the 999 TR3 = "**Segment has data element errors**"
   b) Error IK403 = I12 was found on the CMS CEM Edits Spreadsheet = "**Implementation Pattern Match Failure**"
      Excerpt from CMS CEM Edits Spreadsheet:

X222.480.2430.SVD01.020	**SVD01**	**999**	**R**	**IK403 = I12: "Implementation Pattern Match Failure" 2430.SVD01 must = 2330B.NM109 (for the same payer).**

5) Look at the values in the following data elements they must match
   a) 2430 Loop, data element SVD01
   b) 2330B Loop, data element NM109
6) Correct the values in SVD01 and NM109
7) After all encounters in the transaction set are corrected, resubmit the transaction set

6.5 277CA Acknowledgement Report

After the file is accepted through the translator, the next level of editing occurs within the CEM in order to create the 277CA acknowledgement report. The 277CA acknowledgement report is used to provide notification to MAOs and other entities of the status of an encounter as a result of CEM processing.

The 277CA acknowledgement report provides the status of each encounter as either accepted or rejected. Encounters noted as accepted on the 277CA acknowledgement report are assigned an EDS Internal Control Number (ICN), whereas rejected encounters will not receive an ICN. 277CA acknowledgement report rejections typically reflect problems that are addressed by the MAO or other entity's billing advisor. The 277CA acknowledgement report is an unsolicited acknowledgement report from CMS to MAOs and other entities, and will be returned within 48 hours of file submission.

If the file is accepted on the 999 or accepted with errors, a 277CA will be produced to indicate if the encounter passed editing.

The 277CA acknowledgement report represents the following encounter level CEM processing:

- Business rule errors
  - Medicare specific edits
  - CMS-selected TR3 edits
- Individual encounter level reporting as opposed to the entire file
- Total number of encounters accepted and rejected, as well as the rejection reasons

When a 277CA acknowledgement report is received, MAOs and other entities must perform the following actions:

- Recognize rejected encounters, the business rule error that occurred, and address problems using billing/claims processing experts
  - Billing staff will most likely need reports created from the 277CA acknowledgement report that they can correct errors
- Correct the rejected encounters based on the error reported and the following references:
  - WPC TR3

  - Health Care Code Lists
    - Claim Status Category Codes
    - Claim Status Codes
  - CMS CEM Edits Spreadsheet
  - EDS Companion Guides
- Recognize accepted encounters
  - Use returned ICN for future encounter modification, linked chart review submissions, and/or inquiries

6.5.1 277CA Failure Reasons

Table 6K shows an example of a 277CA edit, A7:249, from the CMS CEM Edits Spreadsheet, which provides the reason for the receipt of error.

Error A7:249 indicates there is invalid data in the SV105 data element. MAOs and other entities must check the value populated in data element SV105, segment SV1, Loop 2400, on the 837-P file, to ensure the POS value is a valid value as of the date of the 837-P transmission file.

TABLE 6K – 277CA EDIT EXAMPLE FROM CMS CEM EDITS SPREADSHEET

Edit Reference	Segment or Element	Description	TA1/ 999/ 277CA	Accept/ Reject	Disposition / Error Code	Proposed 5010A1 Edits Part B
X222.351.2400.SV105.010	SV105	Place of Service Code	277	C	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 249: "Place of service"	2400.SV105 must be a valid Place of Service Code on the date in BHT04.

6.5.2 Reading the 277CA Acknowledgement

The 277CA acknowledgement report is divided into hierarchical levels and each level is representative of the following:

- Information Source (Hierarchical Level (HL) Code = 20)
- Information Receiver (HL Code = 21)
- Provider of Service (HL Code = 19)
- Patient (HL Code = PT)

The first hierarchical level is the Information Source, which represents the creator of the 277CA. The EDS processing information source is Palmetto GBA South Carolina. After each level, the Information Source sends the 277CA Acknowledgement status (“STC”) of the data received from the 837X file.

MAOs and other entities should be able to map the value in the 837X BHT03 data element (MAO or other entity’s Application Transaction Identifier/ Batch Control Number), to the value in the TRN02 data element (Information Application Trace Identifier) Information Receiver Level on the 277CA acknowledgement report, following the guidance below.

- BHT*0019*00*000090028*20091006*124824*CH~

- The BHT03 data element has the value of "000090028"

The 277CA acknowledgement returned as a result of the file submission includes the following segment:

- Loop 2200B
  - TRN*2*000090028~
    - The TRN02 data element has the value of "000090028"

Table 6L provides the key 277CA Acknowledgement segments and its description.

TABLE 6L – 277CA ACKNOWLEDGEMENT REPORT KEY SEGMENTS

Segment	Description
ST	Transaction Set Header
BHT	Beginning of Hierarchical Transaction (BHT) = "0085" which indicates the file structure is: ▪ Information Source (Hierarchical Level (HL) Code = 20) ▪ Information Receiver (HL Code = 21) ▪ Provider of Service (HL Code = 19) ▪ Patient (HL Code = PT
2000A - HL	Hierarchical Level 1 - Information Source Level –PALMETTO GBA SOUTH CAROLINA
2100A - NM1	Information Source Name
2200A - TRN (Indicator = "1")	Transmission Receipt Control Identifier
2200A - DTP	Information Source Receipt Date
2200A - DTP	Information Source Process Date
2000B - HL	Hierarchical Level 2 - Information Receiver Level – this is who will receive the Claim Acknowledgement (277) – will be the Submitter
2100B - NM1	Information Receiver Name
2200B - TRN (Indicator = "2")	Information Receiver Application Trace Identifier
2200B - STC	Information Receiver Status Information
2200B - QTY (Indicator = "90")	Total Accepted Quantity
2200B - QTY (Indicator = "AA")	Total Rejected Quantity
2200B - AMT (Indicator = "YU")	Total Accepted Amount
2200B - AMT (Indicator = "YY")	Total Rejected Amount
2000C - HL	Hierarchical Level XX - Billing Provider of Service (or Service Provider) Level
2100C - NM1	Billing Provider Name
2200C - TRN (Indicator = "1")	Provider of Service Information Trace Identifier
2200C - STC	Billing Provider Status Information
2200C - REF	Provider Secondary Identifier
2200C - QTY (Indicator = "QA")	Total Accepted Quantity
2200C - QTY (Indicator = "QC")	Total Rejected Quantity
2200C - AMT (Indicator = "YU")	Total Accepted Amount
2200C - AMT (Indicator = "YY")	Total Rejected Amount
2000D - HL	Hierarchical Level XX - Patient Level
2100D - NM1	Patient Name
2200D - TRN (Indicator = "2")	Claim Status Tracking Number
2200D - STC	Claim Level Status Information
2200D - REF (Indicator = "1K")	Payer Claim Control Number (Internal Claim Number (ICN), Present on Accepted Encounters Only
2200D - REF (Indicator = "D9")	MAO or Other Entity Claim Identifier Number
2200D - DTP	Claim Level Service Date
2220D - SVC	Service Line Information
2220D - STC	Service Line Level Status Information

TABLE 6L – 277CA ACKNOWLEDGEMENT REPORT KEY SEGMENTS (CONTINUED)

Segment	Description
2220D - REF (Indicator = "FJ")	Service Line Item Identification
2220D - REF	Line Item Control Number
2220D - DTP	Service Line Date
SE	Transaction Set Trailer

6.5.3 Interpreting the 277CA Acknowledgement Report – Submitter Level Accepted

The string provided in Figure 6F below is an example of a 277CA acknowledgement report. In this string, MAOs and other entities will be able to obtain a summarization of the 837-P file associated with the 277CA acknowledgement.

Figure 6F – 277CA Acknowledgement Report Example – Submitter Level Accepted

```
1  ISA*00*          *00*          *ZZ*80882          *ZZ*ENC9999        *120403*0818*^*00501*000000001*0*T*:~
2  GS*HN*80882*ENC9999*20120403*081844*2597723*X*005010X214~
3  ST*277*000000001*005010X214~
4  BHT*0085*08*12094*20120403*08052200*TH~
5  HL*1**20*1~
6  NM1*PR*2*       PALMETTO GBA SOUTH CAROLINA*****46*80882~
7  TRN*1*8088220120403000001~
8  DTP*050*D8*20120403~
9  DTP*009*D8*20120403~
10 HL*2*1*21*1~
11 NM1*41*2*ABC MAO*****46*ENC9999~
12 TRN*2*000090028~
13 STC*A1:19:PR*20120403*WQ*12223.87~
14 QTY*90*34~
15 QTY*AA*4~
16 AMT*YU*11626.18~
17 AMT*YY*597.69~
```

The submitter sent a total of 38 encounters totaling $12,223.87, within their ST/SE segment identified as batch 000090028. Of those 38 encounters, 34 were accepted and received an ICN number, and four (4) were rejected. The total amount accepted equals $11,626.18 and the total amount rejected equals $597.69.

Table 6M below provides a more detailed analysis of the Submitter/Information Receiver level.

TABLE 6M – 277CA SUBMITTER/INFORMATION RECEIVER LEVEL EXAMPLE

Data String Line	Data Element	Description
10	HL	277CA segment identifier
	2	Identifies this level as the 2nd level within this ST/SE Segment
	1	Identifies this level as a subordinate to level "1" (HL 1 is parent to this level)
	21	Identifies this level as 21 which means Information Receiver
	1	Identifies that there is at least 1 additional subordinate level beyond this level (a child level follows)

TABLE 6M – 277CA SUBMITTER/INFORMATION RECEIVER LEVEL EXAMPLE (CONTINUED)

Data String Line	Data Element	Description
11	NM1	277CA segment identifier
	41	Entity code, 41 = Submitter
	2	Entity type qualifier, 2 = Non-person entity
	ABC MAO	Information Receiver Name (Submitter Name entered in Loop 1000A, data element NM103 on the 837)
	46	Entity qualifier, 46 = Entity's ID Electronic Transmitter Identification Number (ETIN)
	ENC9999	Identifies the entity's contract number
12	TRN	277CA segment identifier
	2	Trace type code, 2 = Referenced transaction trace number
	000090028	Identifies the Information Source application trace identifier, 00009028 is the ST/SE batch control number from the 837X BHT03 data element
13	STC	277CA segment identifier
	A1:19:PR	Claim status category code, A1 = the claim has been received: claim status code, 19 =entity acknowledges receipt of claim/encounter: entity identifier code, PR = payer
	20120403	Effective date of the status information
	WQ	Action code indicating if ST- SE was accepted, WQ = accepted U = Reject
	12223.87	Sum of all 837X CLM02 amounts (billed amount for claim) within the ST-SE
14	QTY	277CA segment identifier
	90	Acknowledged quantity
	34	Total accepted quantity, 34 = number of accepted encounters
15	QTY	277CA segment identifier, Total Rejected Quantity
	AA	Unacknowledged quantity
	4	Total rejected quantity, 4 = number of rejected encounters
16	AMT	277CA segment identifier, Total Accepted Monetary Amount
	YU	Amount qualifier code, YU =in process
	11626.18	Total monetary amount, $11,626.18 is the amount accepted
17	AMT	277CA segment identifier, Total Rejected Monetary Amount
	YY	Amount qualifier code, YY = returned
	597.69	Total monetary amount, $597.69 is the amount rejected

6.5.4 Interpreting the 277CA Acknowledgement Report - Provider and Encounter Level Accepted

The string provided in Figure 6G below is an example of a 277CA acknowledgement report building upon the previous string provided in section 6.5.3. In this string, MAOs and other entities will be able to identify the provider, patient and ICN for the accepted encounter.

Figure 6G – 277CA Acknowledgement Report Example – Provider and Encounter Level Accepted

```
1  HL*3*2*19*1~
2  NM1*85*2*SMITH CLINIC*****XX*123456789~
3  TRN*1*PP2487057TC01~
4  STC*A1:19:PR**WQ*90~
5  QTY*QA*1~
6  AMT*YU*90~
7  HL*4*3*PT~
8  NM1*QC*1*SMITH*TESTER*A***MI*123456789A~
9  TRN*2*PP2487057TC01~
10 STC*A2:20:PR*20120403*WQ*90~
11 REF*1K*E212094001820TEST~
12 REF*D9*PP2487057TC01~
13 DTP*472*D8*20120114~
```

The submitter sent an encounter for Smith A. Tester who received services by provider "Smith Clinic". The amount billed by Smith Clinic was $90.00 (the encounter header level amount is $90.00). Both the provider and encounter levels passed edits and received an accept status with an ICN being assigned to the encounter.

Table 6N below provides a more detailed analysis of the Provider of Service level.

TABLE 6N – 277CA PROVIDER OF SERVICE LEVEL DETAILS

Data String Line	Data Element	Description
1	HL	277CA segment identifier
	3	Identifies this level as the 3rd level within this ST/SE Segment
	2	Identifies this level as a subordinate to level "2" (HL 2 is parent to this level)
	19	Identifies this level as 19 which means provider of service
	1	Identifies that there is at least 1 additional subordinate level beyond this level (a child level follows)
2	NM1	277CA segment identifier
	85	Entity code, 85 = Organization
	2	Entity type qualifier, 2 = Non-person entity
	SMITH CLINIC	Information Receiver Name (Submitter Name entered in Loop 1000A, data element NM103 on the 837)
	XX	Entity Code, XX = NPI
	123456789	NPI Number
3	TRN	277CA segment identifier
	1	Trace Type Code, 1 = Current Transaction Trace Number
	PP2487057TC01	Identifies the Provider of Service Information Trace Identifier
4	STC	277CA segment identifier
	A1:19:PR	Claim status category code, A1 = the claim has been received: claim status code, 19 =entity acknowledges receipt of claim/encounter: entity identifier code, PR = payer

TABLE 6N – 277CA PROVIDER OF SERVICE LEVEL DETAILS (CONTINUED)

Data String Line	Data Element	Description
4	WQ	Action code indicating provider level accepted, WQ = accepted U = Reject
	90	Amount billed, $90.00 is the amount billed by the provider
5	QTY	277CA segment identifier, Provider Total Accepted Quantity
	QA	Quantity identifier, QA = Approved quantity (If there were disapproved encounter(s) for this provider a "QC" meaning quantity disapproved identifier would be added)
	1	Total accepted quantity, 1 = the number of encounters accepted for this provider
6	AMT	277CA segment identifier, Total Accepted Monetary Amount
	YU	Amount qualifier code, YU =in process
	90	Total monetary amount, $90.00 is the amount accepted

Table 6O below provides a more detailed analysis of the Encounter level.

TABLE 6O – 277CA ENCOUNTER LEVEL DETAILS

Data String Line	Data Element	Description
7	HL	277CA segment identifier
	4	Identifies this level as the 4th level within this ST/SE Segment
	3	Identifies this level as a subordinate to level "3" (HL 3 is parent to this level)
	PT	Identifies this level as PT which means patient
8	NM1	277CA segment identifier
	QC	Entity code, QC = Patient
	1	Entity type qualifier, 1 = Person
	SMITH, TESTER A	Patient Name
	MI	Entity qualifier, MI = Member Identification Number
	123456789A	Identifies the members ID, value received from the 837X, Loop 2010BA NM109 data element
9	STC	277CA segment identifier, Claim/Encounter Level Status Information
	A2:20:PR	Claim status category code, A2 = claim accepted: claim status code, 20 = accepted for processing: entity identifier code, PR = Payer
	20120403	Effective date of the status information
10	WQ	Status information action code,
	90	Total claim charge amount, $90.00 is the 837X, Loop 2300, CLM02 data element value WQ = Accept U = Reject
11	REF	277CA segment identifier, Reference information segment
	1K	Reference Identification Qualifier, 1K = Payer's Claim Number (ICN)
	E212094001820TEST	Internal Control Number assigned to claim by the payer, E212094001820TEST = number assigned by CMS as the ICN for the accepted encounter

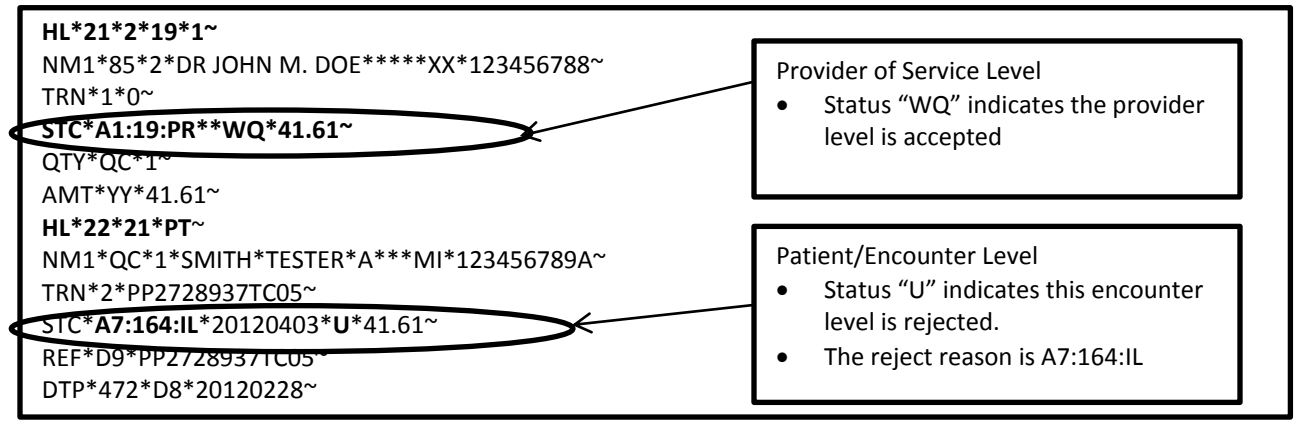
TABLE 6O – 277CA ENCOUNTER LEVEL DETAILS (CONTINUED)

Data String Line	Data Element	Description
12	REF	277CA segment MAO or other entity transmission claim identifier
	D9	Reference Identification Qualifier, D9 = Claim Number
	PP2487057TC01	MAO or other entity claim identifier number to identify their transmission, PP2487057TC01 = number populated on the 837X, Loop 2300, REF02 data element
13	DTP	277CA segment identifier
	472	Date/Time qualifier, 472 – Service Date:
	D8	Identifies the format of the date time period format qualifier, D8 = Date Expressed in Format CCYYMMDD 837-P - Earliest service date from 837 - 2400 (DTP01 -472) 837-I - Statement period from 837- 2300 (DTP01 - 434)
	20120114	Service Date

6.5.5 Interpreting the 277CA Acknowledgement Report - Encounter Level Rejection

The string provided in Figure 6H below is an example of a 277CA acknowledgement report. In this string, MAOs and other entities will be able to identify the rejected encounter.

Figure 6H – 277CA Acknowledgement Report Example – Encounter Level Rejection



In the example provided above, the submitter sent an encounter for Smith, Tester who received services by provider "Dr. John M. Doe". The amount billed by Dr. John M Doe was $41.61. The encounter claim amount is $41.61. The provider level was accepted, the encounter level failed due to the Health Care Claim Status Category Code A7, Claim Status Code 164 and Entity Code IL.

6.5.6 Interpreting the 277CA Acknowledgement Report – Line Level Rejection

The string provided in Figure 6I below is a sample of a 277CA acknowledgement report. In this string, MAOs and other entities will be able to identify the line level rejection cause.

Figure 6I – 277CA Line Level Rejection Example

```
1  HL*49*2*19*1~
2  NM1*85*2*SMITH CLINIC*****XX*123456789~
3  TRN*1*PP2699431TC17~
4  STC*A1:19:PR**WQ*131.08~
5  QTY*QC*1~
6  AMT*YY*131.08~
7  HL*50*49*PT~
8  NM1*QC*1*SMITH*TESTER*A***MI*123456789A~
9  TRN*2*PP2699431TC17~
10 STC*A1:19:PR*20120403*U*131.08~
11 DTP*472*D8*20120301~
12 SVC*HC:99214*131.08*****1~
13 STC*A7:249**U~
14 REF*FJ*000001~
15 DTP*472*D8*20120301~
```

Patient/Encounter Level
- Status "U" indicates the encounter level rejected
- The encounter rejected because the one line on the encounter rejected
- Line reject reason A7:249

The submitter sent an encounter for Smith, Tester who received services by a provider named Smith Clinic. The amount billed by Smith Clinic was $131.08. The encounter claim amount is $131.08. The provider level was accepted, but the encounter level failed due to invalid information in the Place of Service data element.

Table 6P below provides a more detailed analysis of the line level rejection.

TABLE 6P – 277CA LINE LEVEL REJECTION DETAILS

Data String Line	Data Element	Description
12	SVC	277CA segment identifier , service Line Information
	HC:99214	Composite Medical Procedure Identifier, HC = Health Care Financing Administration Common Procedural Coding System [HCPCS] codes: Product/Service ID, 99214 = Office/outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components
	131.08	Monetary Amount, $131.08 is the line item amount
	1	Quantity
13	STC	277CA segment identifier (Service Line Level Status Information
	A7:249	Claim Status Category Code, A7 = Acknowledgement /Rejected for Invalid Information… Health Care Claim Status Code, 249 = Place of service
	U	Action code, U = Reject
14	REF	277CA segment identifier, service line information
	FJ	Reference Identification Qualifier, FJ = Line Item Control Number
	000001	Populated with value received from the 837X, Loop 2400, segment REF (Line item control number), data element REF02

6.5.7 Interpreting the 277CA Acknowledgement Report – Multiple ST/SE Rejections

The string provided in Figure 6J below is an example of a 277CA acknowledgement report. In this string, MAOs and other entities will be able to identify several ST/SE rejections.

Figure 6J – 277CA Acknowledgement Report – Multiple ST/SE Rejections

ISA*00* *00* *ZZ*80882 *ZZ*ENC9999 *120403*0318*^*00501*000000001*0*T*:~
GS*HN*80882*ENC9999*20120403*031834*2581349*X*005010X214~
ST*277*000000001*005010X214~
BHT*0085*08*12094*20120403*02344200*TH~
HL*120*1~**
NM1*PR*2* PALMETTO GBA SOUTH CAROLINA*****46*80882~
TRN*1*80882201204030000001~
DTP*050*D8*20120402~
DTP*009*D8*20120403~
HL*2*1*21*0~
NM1*41*2*ABC MAO*****46*ENC9999~
TRN*2*6F7E5A38-8D59-4744-B40C-014AC~
STC*A8:746:40*20120403*U*1274321.46~
QTY*AA*4908~
AMT*YY*1274321.46~
SE*14*000000001~
ST*277*000000002*005010X214~
BHT*0085*08*12094*20120403*02344200*TH~
HL*120*1~**
NM1*PR*2* PALMETTO GBA SOUTH CAROLINA*****46*80882~
TRN*1*80882201204030000001~
DTP*050*D8*20120402~
DTP*009*D8*20120403~
HL*2*1*21*0~
NM1*41*2*ABC MAO*****46*ENC9999~
TRN*2*756946F2-CF0F-41B2-9FF5-C8464~
STC*A8:746:40*20120403*U*1427014.03~
QTY*AA*4940~
AMT*YY*1427014.03~
SE*14*000000002~
GE*2*2581349~
IEA*1*000000001

1st ST-SE Segment Failed at the Information Receiver Level 21 (Submitter)

2nd ST-SE Segment Failed at the Information Receiver Level 21 (Submitter)

The submitter sent an 837X file with two (2) ST/SE transaction sets, which both failed with relational field in error, duplicate submission, and entity receiver message.

6.5.8 277CA Acknowledgement Report Resolution Steps - Encounter Level Rejection

In order to properly reconcile the 277CA acknowledgement report, MAOs and other entities must follow the guidance provided below:

1. Access the current version of the CMS CEM Edits Spreadsheet
2. Access the WPC Health Care Claim Status Category Code (CSCC) list, provided on www.wpc-edi.com
3. Access the Claim Status Code (CSC) list, provided on www.wpc-edi.com
4. Obtain the description of the error code(s):
   a. Search the CMS CEM Edits Spreadsheet for claim status code **164**, with a category code **A7**, and an entity code IL.
5. Edit X222.121.2010BA.NM109.020, was found on the CMS CEM Edits Spreadsheet providing the error reason:
   a. CSCC A7 = **Acknowledgement /Rejected for Invalid Information**
   b. CSC 164 = **Entity's contract/member number**
   c. EIC: IL = **Subscriber**
6. Look at the proposed edit column for the resolution
   a. In this example the edit reads – If Medicare IDs: 2010BA.NM109 must be 10 - 11 positions in the format of NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN where "A" represents an alpha character and "N" represents a numeric digit.
   b. This means the value populated as the subscriber number in Loop 2010BA, segment NM1, data element NM109 is incorrect
7. Enter a valid subscriber number value using the correct format for the NM109 data element
8. Resubmit the encounter

6.5.9 277CA Acknowledgement Report Resolution Steps – Line Level Rejection

In order to properly reconcile the 277CA acknowledgement report, MAOs and other entities must follow the guidance provided below:

1. Access the current version of the CMS CEM Edits Spreadsheet
2. Access the WPC Health Care Claim Status Category Code (CSCC) list, provided on www.wpc-edi.com
3. Access the Claim Status Code (CSC) list, provided on www.wpc-edi.com
4. Obtain the description of the error code(s):
   a. Search the CMS CEM Edits Spreadsheet for claim status code **249**, with a category code **A7**
5. Edit X222.351.2400.SV105.010, was found on the CMS CEM Edits Spreadsheet providing the error reason:
   a. CSCC A7 = **Acknowledgement /Rejected for Invalid Information**
   b. CSC 249 = **Place of service**
6. Look at the proposed edit column for the resolution
   a. In this example, the edit reads – 2400.SV105 must be a valid Place of Service Code on the date in BHT04.
   b. This means the value populated in Loop 2400, segment SV1, data element SV105 must be a valid Place of Service as of the date displayed in the BHT04 data element.
7. Enter a valid Place of Service code in Loop 2400, segment SV1, data element SV105
8. Resubmit the encounter

6.5.10 277CA Acknowledgement Report Resolution Steps – Multiple ST/SE Rejection

In order to properly reconcile the 277CA acknowledgement report, MAOs and other entities must follow the guidance provided below:

1. Access the current version of the CMS CEM Edits Spreadsheet
2. Access the WPC Health Care Claim Status Category Code (CSCC) list, provided on www.wpc-edi.com
3. Access the Claim Status Code (CSC) list, provided on www.wpc-edi.com

4. Obtain the description of the error code(s):
   a. Search the CMS CEM Edits Spreadsheet for claim status code **746**, with a category code **A8**:
      1) A8 = **Acknowledgement / Rejected for relational field in error**
      2) 746 = **Duplicate Submission** (Not found on the CMS CEM Edits Spreadsheet)
      3) Entity 40 is the **receiver identifier**
5. Per Palmetto, to resolve this type of error MAOs and other entities must:
   a. Look at the value in the following data elements in combination
      1) ISA13 = Interchange Control Number, this number must not be duplicated within a twelve month period
      2) GS06 = Group Control Number
      3) ST02 = Transaction Set Control Number
6. **To resolve the 1st ST/SE error**
   a. Identify the number in the Transaction Set Control Number listed on the 277CA in the TRN02 data element:
      1) **String Example:** TRN*2*6F7E5A38-8D59-4744-B40C-014AC~
   b. Identify the 837-P Transaction Set in error by searching the BHT03 data element for the following value "6F7E5A38-8D59-4744-B40C-014AC":
      1) **String Example:** BHT*0019*00*6F7E5A38-8D59-4744-B40C-014AC*20091006*124824*CH~
   c. In the file that contains the identified transaction set control number
      1) Look at the values in the ISA13, GS06 and ST02 data elements
   d. Correct the duplicate combination
   e. Resubmit the transaction set
7. **To resolve the 2nd ST/SE error**
   a. Identify the Transaction Set Control Number listed on the 277CA in the TRN02 data element:
      1) **String Example:** TRN*2*756946F2-CF0F-41B2-9FF5-C8464~
   b. Identify the 837-P Transaction Set in error by searching the BHT03 data element for the following value "756946F2-CF0F-41B2-9FF5-C8464":
      1) **String Example:** BHT*0019*00*756946F2-CF0F-41B2-9FF5-C8464*20091006*124824*CH~
   c. In the file that contains the identified transaction set control number
      1) Look at the values in the ISA13, GS06 and ST02 data elements
   d. Correct the duplicate combination
   e. Resubmit the transaction set

6.6 EDFES Notifications

The EDFES provides notifications to inform MAOs and other entities of the reason the submitted file was not sent to the Encounter Data Processing System (EDPS). These are in addition to the EDFES acknowledgement reports, including the TA1, 999, and 277CA and to the EDPS Reports.

The file has an 80 character record length. Table 6Q identifies information included in the record layout:

TABLE 6Q – EDFES NOTIFICATION RECORD LAYOUT

Positions	Item
FILE NAME RECORD	
1 – 7	Blank Spaces
8 – 18	File Name:

TABLE 6Q – EDFES NOTIFICATION RECORD LAYOUT (CONTINUED)

Positions	Item
19 – 62	Name of the Saved File
63 – 80	Blank Spaces
FILE CONTROL RECORD	
1 – 4	Blank Spaces
5 – 18	File Control:
19 – 27	File Control Number
28 – 80	Blank Spaces
FILE COUNT RECORD	
1 – 18	Number of Claims:
19 – 24	File Claim Count
25 – 80	Blank Spaces
FILE SEPARATOR RECORD	
1 – 80	(-------)
FILE MESSAGE RECORD	
1 – 80	FILE WAS NOT SENT TO THE EDPS BACK-END PROCESS FOR THE FOLLOWING REASON(S)
FILE MESSAGE RECORD	
1 – 80	(Specific File Message)

The report format example is as follows:

FILE NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
FILE CONTROL: XXXXXXXXX
NUMBER OF CLAIMS: 99,999

FILE WAS NOT SENT TO THE EDPS BACK-END PROCESS FOR THE FOLLOWING REASON(S)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Table 6R below provides the file type, notification message, and notification message description for the EDFES notifications.

TABLE 6R – EDFES NOTIFICATIONS

Applies To	Encounter Type	Notification Message	Notification Message Description
All files submitted	All	FILE ID (XXXXXXXXX) IS A DUPLICATE OF A FILE ID SENT WITHIN THE LAST 12 MONTHS	The file ID must be unique for a 12 month period
All files submitted	All	SUBMITTER NOT AUTHORIZED TO SEND CLAIMS FOR PLAN (CONTRACT ID)	The submitter is not authorized to send for this plan
All files submitted	All	PLAN ID CANNOT BE THE SAME AS THE SUBMITTER ID	The Contract ID cannot be the same as the Submitter ID
All files submitted	All	AT LEAST ONE ENCOUNTER IS MISSING A CONTRACT ID IN THE 2010BB-REF02 SEGMENT	The Contract ID is missing

TABLE 6R – EDFES NOTIFICATIONS (CONTINUED)

Applies To	Encounter Type	Notification Message	Notification Message Description
End-to-End Testing – File 1	All	SUBMITTER NOT FRONT-END CERTIFIED	The submitter must be front-end certified to send encounters for validation
All files submitted	All	THE DATE ON ALL CLAIMS MUST START IN THE YEAR 2012	Encounters must contain dates in the year 2012
Production files submitted	All	SUBMITTER NOT CERTIFIED FOR PRODUCTION	The submitter must be certified to send encounters for production
Production files submitted	All	THE INTERCHANGE USAGE INDICATOR MUST EQUAL 'T'	The Professional Tier 2 file is being sent with a 'P' in the ISA15 field
Tier 2 file submitted	All	PLAN (CONTRACT ID) HAS (X,XXX) CLAIMS IN THIS FILE. ONLY 2,000 ARE ALLOWED	The number of encounters for a Contract ID cannot be greater than 2,000
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	Professional	FILE CANNOT CONTAIN MORE THAN 38 ENCOUNTERS	The number of encounters cannot be greater than 38
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	Institutional	FILE CANNOT CONTAIN MORE THAN 24 ENCOUNTERS	The number of encounters cannot be greater than 24
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	DME	FILE CANNOT CONTAIN MORE THAN 5 ENCOUNTERS	The number of encounters cannot be greater than 5
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	All	PATIENT CONTROL NUMBER IS MORE THAN 20 CHARACTERS LONG THE TC# WAS TRUNCATED	The Claim Control Number, including the Test Case Number, must not exceed 20 characters
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	Professional, Institutional	FILE CANNOT CONTAIN BOTH UNLINKED AND LINKED TEST CASES	The test cases from File 1 and File 2 cannot be in the same file
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	Professional, Institutional	CANNOT SEND LINKED TEST CASES UNTIL ALL UNLINKED TEST CASES HAVE BEEN ACCEPTED	The test cases for File 2 cannot be sent before all File 1 test cases are accepted
End-to-End Testing – File 1	All	FILE CONTAINS (X) TEST CASE (X) ENCOUNTER(S)	The file must contain two (2) of each test case
End-to-End Testing – Additional File(s)	All	ADDITIONAL FILES CANNOT BE VALIDATED UNTIL AN MAO-002 REPORT HAS BEEN RECEIVED	The MAO-002 report must be received before additional files can be submitted

6.7 TA1 Practice Worksheets

Identify the following by analyzing the TA1 report:

- If the file was accepted or rejected
- If it was rejected, why was it rejected
- The data element that references the reason for the reject, if applicable)

ISA*00* *00* *ZZ*80882 *ZZ*ENC9999 *120406*1714*^*00501*110000001*0*T*:~
TA1*110000001*120406*1714*R*011~
IEA*0*110000001~

File Status (Accepted or Rejected)	Reject Reason(s)	Reject Reason Code(s)/Data Element(s)

6.8 999 Practice Worksheets

Identify the following by analyzing the 999 report:

- If the file was accepted or rejected
- If it was rejected, why was it rejected
- The data element(s) that reference the reason(s) for the reject, if applicable)

ISA*00* *00* *ZZ*123456789*ZZ*987654321*041117*1024*^*00501*000000286*0*P:
GS*FA*RCVR*SNDR*20041117*1024*287*X*005010X231~
ST*999*2870001*005010X231~
AK1*HC*17456*005010X222~
AK2*837*0001~
IK5*A
AK2*837*0002~
IK3*CLM*22**8~
CTX*CLM01:123456789~
IK4*2*782*1~
IK5*R*5~
AK2*837*0003~
IK3*REF*57**3~
CTX*SITUATIONAL TRIGGER*CLM*43**5:3*C023:1325~
CTX*CLM01:987654321~
IK5*R*5~
AK9*P*3*3*1~
SE*16*2870001~
GE*1*287~
IEA*1*000000286~

File Status (Accepted or Rejected)	Reject Reason(s)	Reject Reason Code/Data Element

6.9 277CA Practice Worksheets

Summarize each Hierarchical level in the table below, note the level name , what the data elements is reporting, error (if applicable), status (accept or reject) and resolution steps.

ISA*00* *00* *ZZ*80882 *ZZ*ENC9999
*120403*0818*^*00501*000000001*0*T*:~
GS*HN*80882*ENC9999*20120403*081844*2597723*X*005010X214~
ST*277*000000001*005010X214~
BHT*0085*08*12094*20120403*08052200*TH~
HL*1**20*1~
NM1*PR*2* PALMETTO GBA SOUTH CAROLINA*****46*80882~
TRN*1*8088220120403000001~
DTP*050*D8*20120403~
DTP*009*D8*20120403~
HL*2*1*21*1~
NM1*41*2*ABC MAO*****46*ENC9999~
TRN*2*000090028~
STC*A1:19:PR*20120403*WQ*346.61~
QTY*90*1~
QTY*AA*3~
AMT*YU*90~
AMT*YY*256.61~
HL*3*2*19*1~ RED
NM1*85*2*SMITH CLINIC*****XX*123456789~
TRN*1*PP2487057TC01~
STC*A1:19:PR**WQ*90~
QTY*QA*1~
AMT*YU*90~
HL*4*3*PT~
NM1*QC*1*SMITH*TESTER*A***MI*123456789A~
TRN*2*PP2487057TC01~
STC*A2:20:PR*20120403*WQ*90~
REF*1K*E212094001820TEST~
REF*D9*PP2487057TC01~
DTP*472*D8*20120114~
HL*5*2*19*1~ Red
NM1*85*2*DR JOHN M. DOE*****XX*123456788~
TRN*1*0~
STC*A1:19:PR**WQ*41.61~
QTY*QC*1~
AMT*YY*41.61~
HL*6*5*PT~
NM1*QC*1*SMITH*TESTER*A***MI*123456789A~
TRN*2*PP2728937TC05~
STC*A7:164:IL*20120403*U*41.61~
REF*D9*PP2728937TC05~
DTP*472*D8*20120228~
HL*7*2*19*1~ RED
NM1*85*2*SMITH CLINIC*****XX*123456789~
TRN*1*PP5715051TC11~
STC*A1:19:PR**WQ*215~

QTY*QC*1~
AMT*YY*215~
HL*8*7*PT~
NM1*QC*1*SMITH*TESTER*A***MI*123456789A~
TRN*2*PP5715051TC11~
STC*A8:521:GB*20120403*U*215******A8:516:GB~
STC*A8:521:GB*20120403*U*215******A8:516:GB~
REF*D9*PP5715051TC11~
DTP*472*D8*20120218~
SE*508*000000001~
GE*1*2597723~
IEA*1*000000001~

Encounter Status (Accepted or Rejected)	Reject Reason(s)	Reject Reason Code/Data Element

6.10 Summary

MAOs and other entities must use unique control identification numbers in the ISA, GS, ST and BHT segments when submitting their 837X file. The use of a unique numbering scheme will allow MAOs and other entities the ability to easily map their 837X file details to the appropriate TA1, 999 and 277CA error identification segment and/or data element.

MAOs and other entities will receive a TA1 acknowledgement report to indicate Interchange level rejections. The 999 acknowledgement report will indicate accepts and rejections at the Functional Group and Transaction Set levels. The 277CA acknowledgement report will indicate accepts and rejections at the submitter, billing provider, encounter and line levels.

MODULE 7 – EDPS REPORTS

Purpose

The goal of collecting utilization data that will determine future risk adjustment model calibration is dependent on accurate processing of encounter data. This module provides MAOs and other entities with strategies that will assist in reconciliation of data submitted against the data stored in the CMS databases.

Learning Objectives

At the completion of this module, participants will be able to:

- Identify key elements of the EDPS reports.
- Map EDPS report errors to the 837X file submissions.
- Understand the EDPS report editing logic.
- Describe the steps for error resolution.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

7.1 EDPS Reports Overview

The Encounter Data Processing System (EDPS) suite of reports was developed to communicate the disposition of the encounters throughout the processing and risk adjustment filtering. In addition, the reports design offers the submitter the flexibility to support the various business needs; therefore, submitters may access each report as a data file or a formatted report. Through 2012, EDPS will continue to implement enhancements that will allow for a more expedited report delivery time. Table 7A illustrates the anticipated release response times.

TABLE 7A – EDPS REPORT DELIVERY TIME

Stage	Delivery Time
Testing Phase	Seven (7) Business Days of Receipt from EDFES
Preliminary Production Phase	Five (5) Business Days of Receipt from EDFES
Target Production Phase	Two (2) Business Days of Receipt from EDFES

CMS has developed reports to provide MAOs and other entities with the disposition of encounters submitted. Table 7B provides a brief description of the purpose of each MAO report.

TABLE 7B – ENCOUNTER DATA PROCESSING SYSTEM REPORTS DETAILS

Report Number	Report Name	Report Description
MAO-001	Encounter Data Duplicates Report	Identifies and displays ICNs based on duplicate key data fields on the encounters level: **Institutional** • Beneficiary HICN • Beneficiary Last Name • Date of Service • Type of Bill • Revenue Code(s) • Procedure Code(s) • Billing Provider NPI • Paid Amount **Professional and DME** • Beneficiary HICN • Beneficiary Name • Date of Service • Place of Service • Type of Service • Procedure Code(s) and 4 modifiers • Rendering Provider NPI • Paid Amount
MAO-002	Encounter Data Processing Status Report	• Provides the status of encounter submissions during the adjudication process at various levels of validation (accepted or rejected) back to the MAO or other entity during processing • Informational validation messages will be included on accepted files at the line level • Identifies processing errors, edits, and validations • Displays encounter level and service line level error codes for correction
MAO-004*	Encounter Data Risk Filter Report	• Identifies diagnoses that are accepted and identified for risk score calculation • Displays encounter ICN, diagnoses, date of service, and transaction date that identify accepted data for risk adjustment
MAO-005*	Encounter Summary Report	• Identifies the number of encounters accepted and rejected for encounter data purposes per transaction
MAO-006*	Edit Disposition Summary Report	• Identifies the error codes associated with an encounter data record submission • Provides a summary count of the types of errors found
MAO-007*	Encounter Detail Report	• Displays the encounter level information submitted and the details for each encounter associated with the reject

* Will be provided in a future release

7.2 MAO Report Files Naming Convention

EDPS reports are distributed to MAOs and other entities through CMS approved connectivity methods, including Connect: Direct (NDM), Gentran, and FTP. Files are tracked by the date and time the file was sent, using the Submission Interchange Number, which is a combination of the following required 837X fields:

- Interchange Sender ID (ISA06) – field length minimum = 15; field length maximum = 15
- Interchange Control Number (ISA13) – field length minimum = 9; field length maximum = 9
- Interchange Date (ISA09) – field length minimum = 6; field length maximum = 6

Tables 7C and 7D provide the EDPS reports naming conventions. MAOs and other entities should note that Connect: Direct (NDM) users' reports file naming conventions are user defined.

TABLE 7C – TESTING FILE NAMING CONVENTION BY CONNECTIVITY METHOD

CONNECTIVITY METHOD	TESTING NAMING CONVENTION FORMATTED REPORT	TESTING NAMING CONVENTION FLAT FILE LAYOUT
GENTRAN	T .xxxxx.EDPS_001_DataDuplicate_Rpt T .xxxxx.EDPS_002_DataProcessingStatus_Rpt T .xxxxx.EDPS_004_RiskFilter_Rpt T .xxxxx.EDPS_005_DispositionSummary_Rpt T .xxxxx.EDPS_006_EditDisposition_Rpt T .xxxxx.EDPS_007_DispositionDetail_Rpt	T .xxxxx.EDPS_001_DataDuplicate_File T .xxxxx.EDPS_002_DataProcessingStatus_File T .xxxxx.EDPS_004_RiskFilter_File T .xxxxx.EDPS_005_DispositionSummary_ File T .xxxxx.EDPS_006_EditDisposition_ File T .xxxxx.EDPS_007_DispositionDetail_ File
FTP	RPTxxxxx.RPT.EDPS_001_DATDUP_RPT RPTxxxxx.RPT.EDPS_002_DATPRS_RPT RPTxxxxx.RPT.EDPS_004_RSKFLT_RPT RPTxxxxx.RPT.EDPS_005_DSPSUM_RPT RPTxxxxx.RPT.EDPS_006_EDTDSP_RPT RPTxxxxx.RPT.EDPS_007_DSTDTL_RPT	RPTxxxxx.RPT.EDPS_001_DATDUP_File RPTxxxxx.RPT.EDPS_002_DATPRS_File RPTxxxxx.RPT.EDPS_004_RSKFLT_ File RPTxxxxx.RPT.EDPS_005_DSPSUM_ File RPTxxxxx.RPT.EDPS_006_EDTDSP_ File RPTxxxxx.RPT.EDPS_007_DSTDTL_ File

* Note: There is a limit of 20 characters on the description of the file. The description starts after “RPT” or “ZIP”.

TABLE 7D – PRODUCTION FILE NAMING CONVENTION BY CONNECTIVITY METHOD

CONNECTIVITY METHOD	PRODUCTION NAMING CONVENTION FORMATTED REPORT	PRODUCTION NAMING CONVENTION FLAT FILE LAYOUT
GENTRAN	P.xxxxx.EDPS_001_DataDuplicate_Rpt P.xxxxx.EDPS_002_DataProcessingStatus_Rpt P.xxxxx.EDPS_004_RiskFilter_Rpt P.xxxxx.EDPS_005_DispositionSummary_Rpt P.xxxxx.EDPS_006_EditDisposition_Rpt P.xxxxx.EDPS_007_DispositionDetail_Rpt	P.xxxxx.EDPS_001_DataDuplicate_File P.xxxxx.EDPS_002_DataProcessingStatus_File P.xxxxx.EDPS_004_RiskFilter_File P.xxxxx.EDPS_005_DispositionSummary_ File P.xxxxx.EDPS_006_EditDisposition_ File P.xxxxx.EDPS_007_DispositionDetail_ File
FTP	RPTxxxxx.RPT.PROD_001_DATDUP_RPT RPTxxxxx.RPT.PROD_002_DATPRS_RPT RPTxxxxx.RPT.PROD_004_RSKFLT_RPT RPTxxxxx.RPT.PROD_005_DSPSUM_RPT RPTxxxxx.RPT.PROD_006_EDTDSP_RPT RPTxxxxx.RPT.PROD_007_DSTDTL_RPT	RPTxxxxx.RPT.PROD_001_DATDUP_File RPTxxxxx.RPT.PROD_002_DATPRS_File RPTxxxxx.RPT.PROD_004_RSKFLT_ File RPTxxxxx.RPT.PROD_005_DSPSUM_ File RPTxxxxx.RPT.PROD_006_EDTDSP_ File RPTxxxxx.RPT.PROD_007_DSTDTL_ File

* Note: There is a limit of 20 characters on the description of the file. The description starts after “RPT” or “ZIP”.

Table 7E provides a description of the file name components for FTP and Gentran mailbox files, which will assist MAOs and other entities in identifying the report type.

TABLE 7E –MAILBOX FILE NAME COMPONENT DESCRIPTION

File Name Component	Description
RPTxxxxx	This is the type of data ‘RPT’ and a sequential number assigned by the server ‘xxxxx’
RPT / ZIP	This determines if the file is plain text ‘RPT’ or compressed ‘ZIP’
EDPS_XXX	Identifies this as one of the EDPS reports along with the report number (i.e. ‘001’, ‘002’, etc.)
XXXXXXX	7 Characters available to be used as a short description of the contents of the file
RPT / FILE	Identifies if this is a report ‘RPT’ or flat file ‘FILE’

7.3 Report Layout

The MAO reports are delivered to the submitter's EDS mailbox in two (2) forms: flat file and formatted reports. MAOs and other entities may choose either layout for reconciliation.

The MAO flat file layout is a delimited text file that provides a detailed description of the processing status for 837X encounter data submissions.

The formatted report layout is a text file that allows MAOs and other entities to identify and review reports based on the Submission Interchange Number, Report Date, and Transaction date located in the top right corner of the report. MAOs and other entities can also find the Contract ID and Report Run date and time in the header of the report for tracking purposes.

Formatted report layouts are sorted by the following values by Submitter ID:

- Contract ID
- Plan ID (CCN)
- Encounter ICN
- Line Number

Multiple Contract IDs submitted in a file are separated by a page break with associated records and detail lines immediately following the header.

7.4 MAO-001 Encounter Data Duplicates Report

The MAO-001 Encounter Data Duplicates Report provides MAOs and other entities detailed information on encounters generating edit 98325 - Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim. Edit 98325 may be generated for one (1) or both of the following two (2) levels of duplicate errors:

- Service line level within an encounter
- Encounter level to another previously accepted and stored encounter

Edit 98325 is generated for service line duplicate errors when a service line submitted on an encounter is the exact same as another service line submitted on an encounter. The second level of duplicate checking ensures that encounters submitted are not an exact duplicate of another previously accepted and stored encounter in EODS. Table 7F provides the key data fields used for encounter level duplicate checking.

TABLE 7F – ENCOUNTER LEVEL DUPLICATE CHECKING

Institutional	Professional and DME
Beneficiary HICN	Beneficiary HICN
Beneficiary Last Name	Beneficiary Last Name
Date of Service	Date of Service
Type of Bill	Place of Service
Revenue Code(s)	Type of Service
Billing Provider NPI	Procedure Code(s) and 4 modifiers
Paid Amount	Rendering Provider NPI
Procedure Code	Paid Amount

Example

Green Health Plan submitted an encounter to EDS on July 8, 2012 for Mary Joe, who received ambulance services on May 15, 2012 provided by Billing Provider NPI 1382938398 (NPI USED FOR EXAMPLE PURPOSES ONLY). The encounter submitted included Type of Bill 12X and revenue code 0540, as well as a paid amount of $198.00. Green Health Plan receives an MAO-002 report indicating the encounter submitted was accepted through the EDPS. Green Health Plan then submitted the encounter with the exact same beneficiary HICN, beneficiary last name, DOS, Type of Bill, revenue code, NPI, and paid amount. An MAO-001 report is generated reflecting the lines and values causing edit 98325.

Example

Blue Health Plan submitted an encounter to EDS with five (5) service lines on an 837-P. Three (3) of the service lines submitted on the encounter included HCPCS A4259 with modifier KL. As a result, an MAO-001 report is generated reflecting the lines and values causing edit 98325.

7.4.1 MAO-001 Flat File Layout

The MAO-001 flat file format is distributed to MAOs and other entities as a delimited text file. The beneficiary HICN and DOS are provided as verification of the encounter submitted for the specified beneficiary. In addition, the specific lines causing the duplicate error are provided in the detail record of the flat file. Table 7G below provides the flat file layout for the MAO-001 report.

TABLE 7G – MAO-001 FLAT FILE LAYOUT

HEADER RECORD (There is only one header per record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	0=Header	1	Numeric, no commas and/or decimals
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "**MAO-001"**	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Report Date	Date that the report was created by EDPSC.	8	Numeric, format CCYYMMDD
19	Delimiter		1	Uses the * character value
20-27	Transaction Date		8	Numeric, format CCYYMMDD
28	Delimiter		1	Uses the * character value
29-67	Report Description	Value is **"Encounter Data Duplicates Report"**	39	Alpha Numeric, Left justify, blank fill
68	Delimiter		1	Uses the * character value
69-73	Filler		5	Blank – (Removal of Contract ID)
74	Delimiter		1	Uses the * character value
75-104	Submission Interchange Number	Interchange Sender ID (ISA06) + Interchange Control Number (ISA13) + Interchange Date (ISA09)	30	Alpha Numeric

TABLE 7G – MAO-001 FLAT FILE LAYOUT

HEADER RECORD (There is only one header per record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
105	Delimiter		1	Uses the * character value
106-108	Record Type	Value is **"INS", "PRO", "DME"**	3	Alpha Numeric
109	Delimiter		1	Uses the * character value
110-113	Submission File Type	Value is **"TEST"** or **"PROD"**	4	Alpha Numeric
114	Delimiter		1	Uses the * character value
115-128	Filler		14	Spaces
DETAIL RECORD (There may be multiple detail records per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	1=Detail	1	Numeric, no commas and/or decimals
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "**MAO-001**"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-15	Medicare Advantage Contract ID	Medicare Contract ID assigned to the MA Plan	5	Alpha Numeric
16	Delimiter		1	Uses the * character value
17-36	Plan ID (CCN)	Plan internal control number.	20	Alpha Numeric
37	Delimiter		1	Uses the * character value
38-56	Encounter ICN	Internal Control Number. In encounter data, only 13 spaces represent the ICN however additional spaces allow for other use.	19	Alpha Numeric
57	Delimiter		1	Uses the * character value
58-60	Encounter Line Number	Internal line number generated by EDPS.	3	Numeric, no commas and/or decimals
61	Delimiter		1	Uses the * character value
62-81	Duplicate Plan Encounter ID (CCN)	Duplicate Plan ID stored in EODS	20	Alpha Numeric
82	Delimiter		1	Uses the * character value
83-101	Duplicate Encounter ICN	Duplicate Encounter ICN identified in EODS. In encounter data, only 13 spaces represent the ICN -additional spaces allow for other use.	19	Alpha Numeric
102	Delimiter		1	Uses the * character value
103-105	Duplicate Encounter Line Number	Internal line number generated by EDPS.	3	Numeric, no commas and/or decimals
106	Delimiter		1	Uses the * character value
107-118	Beneficiary HICN	Beneficiary Health Insurance Encounter Number	12	Alpha Numeric

TABLE 7G – MAO-001 FLAT FILE LAYOUT (CONTINUED)

DETAIL RECORD (There may be multiple detail records per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
119	Delimiter		1	Uses the * character value
120-127	Date of Service		8	Numeric, format CCYYMMDD
128	Delimiter		1	Uses the * character value
TRAILER RECORD (There is only one trailer per record file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	9=Trailer	1	Numeric, no commas and/or decimals
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "**MAO-001**"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Total Number of Duplicate Encounter Lines Rejected		8	Numeric, no commas and/or decimals
19	Delimiter		1	Uses the * character value
20-27	Total Number of Encounter Lines Submitted		8	Numeric, no commas and/or decimals
28	Delimiter		1	Uses the * character value
29-36	Total Number of Encounter Records Submitted		8	Numeric, no commas and/or decimals
37	Delimiter		1	Uses the * character value
38-128	Filler		91	Numeric, no commas and/or decimals

7.4.2 MAO-001 Formatted Report Layout

The formatted report layout provides text data similar to the flat file layout. Figure 7A below provides an example of a formatted report layout of the MAO-001 report.

Figure 7A – MAO-001 Formatted Report Layout

Encounter Data Duplicates Report
Report Run Date 07/09/2012 12:51 PM
Medicare Advantage Contract ID: H9999
PROD

Page 1

Submission Interchange Number: ENH29060000000132012070 5
Report Date: 07/09/2012
Report ID: MAO-001
Transaction Date: 07/08/2012

Record Type	Plan Encounter ID (CCN)	Encounter ICN	Encounter Line Number	Duplicate Plan Encounter ID (CCN)	Duplicate Encounter ICN	Duplicate Encounter Line Number	Beneficiary HICN	Date of Service
PRO	231181789	2509061539016	001	222186298	2509061539028	001	567185299	06/15/2012
PRO	231181790	2509061539013	002	222186398	2509061539047	002	567186299	06/15/2012

TOTALS :

Total Number of Duplicate Encounter Lines Rejected: 2
Total Number of Encounter Lines Submitted: 2
Total Number of Encounter Records Submitted: 2

7.5 MAO-002 Encounter Data Processing Status Report

The MAO-002 report provides MAOs and other entities with the processing status of encounters submitted to the EDPS. Table 7H provides the enhancements on any MAO-002 reports processed on or after September 4, 2012.

TABLE 7H – EDPS REPORTS ENHANCEMENTS

Enhancement	Enhancement Description
Submission Record Type	"PRO" (Professional) "INS" (Institutional) "DME" (DME)
Submission File Type	"TEST" (Test Data) "PROD" (Production Data)
Contract ID	Flat File – The Contract ID will be provided on the detail record for each Contract ID submitted in a file Formatted – The Contract ID will appear in the header; however, a new report page will begin for each submitted Contract ID in the file, followed by the encounter detail lines for that specific contract.

7.5.1 MAO-002 Flat File Format

The MAO-002 Encounter Data Processing Status Report flat file layout is distributed as a delimited text file. It provides the overall number of encounter processing errors rejected and the number of encounter records that are accepted or rejected in the submission. Encounter data lines that are submitted and rejected are also provided with a total count summary. Table 7I below provides the MAO-002 report flat file layout.

TABLE 7I – MAO-002 REPORT FLAT FILE LAYOUT

HEADER RECORD (There is only one header per record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	0=Header	1	Numeric, no commas and/or decimals.
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "**MAO-002"**	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Report Date	Date that the report was created by EDPSC.	8	Numeric, format CCYYMMDD
19	Delimiter		1	Uses the * character value
20-27	Transaction Date		8	Numeric, format CCYYMMDD
28	Delimiter		1	Uses the * character value
29-67	Report Description	Value is **"Encounter Data Processing Status Report"**	39	Alpha Numeric
68	Delimiter		1	Uses the * character value
69-73	Filler		5	Blank – (Removal of Contract ID)
74	Delimiter		1	Uses the * character value
75-104	Submission Interchange Number	Interchange Sender ID (ISA06) + Interchange Control Number (ISA13) + Interchange Date (ISA09)	30	Alpha Numeric
105	Delimiter		1	Uses the * character value
106-108	Record Type	Value is **"INS", "PRO", "DME"**	3	Alpha Numeric
109	Delimiter		1	Uses the * character value
110-113	Submission File Type	Value is **"TEST"** or **"PROD"**	4	Alpha Numeric
114	Delimiter		1	Uses the * character value
115-160	Filler		46	Spaces
DETAIL RECORD (There may be multiple detail records per encounter line dependent upon the number of errors on a line. Up to 10 errors will be reported for an encounter line.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	1=Detail	1	Numeric, no commas and/or decimals.
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is **"MAO-002"**	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-15	Medicare Advantage Contract ID	Medicare Contract ID assigned to the MA Plan	5	Alpha Numeric
16	Delimiter		1	Uses the * character value
17-54	Plan ID (CCN)	Plan internal encounter control number.	38	Alpha Numeric

TABLE 7I – MAO-002 REPORT FLAT FILE LAYOUT (CONTINUED)

DETAIL RECORD (There may be multiple detail records per encounter line dependent upon the number of errors on a line. Up to 10 errors will be reported for an encounter line.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
55	Delimiter		1	Uses the * character value
56-99	Encounter ICN	Internal Control Number. In encounter data, only 13 spaces represent the ICN however 44 spaces are coded to allow enhancement of the ICN.	44	Alpha Numeric
100	Delimiter		1	Uses the * character value
101-103	Encounter Line Number	Internal line number generated by EDPS. For any given ICN (claim document) the line numbers will start from “000” representing the claim level, the first encounter line will start from “001” and increment by 1 for every additional line.	3	Numeric, no commas and/or decimals.
104	Delimiter		1	Uses the * character value
105-112	Encounter Status	Value is "**Accepted**" or "**Rejected**"	8	Alpha Numeric
113	Delimiter		1	Uses the * character value
114-118	Error Code		5	Alpha Numeric
119	Delimiter		1	Uses the * character value
120-159	Error Description	Description associated with error code identified.	40	Alpha Numeric
160	Delimiter		1	Uses the * character value
TRAILER RECORD (There is only one trailer per record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	9=Trailer	1	Numeric, no commas and/or decimals.
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "**MAO-002**"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Total Number of Processing Errors		8	Numeric, no commas and/or decimals.
19	Delimiter		1	Uses the * character value
20-27	Total Number of Encounter Lines Accepted		8	Numeric, no commas and/or decimals.
28	Delimiter		1	Uses the * character value
29-36	Total Number of Encounter Lines Rejected		8	Numeric, no commas and/or decimals.
37	Delimiter		1	Uses the * character value

FIGURE 7I – MAO-002 REPORT FLAT FILE LAYOUT (CONTINUED)

TRAILER RECORD (There is only one trailer per record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
38-45	Total Number of Encounter Lines Submitted		8	Numeric, no commas and/or decimals.
46	Delimiter		1	Uses the * character value
47-54	Total Number of Encounter Records Accepted		8	Numeric, no commas and/or decimals.
55	Delimiter		1	Uses the * character value
56-63	Total Number of Encounter Records Rejected		8	Numeric, no commas and/or decimals.
64	Delimiter		1	Uses the * character value
65-72	Total Number of Encounter Records Submitted		8	Total Number of Encounter Records Submitted
73	Delimiter		1	Uses the * character value
74-160	Filler		87	Spaces

7.5.2 MAO-002 Formatted Report Layout

The MAO-002 formatted layout allows MAOs and other entities to more easily interpret and determine the disposition of encounters submitted. Figure 7B below is an example of an MAO-002 report reflecting one (1) rejected encounter line and one (1) accepted encounter line. If an encounter record contains a minimum of one (1) "Accepted" encounter line, the entire record is accepted in EDPS. The header line '000' indicates that the encounter record is accepted.

Figure 7B – MAO-002 Report Example

Encounter Data Processing Status Report
Report Run Date 07/06/2012 06:35 PM
Medicare Advantage Contract ID: H9999
PROD

Page 1

Submission Interchange Number: ENC00450000000 7420120703
Report Date: 07/06/2012
Report ID: MAO-002
Transaction Date: 07/05/2012

Record Type	Plan Encounter ID CCN	Encounter ICN	Encounter Line Number	Encounter Status	Error	Error Description
PRO	XXXX0000001	E000000000001	000	Accepted	-	-
			001	Rejected	98325	Exact Duplicate of a Service Line With
			002	Accepted	02106	I: Invalid Beneficiary Last Name

TOTALS:

Total Processing Errors:	1		
Total Number of Encounter Lines Accepted:	1	Total Number of Encounter Records Accepted:	1
Total Number of Encounter Lines Rejected:	1	Total Number of Encounter Records Rejected:	0
Total Number of Encounter Lines Submitted:	2	Total Number of Encounter Records Submitted:	1

7.5.3 MAO-002 Edit Logic

EDPS edits are used to validate the 837-I and 837-P files. The Professional, Institutional, and DME processing and pricing edits are documented in the Encounter Data Companion Guides, as well as in Module 3 (Professional Submission), Module 4 (Institutional Submission), and Module 5 (DME Submission). Encounter data files are validated for accuracy of beneficiary information, provider information, reference and limitation factors, NCCI coding, duplicate and pricing factors.

Figure 7C provides an example of an MAO-002 report that reflects one (1) rejected encounter line at the detail line level which causes the entire encounter record to reject at the '000' header level. The encounter line must be corrected and resubmitted.

The rejected encounter line and record will not be stored in EODS for risk adjustment and pricing.

Figure 7C – MAO-002 REPORT – REJECTED LINE

Encounter Data Processing Status Report
Report Run Date 07/06/2012 06:35 PM
Medicare Advantage Contract ID: H1239
PROD

Page 1 Submission Interchange Number: ENC00350000000732012070 3
Report Date: 07/06/2012
Report ID: MAO-002 Transaction Date: 07/05/2012

Record Type	Plan Encounter ID CCN	Encounter ICN	Encounter Line Number	Encounter Status	Error	Error Description
PRO	XXXX0000002	E000000000002	000	Rejected		-
			001	Rejected	98325	Exact Duplicate of a Service Line With

TOTALS:

Total Processing Errors:	1		
Total Number of Encounter Lines Accepted:	0	Total Number of Encounter Records Accepted:	0
Total Number of Encounter Lines Rejected:	1	Total Number of Encounter Records Rejected:	1
Total Number of Encounter Lines Submitted:	1	Total Number of Encounter Records Submitted:	1

7.6 MAO-004 Encounter Data Risk Filter Report

The MAO-004 Encounter Data Risk Filter Report identifies ICD-9-CM diagnosis codes that are risk adjustment eligible. Diagnosis codes and descriptions reflected on this report provide diagnoses associated with the accepted encounter and service lines that successfully processed in EDPS. The risk filtering report design is currently under review with the Encounter Data team and additional information will be released as it becomes available.

MAOs and other entities will continue to submit RAPS data for 2012 and 2013. RAPS submissions will be used to calculate the risk adjustment for 2012 and 2013.

7.6.1 Risk Filtering Logic

It is CMS' intent that once CMS transitions from RAPS to EDS, all diagnoses used for risk score calculation will be based on the EDS risk adjustment filtering logic. The current risk adjustment filtering logic includes the following factors:

- Date of service within the payment year
- Facility/Provider included in the risk adjustment acceptable sources list
- Risk adjustment eligible diagnosis codes

Although the MAO-004 report will provide MAOs and other entities with the diagnosis codes that are risk adjustment eligible, the MAO-002 report serves as the primary source of reference to reconcile rejected encounters and/or lines within an accepted encounter. The EDPS follows the guidance provided below to determine the diagnosis codes that are eligible for risk adjustment extraction:

- Diagnoses submitted on accepted encounter lines are stored in EODS and extracted for risk adjustment
- Diagnoses submitted on rejected encounter lines are stored in EODS but are not extracted for risk adjustment
- Diagnoses submitted on the header level without association to a service line must be stored in EODS and extracted for risk adjustment.

Example

Happy Health Plan submits an encounter, which includes two (2) service lines. Service line one (1) points to a diagnosis code that is included in model. Service line two (2) points to a diagnosis code that is not included in the model. Happy Health Plan receives an MAO-002 report, which reflects that service line one (1) rejected and service line two (2) accepted. Happy Health Plan resubmits the encounter to correct service line one (1) in order for the pointed diagnosis code to be risk adjustment eligible. After resubmission, Happy Health Plan receives an MAO-002 report reflecting that both submitted service lines are accepted. The EDPS generates an MAO-004 report reflecting the diagnosis code submitted on the encounter is eligible for risk adjustment.

7.6.2 MAO-004 Flat File Layout

The MAO-004 Encounter Data Risk Filter Report flat file layout is distributed as a delimited text file. The report displays the ICD-9 diagnosis codes accepted for risk adjustment and allows up to 12 diagnosis codes per encounter for Professional submissions and 25 diagnosis codes per encounter for Institutional submissions. Table 7J below provides the MAO-004 flat file layout.

TABLE 7J - MAO-004 ENCOUNTER DATA RISK FILTER REPORT FLAT FILE LAYOUT

HEADER RECORD (There is only one header record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	0=Header	1	Numeric, no commas and/or decimals.
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "**MAO-004**"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Report Date	Date that the report was created by EDPSC.	8	Numeric, format CCYYMMDD
19	Delimiter		1	Uses the * character value
20-27	Transaction Date		8	Numeric, format CCYYMMDD
28	Delimiter		1	Uses the * character value
29-67	Report Description	Value is "Encounter Data Risk Filter Report"	39	Alpha Numeric, Left justify, blank fill
68	Delimiter		1	Uses the * character value
69-73	Filler		5	Blank – (Removal of Contract ID)
74	Delimiter		1	Uses the * character value
75-104	Submission Interchange Number	Interchange Sender ID (ISA06) + Interchange Control Number (ISA13) + Interchange Date (ISA09)	30	Alpha Numeric
105	Delimiter		1	Uses the * character value
106-108	Record Type	Value is "**INS**", "**PRO**", or "**DME**"	3	Alpha Numeric
109	Delimiter		1	Uses the * character value
110-113	Submission File Type	Value is "**TEST**" or "**PROD**"	4	Alpha Numeric

TABLE 7J - MAO-004 ENCOUNTER DATA RISK FILTER REPORT FLAT FILE LAYOUT

HEADER RECORD (There is only one header record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
114	Delimiter		1	Uses the * character value
115-227	Filler		113	Spaces
DETAIL RECORD (There may be multiple detail records per encounter line dependent upon the number of errors on a line. Up to ten (10) errors will be reported for an encounter line.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	1=Detail	1	Numeric, no commas and/or decimals.
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is **"MAO-004"**	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-15	Medicare Advantage Contract ID	Medicare Contract ID assigned to the MA Plan	5	Alpha Numeric
16	Delimiter		1	Uses the * character value
17-54	Plan ID (CCN)	Plan internal control number.	38	Alpha Numeric
55	Delimiter		1	Uses the * character value
56-99	Encounter ICN	Internal Control Number assigned by the EDPSC. In encounter data, only 13 spaces represent the ICN however, 44 spaces are coded to allow enhancement of the ICN.	44	Numeric
100	Delimiter		1	Uses the * character value
101-108	Transaction Date	Identifies data submission date	8	Numeric, format CCYYMMDD
109	Delimiter		1	Uses the * character value
110-121	Beneficiary HICN	Beneficiary Health Insurance Encounter Number	12	Alpha Numeric
122	Delimiter		1	Uses the * character value
123-130	Date of Service		8	Numeric, format CCYYMMDD
131	Delimiter		1	Uses the * character value
132-139	Diagnosis Code	ICD-9 codes will be accepted for calculation prior to October 1, 2014. ICD-10 codes will be accepted for calculation on or after October 1, 2014.	8	Alpha Numeric, with decimal
140	Delimiter		1	Uses the * character value
141-220	Diagnosis Description		80	Alpha Numeric
221	Delimiter		1	Uses the * character value

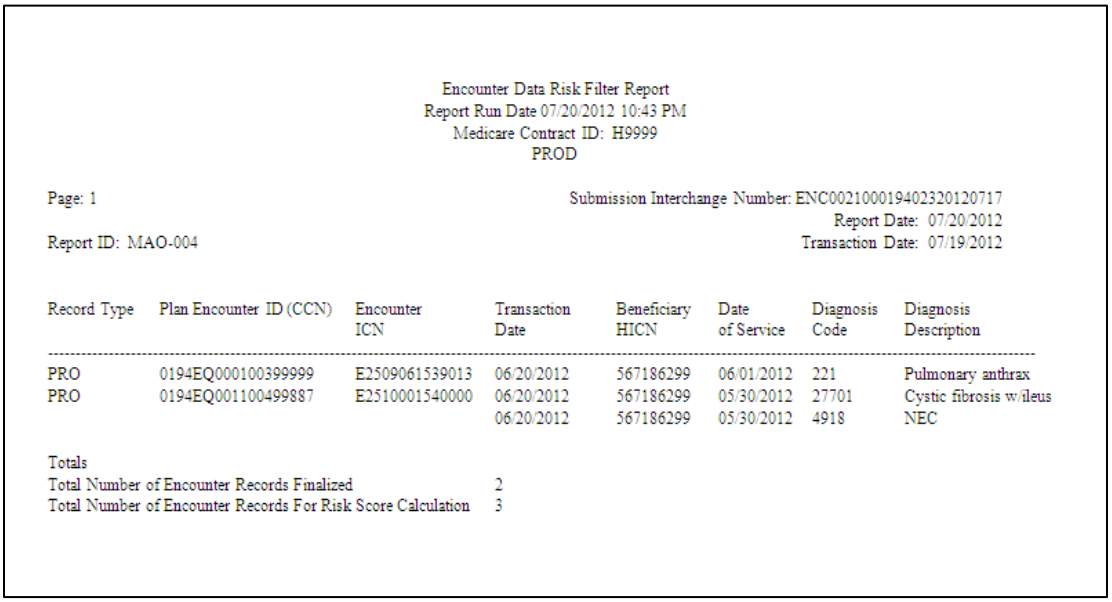
TABLE 7J - MAO-004 ENCOUNTER DATA RISK FILTER REPORT FLAT FILE LAYOUT (CONTINUED)

DETAIL RECORD (There may be multiple detail records per encounter line dependent upon the number of errors on a line. Up to ten (10) errors will be reported for an encounter line.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
222-226		Additional Diagnoses – up to 12 for Professional and 25 for Institutional	5	Alphanumeric, with decimal
227	Delimiter		1	Uses the * character value
TRAILER (TOTALS) RECORD				
Position(s)	**Item**	**Notes**	**Length**	**Format**
1	Record Type	9=Trailer	1	Numeric, no commas and/or decimals.
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "**MAO-004**"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Total Number of Encounter Records Finalized		8	Numeric, no commas and/or decimal points.
19	Delimiter		1	Uses the * character value
20-27	Total Number of Encounter Records For Risk Score Calculation		8	Numeric, no commas and/or decimal points.
28	Delimiter		1	Uses the * character value
29-227	Filler		199	Spaces

7.6.3 MAO-004 Formatted Report

MAOs and other entities may use the MAO-004 formatted report to understand the diagnosis codes used for risk adjustment. Figure 7D provides an example of an MAO-004 report.

Figure 7D - MAO-004 Encounter Data Risk Filter Report Formatted Report Layout



Encounter Data Risk Filter Report
Report Run Date 07/20/2012 10:43 PM
Medicare Contract ID: H9999
PROD

Page: 1
Submission Interchange Number: ENC00210001940232012071 7
Report Date: 07/20/2012
Report ID: MAO-004
Transaction Date: 07/19/2012

Record Type	Plan Encounter ID (CCN)	Encounter ICN	Transaction Date	Beneficiary HICN	Date of Service	Diagnosis Code	Diagnosis Description
PRO	0194EQ000100399999	E2509061539013	06/20/2012	567186299	06/01/2012	221	Pulmonary anthrax
PRO	0194EQ001100499887	E2510001540000	06/20/2012	567186299	05/30/2012	27701	Cystic fibrosis w/ileus
			06/20/2012	567186299	05/30/2012	4918	NEC

Totals
Total Number of Encounter Records Finalized 2
Total Number of Encounter Records For Risk Score Calculation 3

7.7 Summary

During this module, EDPS reports were identified. Participants were provided with information on how to distinguish between the various uses of each report and how to reconcile the processing errors in order to ensure encounter data submissions. Information was also provided to assist MAOs and other entities in determining which diagnoses are accepted for risk adjustment calibration based on the interpretation of the MAO-002 report.

MODULE 8 – SPECIAL CONSIDERATIONS

Purpose

Beginning January 2012, MAOs and other entities were required to begin submitting encounter data in the HIPAA compliant 5010 format. Unique service delivery structures exist within the Medicare Advantage program; therefore, special provisions and considerations are required. The purpose of this module is to provide PACE organizations, Cost Plans, and Special Needs Plans (SNPs) with guidance regarding encounter data submissions.

Learning Objectives

At the completion of this session, participants will be able to:

- Determine the PACE implementation timeline.
- Describe the types of encounter data Cost Plans will be required to submit.
- Identify encounter data requirements for dual-eligible SNPs.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

8.1 Overview of PACE Services

The Program of All-Inclusive Care for the Elderly (PACE) is offered by non-profit public or private organizations, as authorized by the Balanced Budget Act of 1997 (BBA), that provide all-inclusive acute and long term care services to frail elderly Medicaid and Medicare enrollees who are at least 55 years old, require a nursing facility level of care, and live in an area served by a PACE organization. PACE enrollees receive unique care coordinated through an Interdisciplinary Team (IDT) of health professionals. The all-inclusive services enable enrollees to acquire care while staying at home, rather than being required to reside in a nursing home or other facility. As of 2011, approximately 82 PACE organizations are operational in 29 states. PACE organizations provide benefits that include, but are not limited to, the following services located in Table 8A:

TABLE 8A – PACE BENEFITS

Primary care	Home care	Recreational therapy
Hospital care	Physical therapy	Dentistry
Medical Specialty Services	Occupational therapy	Laboratory/X-ray services
Prescription drugs	Adult day care	Social work counseling
Nursing home care	Nutritional counseling	Social services

PACE organizations also provide services and items that are not otherwise covered by Medicare or Medicaid, but are determined necessary for PACE beneficiaries. Examples of non-covered PACE services include transportation, meal services, laundry, and other daily living services. PACE organizations may also include services that would normally be offered in an institutional setting, but instead are provided at a PACE day care center. For example, skilled nursing services are provided by PACE organizations at day care centers and therefore may substitute for those provided at skilled nursing facilities. These services would otherwise need to be provided through a Home Health Agency (HHA) or in an institutional setting.

8.1.1 PACE Submission

Most PACE organizations do not code PACE day care center services using CPT/HCPCs coding, and therefore do not use billing forms/electronic submission such as the UB04/837I or 1500/837-P for these services. In addition to unique services, PACE organizations also provide non-PACE day care center services. These other services are normally submitted on an inpatient or outpatient Institutional or Professional claim form.

For 2013, PACE organizations will be required to submit only non-PACE center service encounters, for which the PACE facility has collected a Professional or Institutional claim form. PACE organizations are required to follow the instructions included in Professional, Institutional, and DME Companion Guides.

Example

During a visit at Sky Regional PACE facility, Joe Boon had a severe chronic cough and was referred to Dr. Grey, a Pulmonologist. Dr. Grey determined that a computerized tomography (CT scan) of the chest was required. Dr. Grey has a standalone, private practice and performed the service (NPI = 1453673442, EIN = 123487345). Dr. Grey performed a chest CT scan with contrast (CPT code 71260). Based on the results, Dr. Grey diagnosed Mr. Boon with 491.2-Obstructive chronic bronchitis. The claim was converted to an encounter and submitted to EDS. Using the scenario provided above, populate Table 8B with the loops, segments, and data elements required for the submission of provider information. For submission, refer to Professional Companion Guide.

TABLE 8B – NPI ELEMENTS

Loop	Data Element	Required Value
2010AA	NM109	
2010AA	REF01	
2010AA	REF02	
2310B	NM109	

Example

Rock Ridge PACE facility received a claim from Community Mental Health Center (TOB 76x) for mental health services provided to Bob Jones. Mr. Jones received his first service on December 3, 2011. Mr. Jones then received care on December 15, 2011, January 3, 2012, and his last service on January 10, 2012. Using the information provided in Section 3.5.10 of the Professional Submission Module what loops, data elements, and values should be populated in the following example?

TABLE 8C – DATE OF SERVICE ELEMENTS

Loop	Data Element	Required Value
2300	DTP02	
2300	DTP03	
2300	NTE01	
2300	NTE02	

Example

Sarah Storm is attending Dominion PACE Center. Mrs. Storm was diagnosed with 429.9 – Heart Disease, unspecified, two months ago. As a routine procedure, Mrs. Storm receives a lipid profile (CPT code – 80061). Dominion PACE Center converted the claim to an encounter and submitted it to EDS. The date of service provided on the encounter was August 12, 2012. Dominion PACE Center received an MAO-002 report dated August 3, 2012 with a "reject" status due to Edit 00010 – From Date of Service is Greater Than TCN Date. Dominion PACE Center must correct the date of service on the encounter, as the service could not occur before the date of submission of the encounter. Using the scenario above what steps would you take to reconcile the report?

8.1.2 PACE Testing

If a PACE organization is submitting on their own behalf with a Submitter ID that has not previously certified through EDFES or EDPS, certification will be required on two (2) levels: Encounter Data Front-End System (EDFES) and End-to-End.

In order to receive EDFES certification, PACE organizations must submit two (2) files (one Institutional and one Professional) containing 25-50 encounters per file. PACE organizations must obtain a 277CA reflecting all encounters submitted in the file with an accepted status and an associated ICN.

End-to-End certification requires submission of Institutional, Professional, and DME test cases that will be published on the CSSC website. Table 8D below provides the certification timeline and testing requirements for EDFES and End-to-End testing.

TABLE 8D – CERTIFICATION TIMELINE

Tested System	Testing Begins	Testing Requirements	Testing Ends/Deadline for Certification
Front-End	8/30/12	25-50 unique encounters per file per Submitter ID	10/30/12
Institutional Encounter Testing	9/1/12	13 Test Cases (2 encounters per test case)	11/15/12
Professional Encounter Testing	11/16/12	21 Test Cases (2 encounters per test case)	12/31/12
DME Encounter Testing	1/1/13	6 Test Cases (2 encounters per test case)	2/28/13

8.2 Overview of Cost Plans

In a memorandum dated September 30, 2004, CMS required all §1876 Cost HMOs/CMPs and asked §1833 HCPPs to submit diagnostic data (medical and drug-related) for dates of service on and after July 1, 2004. The 2012 Advance Notice refers to this memo and explains the authority CMS has to collect encounter data from both types of Cost plans and HCPPs beginning in 2012. §1876 Cost HMOs/CMPs and §1833 HCPPs will only be required to submit encounter data for Medicare covered items/services for which plans claim Medicare costs on their CMS Cost Reports. This means that virtually all §1876 Cost HMOs/CMPs and HCPPs (with the exception of one "billing option 2" Cost HMO/CMP) will only need to collect and submit Professional and DME encounters. Since Institutional encounter data will generally not be required, virtually all Cost Plans will not need to do Front-End or End-to-End Institutional testing.

Encounter data collection will be required for the organizations under the following provisions:

- §1876 HMO (Health Maintenance Organization) or CMP (Competitive Medical Plan)
- §1833 HCPP (Health Care Prepayment Plan)

An HMO (Health Maintenance Organization) or CMP (Competitive Medical Plan) paid on a reasonable cost basis is paid the reasonable cost of the Medicare-covered services it furnishes directly to, or arranges for, its Medicare enrollees, and for which it incurs financial liability. These organizations are defined as:

- HMOs/CMPs that cover both hospital and physician services;
- HMOs/CMPs that provide or arrange for the provision of basic and supplemental health services to enrollees;
- HMOs/CMPs that elect to be reimbursed on a reasonable cost basis.

An HCPP (Health Care Prepayment Plans) is paid the reasonable cost of the Medicare-covered non-provider Part B services it furnishes directly to, or arranges for, its Medicare enrollees, and for which it incurs financial liability. These organizations are defined as:

- HCPPs that are union or employer sponsored; and that
- Do not provide, or arrange for the provision of, any inpatient hospital services;
- Are responsible for the organization, financing, and delivery of covered Part B services to a defined population on a prepayment basis;
- Furnish physicians' services through its employees or under a formal arrangement with a medical group, independent practice association, or individual physicians; and
- Elect to be reimbursed on a reasonable cost basis.

8.2.1 Cost Plans Submission

Although §1876 and §1833 Cost Plans are required to allocate appropriate costs between Medicare enrollees and other enrollees (and non-enrollees to whom the HMO/CMP provides services), only services to Medicare enrollees must be submitted to the EDS. Cost Plans will generally submit only Professional encounters and can refer to Module 3 – Professional Submission for further guidance.

8.3 Overview of Special Needs Plans

One of the overarching goals of encounter data is to obtain full beneficiary utilization from MAOs and other entities. Because MAOs and other entities have a large variance in benefits provided to beneficiaries, special consideration for SNP services is required. The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage Coordinated Care Plan that is specifically designed to provide targeted care to individuals with special needs. These coordinated care plans are called Special Needs Plans or SNPs. Table 8E identifies three (3) types of SNPs.

TABLE 8E – TYPES OF SPECIAL NEEDS PLANS

Special Needs Plan	Description
Institutional	Enrollment restricted to MA eligible individuals who, for 90 days or longer, have had, or are expected to need, the level of services provided in a long term care facility such as a long term care (LTC) hospital, SNF, NF, SNF/NF, ICF/MR, or an inpatient psychiatric facility.
Chronic Condition	Enrollment restricted to individuals with specific severe or disabling chronic conditions.
Dual Eligible	Enrollment restricted to individuals who are entitled to both Medicare and Medicaid.

8.3.1 Institutional SNPs Submission

I-SNPs restrict enrollment to MA eligible individuals who, for 90 days or longer, have had, or are expected to need, the level of services provided in a:

- Long-term care (LTC) hospital
- Medicare certified skilled nursing facility (SNF)
- Medicaid certified nursing facility (NF)
- SNF/NF
- Intermediate care facility for the mentally retarded (ICF/MR)
- Inpatient psychiatric facility

A complete list of acceptable types of institutions can be found in Chapter 2 of the Medicare Managed Care Manual.

📖 Chapter 2 of the Medicare Managed Care Manual

For I-SNPs submission, the ANSI X12N 837 Institutional (837I) is the standard for transmitting health care claims electronically, and its Implementation Guide (TR3) requires the use of TOB codes for processing. An institutional service is provided by a SNF, NF, SNF/NF, or ICF/MR, when a patient is admitted to the facility for at least ninety (90) overnight days. Table 8X provides examples of I-SNP institutions and their associated TOB codes, from which MAOs and other entities are responsible for collecting encounter data for the purpose of submitting to EDS.

TABLE 8F- INSTITUTIONAL SERVICES

Institution	TOB Code
Long-Term Care Hospital	11X
Skilled Nursing Facility Inpatient/Swing Bed	18X, 21X
Home Health Facility Inpatient	32X, 33X
Skilled Nursing Facility Outpatient	22X, 23X
Home Health Facility Outpatient	34x
Community Mental Health Center	76x

When an I-SNP opts to enroll individuals prior to having at least 90 days of institutional level of care, a CMS-approved needs assessment must show that the individual's condition makes it likely that either the length of stay or the need for an institutional level of care will be at least 90 days. The needs assessment and enrollment verification forms will not be required for submission of encounter data. For proper submissions, refer to the Institutional Companion Guide. Institutional SNPs, like all other SNPs, will follow HIPAA 5010 guidelines and regulations, as well as the EDS Companion Guides for proper encounter submissions as of January 3, 2012.

Example

Mr. Sam Brown is admitted into Happy Hearts Long Term Care Hospital. Mr. Brown has resided at the facility for more than 90 days and becomes classified as I-SNP eligible and enrolls in Live Well Health Plan. While he is in the LTC, he receives a number of institutional services. Happy Hearts Long Term Care Hospital submits the claim to Live Well Health Plan. When submitting encounter data, Live Well Health Plan will populate and submit the 837-I with the applicable fields and values. Mr. Sam Brown's stay was interrupted for two (2) days; however, Live Well Health Plan will only file one claim for the entire stay.

8.3.2 Chronic Condition SNPs Submission

Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions defined in 42 CFR §422.2. C-SNPs are dedicated to improving care coordination and quality of care and reducing the costs for treating Medicare beneficiaries. Chronic conditions may include:

- Diabetes
- Heart failure
- Chronic obstructive pulmonary disease
- End stage renal disease

In a Chronic condition SNP, the plan must verify that the enrollee has a particular condition. The information must come from a doctor who has diagnosed the enrollee. In some cases, where the plan must have a doctor examine the enrollee to confirm the condition, an encounter may occur. However, plans may verify the condition over the phone with a doctor who has recently treated the beneficiary. Therefore, it is not necessary for the verification of the condition to result in an encounter. Chronic condition SNPs, like all other SNPs, will follow HIPAA 5010 guidelines and regulations, as well as the EDS Companion Guides for proper encounter submissions as of January 3, 2012.

8.3.3 Dual Eligible SNPs Submission

SNP plans are required by regulation to provide care management that focuses on the conditions particular to the enrollees in the plan. In the case of Dual Eligible SNPs (D-SNPs), this means coordinating Medicare and Medicaid benefits. These enrollees may have encounters which are covered by Medicaid, but not Medicare. Table 8G provides a comparison of the types of services Medicare and Medicaid cover versus those services only covered by Medicaid.

TABLE 8G – MEDICARE VS. MEDICAID SERVICES

Medicare and Medicaid Services	Medicaid-only Services
Inpatient hospital	Personal care
Physician Visits	Caregiver respite care
Emergency Room	Adult day health care
Prescription drugs	Meal delivery

Dual eligible beneficiaries receive most acute care services (inpatient hospital, physician, emergency room, prescription drugs) from Medicare and most long-term-care services (nursing facility and home- and community-based care) from Medicaid. Both programs provide some services (nursing facility, home health, and hospice). Typically providers file dual eligible claims with Medicare as the primary payer. Once Medicare pays its portion, Medicare sends the claim to Medicaid (secondary payer) for payment of the beneficiary's Medicare cost-sharing. If the dual eligible is in an MA plan, the provider does not bill Medicare; the provider bills the plan or receives a capitated payment from the plan. MAOs and other entities typically receive a capitation payment from both Medicare (from CMS) and Medicaid (from the State). CMS requires MAOs and other entities to submit all encounter data for services that are normally paid by Medicare and that are a mixture of Medicare and Medicaid services.

Currently many states have implemented Medicaid Encounter Data Systems (MEDS). MEDS comply with HIPAA 5010 standards. Generally, these various systems are designed to collect, process, store, and report managed care service activities, as well as prescription drug utilization. The states then submit the encounter data to CMS. Therefore, it is unnecessary for MAOs and other entities to submit Medicaid-only paid services to EDS. To prevent MAOs and other entities from submitting duplicate data to CMS, MAOs and other entities must extract the Medicaid service lines from the encounter submission. Since this would require the MAO or other entity to modify the encounter submitted by the provider, the justification for the modification must be included on the encounter. For auditing purposes MAOs and other entities must note the justification as 'MEDICAID CLAIM CHANGE DUE TO MEDICAID SERVICE LINE EXTRACTION'.

Please see section 2.4.2 of the Policy, Monitoring, and Compliance Module for more on proxy claim information.

Example

Happy Health Plan receives a claim from a provider that contains service lines that were covered and paid by only Medicaid. Happy Health Plan must submit service lines that only contain Medicare payable services for EDS processing. Happy Health Plan must extract the Medicaid service lines prior to EDS submission. Using the

information provided in Section 3.5.10 of the Professional Submission Module what loops, data elements, and values should be populated in the following example?

TABLE 8H – MEDICAID EXTRACTION ELEMENTS

Loop	Data Element	Required Value
2300	NTE01	
2300	NTE02	

8.4 Summary

During this module, participants were provided with an overview of PACE organization, Cost Plan, and SNPs submission requirements. In addition, the key provisions, validations, and data necessary for encounter data collection were identified.