CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2012 Regional Technical Assistance Presentation Slides

Monday, August 6 –
Tuesday, August 7, 2012

Encounter Data

ARDX
A. Reddix & Associates

Encounter Data

2012 Regional Technical Assistance

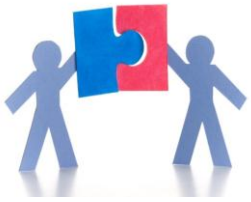
Baltimore, MD
August 6 – August 7, 2012

2012 Regional Technical Assistance

Encounter Data

Introduction

Purpose



- Provide the resources necessary to prepare for the collection, submission, and processing of encounter data
- Become familiar with the Encounter Data rules and associated compliance actions, reports generated from the EDS, and edit resolution

Audience

- Medicare Advantage (MA) Plans
- Medicare Advantage-Prescription Drug Plans (MA-PDs)
- 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)

Training Tools

- Participant Guide
- PowerPoint Slides
- Response Cards
- Evaluation Form

- Other Resources
  - Official CMS Notices
  - List of Acronyms
  - List of web-based resources

Pop Quiz! Example

Select your response to the following question:

What is your favorite vacation spot?

1. The beach
2. The mountains
3. A cruise
4. None of the above

Learning Objectives

- Identify the Encounter Data rules and information regarding monitoring and compliance actions
- Determine services acceptable for encounter data
- Interpret and reconcile data communicated on the EDFES and EDPS reports
- Recognize 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

Support and Technical Assistance

- Customer Service and Support Center (CSSC) http://www.csscoperations.com/internet/cssc.nsf/Home
- A. Reddix & Associates (ARDX)
  - EDS Inbox: EDS@ardx.net
  - Encounter Data Outreach Registration: www.tarsc.info

Agenda Topics (Day 1)

Module
1. Overview
2. Policy, Monitoring, and Compliance
3. Professional Submission
4. Institutional Submission
5. DME Submission
6. EDFES Reports

Agenda Topics (Day 2)

Module
7. EDPS Reports
8. Special Considerations
9. Best Practices

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Encounter Data

Overview

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Purpose

- Understand the process of collecting and submitting accurate encounter data
- Provide participants with important encounter data terms
- Outline the encounter data process flow
- Utilize encounter data resources to assist with understanding of encounter data

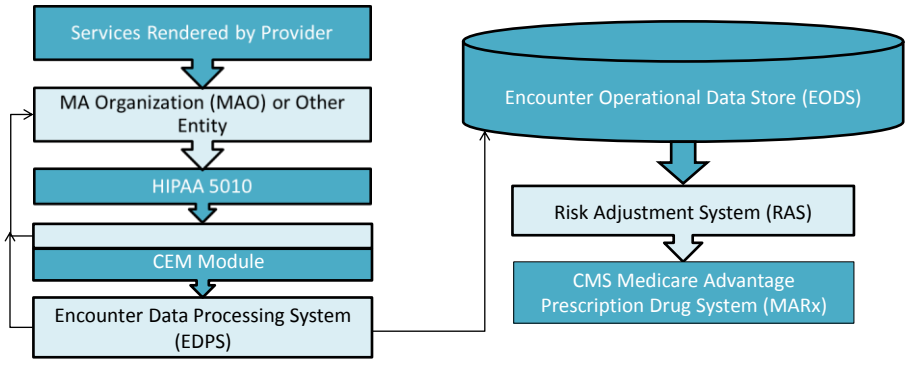
Learning Objectives

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

Encounter Data Terminology

Terminology	Acronym
Encounter Data DME Processing and Pricing Sub-system	EDDPPS
Encounter Data Front-End System	EDFES
Encounter Data Institutional Processing and Pricing Sub-system	EDIPPS
Encounter Data Professional Processing and Pricing Sub-system	EDPPPS
Encounter Data Processing System	EDPS
Encounter Data System	EDS
Encounter Operational Data Store	EODS

Encounter Data Flow



Encounter Data Resources

1. Type 3 Technical Report (TR3)
2. CMS CEM Edits Spreadsheet
3. Encounter Data Companion Guides

Encounter Data Resources
(continued)

4. EDPS Bulletins

5. EDS Incident Tracking Tool

6. User Group, Industry Updates, and Q&As

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 to submit encounter data to CMS, to receive EDFES acknowledgement, and receive EDPS processing status reports

Connectivity (continued)

- New submitters must complete an Encounter Data Electronic Data Interchange (EDI) Agreement 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 that represents the MAO or other entity must sign this document

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 5,000 CLMS per ST-SE

Tier 1 Testing

- Tier 1 testing required MAOs and other entities to submit specific test cases in two (2) separate files

Tier 2 Testing

- Allowed for Professional, Institutional, and DME testing of MAO and other entities' specific test case scenarios
- 2,000 maximum encounter submissions per file

Encounter Data Certification Timeline

First Year Implementation End-to-End Testing 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

Encounter Data Certification Timeline (continued)

Second Year Implementation End-to-End Testing Timeline

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

Training and Support

Initiative	Description
Customer Service & Support Center (CSSC)	This toll free help line (1-877-534-2772) is available Monday – Friday, 8:00 A.M. EST to 7:00 P.M. EST.
www.csscoperation.com	CSSC website is the gateway to EDS for information, resources, submitting questions regarding data submission, and training information
Work Groups and Industry Updates	Conducted as announced to provide information regarding the progress of updates for encounter data implementation. Register at www.tarsc.info
www.tarsc.info	Website for encounter data training, work groups, locations, online registration, and encounter data FAQs
eds@ardx.net	Method for submitting encounter data policy and operational questions during implementation

Summary

- Defined the terminology and identified acronyms
- Illustrated the process and flow of encounter data
- Provided end-to-end testing timelines
- Identified CMS outreach efforts

Evaluation

Please take a moment to complete the evaluation form for the following module:

Overview

Your Feedback is Important!
Thank you!

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Encounter Data

Policy, Monitoring, and Compliance

Purpose

To provide MAOs and other entities the policy guidance that supports the encounter data program

Learning Objectives

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

Background

- The final 2009 Inpatient Prospective Payment system (IPPS) Rule (73 FR 48434) clarifies that CMS has the authority to require MAOs and other entities to submit encounter data for each item and service provided to beneficiaries at 42 CFR 422.310(d)
- MAOs and other entities are required to submit this data for dates of service January 1, 2012 and later

Background (continued)

- Encounter data can be used to develop and calibrate CMS-HCC risk adjustment models
- Using such models to pay MAOs and other entities can improve payment accuracy
- CMS may also use the data for calculating Medicare DSH percentages, Medicare coverage purposes, and quality review and improvement activities

Implementation - Milestones

2012 Milestones

- Implemented the EDS on January 3, 2012 for submission and processing of encounter data.
- Executed testing of the 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 create solutions for issues related to the collection and submission of encounter data.

Implementation – Milestones (continued)

2012 Milestones

- 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) PACE-specific Work Groups to discuss issues and create possible solutions for final implementation of encounter data.
- Conducted one (1) Industry Update and 14 User Group sessions to provide information regarding the progress of and updates for encounter data implementation.

Data Collection

- Organizations required to submit encounter data
  - Medicare Advantage Organizations
  - Cost Plans (§1876 Cost HMOs/CMPs and §1833 HCPPs)
  - Coordinated Care Plans (including Special Needs Plans)
  - Private Fee For Service Plans
  - Medical Savings Accounts
  - Medicare Advantage-Prescription Drug plans
  - Employer Group Health Plans
  - PACE organizations
  - Demonstration Plans

Data Collection (continued)

Organization Type	Policy Requirements
MAOs	• Submit all accepted and denied adjudicated claims
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
PACE Organizations	• For 2013, PACE will submit claims-based encounters only
Special Needs Plans (SNPs)	• Submit only Medicare services

Adjudicated Claims Submission

- Only fully adjudicated claims with a final disposition of "accepted" or "denied" may be submitted to EDS
- Adjudicated claims/lines with a "denied" status must include the reason for the denial

Disposition	Definition
Accepted	deemed "processable" and given a final disposition of "payment"
Denied	deemed "processable" and given a final disposition of "no payment"
Rejected	deemed "unprocessable" (i.e., Invalid HCPCS or diagnosis code) at any stage in the adjudication process

Submission Requirements

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires 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
- Title XI of the Act, Part C, Sections 1171 – 1180 define various terms and impose several requirements concerning electronic transmission of health information

Submission Format

- Encounter data must be submitted to EDS on the HIPAA compliant **ANSI 837X V5010** format
- Required data elements must be submitted using the 837-I (Institutional) or 837-P (Professional and DME Supplier) 5010 format

Proxy Data

- MAOs and other entities may submit proxy data in a limited set of circumstances for dates of service in 2012
- CMS will use an interim approach for 2012 and provide additional guidance for 2013 encounter data submission
- MAOs and other entities are required to use the NTE field to indicate the reason for the use of proxy information
- Contact CMS if you have questions regarding proxy data submission and when it may be used

Proxy Data

Circumstances for Use of Proxy Data	Reason to be Identified in NTE Field
For 2011 DOS, the "from" and "through" dates must be revised to show 2012 DOS. EXCEPTION: 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

Note: Questions regarding proxy data may be submitted to CMS at eds@ardx.net

Chart Reviews

- Chart reviews are performed for validation of diagnosis codes
- Diagnoses submitted using a chart review encounter must be supported by a medical record
- Types of chart review encounters
  - Linked ICN: linked to an original encounter stored in EODS
  - Unlinked ICN: not linked to an encounter

Bundled Claims

- Bundled Claims – the bundling of claim lines as defined by National Correct Coding Initiative (NCCI) or the bundling of claim lines in adjudication to match the benefit structure of the MAO or other entity
- NCCI edits prevent improper payment for incorrect code combinations
- Only bundled claims identified using NCCI will be accepted for encounter data submission

Minimum Data Elements

- The minimum data elements are required for submission in order to properly process and price encounter data (see the EDS Minimum Data Elements and EDS Companion Guides)
- MAOs and other entities must include at least the minimum data elements for submission of encounter data, including paper, 4010, foreign provider generated, and atypical provider encounters

Home Health Submission

- MAOs and other entities should not include Home Health encounters in their encounter data submissions until notified by CMS
- CMS will provide additional guidance regarding Home Health encounter data submission in the near future

Part B Drug Data

- NDC codes must be submitted, when available; but are not required for Part B drug data submission
- The **ANSI 837X V5010** format is not compatible with NCPDP D.0 format
  - For the time being, Part B drug data received in the NCPDP D.0 format should be excluded from encounter data submissions and held
  - Alternative options for the submission of Part B drug data are being reviewed

Encounter Data Monitoring

- CMS will monitor MAO and other entity submitters individually in order to identify and address plan specific submission issues
- Areas of monitoring will include the following:
  - Timeliness of submission
  - Quantity (volume) of submission
  - Quality of submission
  - Accuracy of submission

Timeliness of Submission

- Timely submission addresses submission of encounter data within certain timeframes and deadlines
- CMS has established compliance standards for timely submission based on certain types of data

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 adjudication date
Chart Review Encounter	Within 25 months of data collection period

Submission Frequency

- MAOs and other entities are required to submit data at the frequency established by the number of Medicare enrollees per Contract ID, and are encouraged to submit more often

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

Quantity of Submission

- The volume of submitted encounters must align with the number of enrollees per contract ID
- Specific metrics may include:
  - Submission rates
  - Proportions of claims per service category
  - Overall volume of submission
- CMS will confirm the anticipated volume annually and analyze submission quantity on a quarterly basis

Quality of Submission

- CMS will analyze encounter data submissions to ensure accurate and complete data
- Quality is evidenced by the number of errors received and number of duplicate encounters submitted per contract ID
- CMS will develop error frequency benchmarks and monitor resubmission and duplicate rates quarterly

Accuracy of Submission

- MAOs and other entities are responsible for the accuracy of all encounter data submitted
- Every submission must be supported by original source documentation, i.e., a medical record
- MAOs and other entities must attest that the data submitted is based on best knowledge, information, and belief

Encounter Data Use

- CMS will use encounter data to:
  - Determine risk adjustment factors for payment
  - Calibrate the risk adjustment model
  - Calculate Medicare DSH percentages, coverage purposes and quality review activities
- To support the calculation of risk scores work in the transition, EDS and RAPS processing will parallel until the EDS transition is complete

Encounter Data Use (continued)

- MAOs and other entities must submit risk adjustment data to RAPS and full encounter data to EDS through 2013
- Risk scores for payment year 2013 will be calculated using RAPS data

Compliance

- It is important that encounter data submission is timely, comprehensive, and accurate
- CMS will expand monitoring of encounter data submission
- CMS is developing a compliance plan to ensure CMS requirements are met
- More information on the compliance plan will be shared later

Summary

- MAOs and other entities were provided with new information regarding encounter data submission
- MAOs and other entities should prepare for parallel submission of data to RAPS and EDS through 2013
- MAOs and other entities are encouraged to comply with EDS requirements in order to optimize the encounter data collected

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Evaluation

Please take a moment to complete the evaluation form for the following module:

Policy, Monitoring, and Compliance

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

Encounter Data

Professional Submission

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Purpose

Provide participants with the data collection, submission, processing, and pricing principles for Professional encounter data that is in accordance with the CMS requirements

Learning Objectives

- 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

Professional/Physician Services

- Professional/Physician Services may be performed by:
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Registered Nurse Anesthetist
  - Certified Nurse Midwife
  - Clinical Psychologist
  - Clinical Social Worker
  - Registered Dietitian
  - Nutrition Professional

Submission Format

- Encounter data must be submitted to the EDS on the **ANSI 837X V5010** format.
- Helpful Resources:
  - WPC Website
  - CMS CEM Edits Spreadsheet
  - EDS Companion Guides

Submission Format – Minimum Data Elements

- MAOs and other entities must include at least the minimum data elements when submitting encounter data
- The Minimum Data Elements list is not inclusive of all situational loops, segments, and data elements in the 837-P TR3

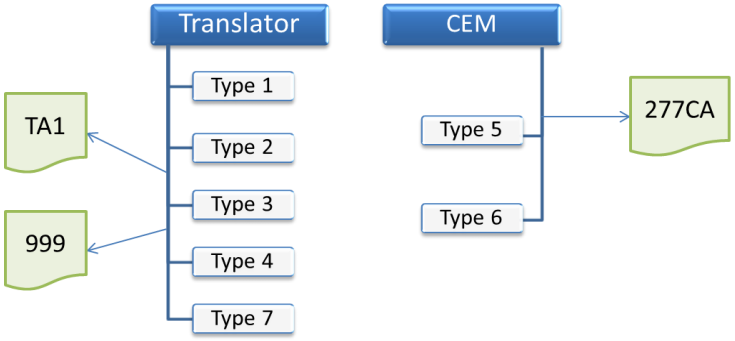
Strategic National Implementation Process (SNIP)

- The Workgroup for Electronic Data Interchange (WEDI) identified practical strategies for reducing administrative costs in healthcare through the implementation of EDI
- WEDI proposed expansion of EDI testing to include seven (7) unique SNIP types to ensure HIPAA compliance
- These SNIP types are grouped for editing purposes and occur in the EDFES translator or CEM

Strategic National Implementation Process (SNIP) (continued)

- Type 1 – Integrity Testing
- Type 2 – Requirement Testing
- Type 3 – Balancing Testing
- Type 4 – Situation Testing
- Type 5 – Code Set Testing
- Type 6 – Line of Business Testing
- Type 7 – Trading Partner-Specific Testing

Strategic National Implementation Process (SNIP) (continued)



Encounter Data Balancing

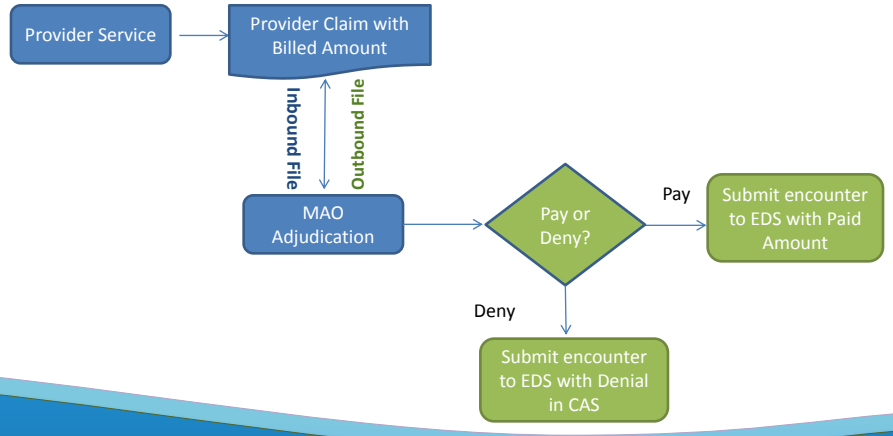
- To ensure encounter integrity, the amounts reported in the 837-P must balance at three (3) different levels
  - Claim charge amounts
  - Claim payment amounts
  - Service line levels
- Encounters that do not balance at these levels will be rejected in the EDFES and returned to the submitter for resubmission

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 received a claim with a charge amount of 100.00. Line 1 service charge was 35.00 and Line 2 service charge was 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

Claim Level Payer Paid Amount Balancing



Claim Level Payer Paid Amount Balancing (continued)

- The sum of all line level payment information minus any claim level adjustments must balance to the claim level payment amount
- In order to ensure balancing, the MAO or other entity must identify the payer associated with the line payment, which must be the same for Loop 2430, SVD01 and Loop 2330B, NM109

Claim Level Payer Paid Amount Balancing (continued)

Claim Charge	**Loop 2300, CLM02**	**$100.00**
Claim Payment	Loop 2320, AMT02	$80.00
Claim Adjustment	Loop 2320, CAS03	$5.00
Line 1 Charge	**Loop 2400, SV102**	**$80.00**
Line 1 Payment	Loop 2430, SVD02	$70.00
Line 1 Adjustment	Loop 2430, CAS03	$10.00
Line 2 Charge	**Loop 2400, SV102**	**$20.00**
Line 2 Payment	Loop 2430, SVD02	$15.00
Line 2 Adjustment	Loop 2430, CAS03	$5.00

Claim Payment = (Line 1 Payment + Line 2 Payment) – Claim Adjustment

80 = (70.00 + 15.00) – 5.00

Claim Level Payer Paid Amount Balancing (continued)

Claim Charge	Loop 2300, CLM02	$100.00
Claim Payment	Loop 2320, AMT02	$80.00
Claim Adjustment	Loop 2320, CAS03	$20.00

Claim Charge = Claim Payment + Claim Adjustment

100 = 80 + 20

Service Line Level Balancing

- Line adjudication information is reported when the MAO or other entity (or true COB) has adjudicated the claim and there was service line payment and/or adjustments
- The sum of the line level adjustment amounts and line level payments must balance to the charge amount for the associated line

Service Line Level Balancing
(continued)

- 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

Service Line Level Balancing
(continued)

- 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

Note: There is NO True COB Service Level Payment Amount information

Service Line Level Balancing
(continued)

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

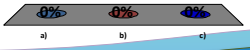
Capitated Submission

- For capitated or staff model arrangements, MAOs and other entities must submit '0.00', **only** if billed and/or payment amount information is not available
- When capitated and non-capitated service lines are submitted on one (1) claim, populate Loop 2400, CN101='05' for each capitated service line
- MAOs and other entities must ensure that capitated provider encounters comply with EDFES balancing edits

Capitated Submission (continued)

Best Health Plan has a capitated arrangement with Dr. Smith for a portion of services provided. Best Health Plan will submit the encounter to EDS and identify it as a capitated encounter by populating:

a) Loop 2400, CN101 = '9'
b) Loop 2300, CLM05-3 = '5'
c) Loop 2400, CN101 = '5'



Place of Service (POS)

- POS codes are two (2)-digit codes used to identify the setting in which a service was provided.
- Use of the National POS code set is are required for transmitting electronic healthcare claims according to national standards established by HIPAA
- Refer to the National POS Code Set at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

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
- Professional encounters are submitted to the EDFES for editing and then to the EDPPPS

Professional Processing Edits

- The EDPPPS contains edits that are applied to each encounter submission
- The edits are organized into nine (9) different categories:

1. Validation	4. Reference	7. Pricing
2. Provider	5. Limit	8. Duplicate
3. Beneficiary	6. Conflict	9. NCCI

Professional Processing Edit Logic

- The EDPPPS performs editing based on header level and line level information
  - If at least one of the lines is accepted and there is no reject edit at the header level, the encounter is accepted
  - If all lines are rejected and there is no reject edit at the header level, the encounter will be rejected
  - If there is a reject edit at the header level, the encounter will be rejected

Professional Processing Edit Logic (continued)

- There are two (2) edit dispositions that are generated on the header and line level: Informational and Reject
  - **Informational** – will not cause processing to cease
  - **Reject** – will cause an encounter to cease processing
    - The edit message is provided on EDPS transaction reports to advise the MAO or other entity of the specific reason for the edit
    - MAO or other entity must resubmit the encounter through the EDFES and successfully pass translator and CEM level editing

Professional Processing Edits

The most common beneficiary edits generated on encounter data:

- **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 DOS**
- **02255 – Beneficiary Not Part A Eligible for Date of Service**
- **02106 – I: Invalid Beneficiary Last Name**
- **02120 – I: Beneficiary Gender Mismatch**

Professional Processing Edits
(continued)

The most common provider edits generated for encounter data:

01405 – Sanctioned Provider

- Occurs 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
- MAOs and other entities should use the OIG Sanction List to verify that a provider is not sanctioned prior to adjudication of encounter data submission published at http://oig.hhs.gov/exclusions/index.asp

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

- Occurs when the Servicing Provider is on the Provider Master tables but is not eligible for the Claim DOS based on the Provider eligibility dates on the Provider Master tables
- MAOs and other entities must ensure that the correct NPI for the rendering provider is populated on the encounter

Professional Processing Edits

The most common validation edits generated for encounter data:

- **00025** – To Date of Service After Date of Claim Receipt Date
- **00065** – Missing Pick Up Point Zip Code
- **00265** – Adjustment of 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
- **00762** – Unable to Void Rejected Claim

Professional Processing Edits (continued)

- Edit 00025 – occurs when service line To DOS is greater than the receipt date portion of the ICN
  - Ensure that the DOS on the encounter is not after the date the encounter was submitted to the EDS
- Edit 00065 – occurs when the ambulance pick-up ZIP Code is not on the encounter
  - Populate the correct ZIP Code, if it is available
  - If the ZIP Code is not available, use the ZIP Code of the Rendering Provider or Billing Provider as populated in Loop 2310E

Professional Processing Edits
(continued)

- Edit 00265 – occurs when the encounter is an adjustment or void and the former ICN is not found in EODS
  - Ensure the ICN provided on a correct/replace or void/delete encounter has an 'accept' status on the 277CA
- Edit 00760 – occurs when the encounter is an adjustment or void and the original ICN indicated is for an encounter that has been adjusted or an adjustment is in progress
  - Wait to receive the MAO-002 report with a status of 'accepted' to confirm initial adjustment or void was processed

Professional Processing Edits
(continued)

- Edit 00761 – occurs when the Billing Provider NPI populated on the void/delete encounters differs from the original encounter submission
  - Submit the exact same encounter as the previously submitted and accepted encounter, except that CLM05-3='8'
- Edit 00762 – occurs when the encounter is a void and the original ICN indicated is for an encounter that is currently in a status of void in EODS
  - Ensure that the ICN referenced on void/delete encounter has a status of 'accept' prior to submission of the void/delete encounter

Special Considerations

- Some submissions require special considerations in order to allow the encounters to pass EDFES and EDPS edits
  - Ambulance
  - Part B Drug Data
  - Default NPIs
  - Chart Review
  - Correct/Replace
  - Void/Delete
  - Proxy Claim Information

Ambulance

- MAOs and other entities must submit Professional ambulance 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:
  - Loop 2310E (Ambulance Pick-Up Location)
  - Loop 2310F (Ambulance Drop-Off Location)

Ambulance (continued)

- If the true ambulance pick-up and drop-off locations are **not** available from the provider
  - Use the Billing Provider's address, including the address line(s), city, state, and ZIP code to populate Loops 2310E and 2310F
  - If the Rendering Provider is different than the Billing Provider
    - populate the Rendering Provider's address, including address line, city, state, and ZIP code information in Loops 2310E and 2310F

Ambulance (continued)

- Morningstar Community Health received a claim that does not include the pick-up and drop-off locations for the service provided
  - Rendering Provider is Dr. Johannes Spielberg
  - Billing Provider is Ambulance of America

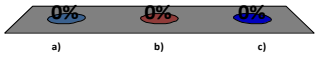
Ambulance (continued)

What provider information should be populated in Loops 2310E and 2310F?

✓a) Rendering Provider

b) Billing Provider

c) Referring Provider



Part B Drug Data

- NDC – a unique, 11-digit, three (3) segment numeric identifier assigned to each medication
  - The segments identify vendor, product, and trade package information

Segment 1	Labeler Code	First four (4) or five (5) digits assigned by FDA
Segment 2	Product Code	Three (3) or four (4) digits and identifies strength, dosage, form and formulation
Segment 3	Package Code	One (1) or two (2) digits and identifies package forms and sizes

Part B Drug Data (continued)

- Pharmaceutical Benefit Managers (PBMs) – Third Party Administrators (TPAs) who oversee prescription drug programs
- Key Responsibilities – Processing and payment of prescription drug encounters
  - Some encounters may be received in the National Council for Prescription Drug Programs (NCPDP D.0) format
  - NCPDP D.0 cannot be used for encounter data submission

Default NPIs

- Submission of encounter data requires the use of a valid National Provider Identifier (NPI)
- NPIs can be verified on the NPI Registry https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do
- Minimum Data Elements must be used for submission

Default NPIs (continued)

- CMS has temporarily provided a default NPI ***when the provider has not been assigned an NPI***

SYSTEM	PAYER ID	DEFAULT NPI VALUE
Professional	80882	1999999984

- Potential exceptions requiring the use of a default NPI
  - Atypical Provider Submissions
  - Paper Claim Submission
  - 4010 Submission
- A valid/true EIN must be used

Default NPIs – Atypical Provider

- Atypical Provider - not considered health care providers and do not provide health care services
- When the EDPS receives an encounter, it reads the atypical provider NPI and bypasses all other edits
  - Default EIN 199999998 may be used with ***atypical provider*** submissions, if the provider EIN is not available
- Diagnoses captured from atypical provider types will not be stored for risk adjustment calculation

Default NPIs – Paper Claim

- Paper Claim Indicator

Loop 2300	
PWK01 = 'OZ'	PWK02 = 'AA'

- Diagnoses captured from Paper Claim submissions are eligible for risk adjustment
- **Note**: PWK must be populated or the encounter will be processed as an atypical provider submission

Default NPIs – 4010

- 4010 Indicator

Loop 2300	
PWK01 = 'PY'	PWK02 = 'AA'

- Diagnoses captured from 4010 Claim submissions are eligible for risk adjustment
- **Note**: PWK must be populated or the encounter will be processed as an atypical provider submission

Default NPIs – 4010 (continued)

Green Plan received a 4010 submission from Dr. Washington, which did not contain an NPI. What is required for Green Plan to convert the 4010 submission to an encounter?

a) Default NPI of 1999999984, Loop 2300 PWK01 = 'PY' and PWK02 = 'AA'

b) Default NPI of 1999999984, Loop 2300 PWK01 = '09' and PWK02 = 'AA'

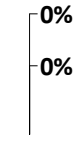


Chart Review

- Must be an appropriate provider specialty and type
- Must be submitted within 25-months of the data collection period
- Diagnoses submitted must be based on a face-to-face visit and supported by medical records
- May or may not be linked to a previously submitted and accepted encounter
- Minimum Data Elements must be used for submission

Chart Review (continued)

- Chart Review Indicator

Loop 2300	
PWK01 = '09'	PWK02 = 'AA'

- May be used to:
  - Add diagnoses to a full encounter
  - Delete diagnoses from a full encounter
  - Replace one chart review with another chart review
  - Add and delete diagnoses on a single full encounter

Note: **Chart reviews cannot void/delete or correct/replace a full encounter**

Chart Review – Add Diagnosis

- Scenario 1
  - 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)**

Chart Review – Add Diagnosis
(continued)

- 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 must submit a linked chart review to add the new diagnosis.

Chart Review – Add Diagnosis
(continued)

Where should A-One Health Plan populate the additional diagnosis code of 402.10?

a) REF02
b) HI01-1
✔ c) HI01-2

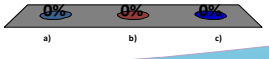


Chart Review – Delete Diagnosis

- Scenario 2
  - 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 = **Deleted diagnosis code(s)**
  - 2300 REF01 = 'EA'
  - 2300 REF02 = '8' (Indicates the deletion of diagnosis HI01-2)

Chart Review – Delete Diagnosis (continued)

- During a medical record review, Statewide Community Care reconciled chart review data and found that Dr. 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=___, REF02=___.

Chart Review – Delete Diagnosis (continued)

What values should be populated in the missing REF01 and REF02 segments?

a) 'F8' and 429.3

✔ b) 'EA' and '8'

c) 'XY' and 149205832

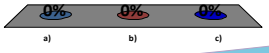


Chart Review – Add/Delete

- Scenario 3
  - 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)**
  - 2300 REF01 = 'EA'
  - 2300 REF02 = Deleted diagnosis code(s)

Chart Review – Add/Delete
(continued)

- Fresh Perspective Health performed a medical record review for Dr. Zynga and located a chart discrepancy for patient, Tracy Bennett. Diagnosis 714.0 – Rheumatoid Arthritis was not valid for the service Dr. Zynga provided. Fresh Perspective Health also noted in the medical record that diagnosis 403.90 – Kidney Disease due to Hypertension was omitted from the original encounter submission. Fresh Perspective Health must submit a linked chart review with Loop 2300 CLM05-3='1', PWK01='09', PWK02='AA', REF01='F8', REF02 = the original accepted ICN, HI01-1=__, HI01-2= ____, REF01='EA', REF02= (deleted diagnosis)

Chart Review – Add/Delete
(continued)

What values should be populated for the missing HI01 segments?

✔a) 'BK' and 403.90
b) 'EA' and 714.0
c) 'BK' and 714.90

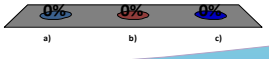


Chart Review – Replace Chart Review with Chart Review

- Scenario 4
  - 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

Chart Review – Duplicate Logic

Linked ICN Chart Review Duplicate Logic
Health Insurance Claim Number (HICN)
Date of Service
Diagnosis Code
Internal Control Number (ICN) from a previously accepted encounter

Unlinked ICN Chart Review Duplicate Logic
Health Insurance Claim Number (HICN)
Date of Service
Diagnosis Code

Correct/Replace

- Submitted for any modification to a previously accepted encounter, including but not limited to, billing or payment information, provider information, and/or diagnosis codes or procedure codes
- Correct/replace encounters will supersede previously accepted encounters

Loop 2300
CLM05-3 = '7'
REF01 = 'F8'
REF02 = ICN of the original accepted encounter

Correct/Replace (continued)

- Happy Health received, processed, and adjudicated a claim from Dr. Clark for Mary Jones with a diagnosis of Diabetes without Complications Type II, Unspecified Not Uncontrolled (25000) and submitted the encounter. Happy Health received a 277CA, for ICN 1567839847389. The encounter was also accepted by EDPS. Two (2) months later, Happy Health receives a claim correction indicating the diagnosis was actually Diabetes without Complications Type II, Unspecified Uncontrolled (25002). Happy Health adjudicated the correct claim and resubmitted the encounter as a correct/replace by correcting the diagnosis code

Correct/Replace (continued)

- What information would Happy Health Plan populate in the following fields?

Loop 2300	
CLM05-3	7
REF01	F8
REF02	1567839847389

Void/Delete

- Submitted when a previously submitted and accepted encounter must be voided from the EDS
- Void/delete encounters will supersede previously accepted encounters.

Loop 2300
CLM05-3 = '8'
REF01 = 'F8'
REF02 = ICN of the original accepted encounter

  - All other information on the void/delete encounter must match the original encounter submission

Proxy Data Information

- All encounters must match the provider's original claim after adjudication
- In some instances, submission of proxy data information is required for successful processing through the EDS
  - Alteration of DOS from 2011 to 2012
  - Anesthesia modifier
  - Removal of rejected lines
  - Medicaid Service lines

Proxy Data Information

- Proxy Data Indicator

Loop 2300

NTE01 = 'ADD'

NTE02 =

for DOS = DOS CLAIM CHANGE DUE TO 2011 DOS DURING EDS IMPLEMENTATION PERIOD

for Modifier = MODIFIER CLAIM CHANGE DUE TO EDS ACCEPTABLE ANESTHESIA MODIFIERS

Proxy Data Information (continued)

- Proxy Data Indicator

Loop 2300

NTE01 = 'ADD'

NTE02 =

for Rejected Lines = REJECTED LINES CLAIM CHANGE DUE TO REJECTED LINE EXTRACTION

for Medicaid = MEDICAID CLAIM CHANGE DUE TO MEDICAID SERVICE LINE EXTRACTION

EDPPPS Duplicate Logic

- The following values are the minimum values used for Professional duplicate logic:

Beneficiary Demographic • HICN • Last Name	Procedure Code(s) and 4 modifiers
Date of Service	Rendering Provider NPI
Place of Service (2 digits)	Paid Amount*
Type of Service **	

** the amount paid by the MAO or other entity populated in Loop ID-2320, AMT02*
*** not submitted on the 837-P but derived from data captured*

Summary

- Submission, processing, and pricing requirements for Professional encounter data were provided
- Professional processing edits, as well as prevention and resolution strategies were provided to assist in successful submission of Professional/Physician Supplier encounter data to the EDS
- Special considerations were identified and operational guidance was provided

2012 Regional Technical Assistance

Evaluation

Please take a moment to complete the evaluation form for the following module:

Professional Submission

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

Encounter Data

Institutional Submission

Purpose

To specify the data collection, submission, and processing principles for Institutional encounter data in accordance with the CMS requirements

Learning Objectives

- 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 appropriate operational guidance for the processing of Institutional encounters

Submission Format

- Submit services for inpatient or outpatient institutional providers
- Encounter data must be submitted to the EDS on the **ANSI 837X V5010** format
- Helpful Resources:
  - WPC Website
  - CMS CEM Edits Spreadsheet
  - EDS Companion Guides

Submission Format – Minimum Data Elements

- Include at least the minimum data elements when submitting encounter data
- The Minimum Data Elements list is not inclusive of all situational loops, segments and data elements in the 837-I TR3
- The situational fields associated with these minimum data elements must be submitted if the situation is present

Type of Bill (TOB)

- Institutional encounter data is processed according to the TOB and revenue code provided
- CMS will collect all EDS acceptable TOBs with 2012 DOS
- **Exceptions:**
  - TOB 11X, 18X, and 21X – Inpatient
    - "From" DOS may be 2011
    - Through DOS must be 2012
    - Interim bills with 2011 DOS should be submitted

Type of Bill – Hospital Scenario

Redwood Health Plan received a claim from Mercy Hospital for Mary Washington, who was admitted to Mercy on December 15, 2011 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.

Type of Bill (TOB) - Exclusions

- Until further notice, the following types of bills will not be accepted by EDS

Facility Type	Type Of Bill
Home Health Inpatient – Part B	32x
Home Health Outpatient	33x
Home Health – Other	34x
SNF Inpatient – Part A	21X
SNF Inpatient – Part B	18X, 22X, 28X
SNF Outpatient	22X, 23X
SNF Swing Bed	18X, 28X
Critical Access Hospital Inpatient/Swing Bed	18X

Institutional Processing

- 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
- Institutional encounters are submitted to the EDFES for editing and then transmitted to the EDIPPS

Institutional Processing Edits

- The EDIPPS contains edits that are applied to each encounter submission
- The edits are organized into nine (9) different categories:

1. Validation	**4. Reference**	**7. Pricing**
2. Provider	**5. Limit**	**8. Duplicate**
3. Beneficiary	**6. Conflict**	**9. NCCI**

Institutional Processing Edits
(continued)

- The most common beneficiary edits generated for encounter data:
  - **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**

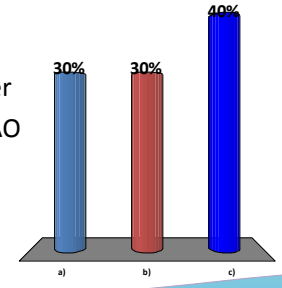
Processing Edits – Scenario 1

Mary Jackson was admitted to NC Hospital and expired on January 11, 2012. NC Hospital submitted a claim to North Carolina Health Plan and included a DOS for January 19, 2012. North Carolina Health adjudicates the claim and submits and encounter to EDS. The encounter processes through the EDFES but receives an MAO-002 report indicating that the encounter was rejected due to edit "02112 – Date of Service is After Beneficiary Date of Death". North Carolina Health's enrollment file has Mary Jackson's date of death as February 3, 2012.

Processing Edits – Scenario 1
(continued)

After verifying through the Social Security Administration, it was determined that Ms. Jackson's date of death was January 12, 2012. How will North Carolina Health reconcile this edit in order for the encounter to be processed correctly?

a) Change the date of death and resubmit encounter
b) Contact the provider to verify DOS, if correct, MAO updates enrollment file and resubmits encounter
c) Change the date of service on the encounter and resubmit



Institutional Processing Edits

- The most common provider edits generated for encounter data:

01405 – Sanctioned Provider

- Occurs when the Performing Provider Type or Specialty is not authorized to provide services based on the restrictions contained on the reference files
- Use the OIG Sanction List to verify that a provider is not sanction prior to adjudication of encounter data submission published at http://oig.hhs.gov/exclusions/index.asp

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

- Occurs when the Servicing Provider is on the Provider Master tables but is not eligible for the Claim DOS based on the Provider eligibility dates on the Provider Master tables
- Ensure that the correct NPI for the rendering provider is populated on the encounter
- **For Group practices,** submit the group practice NPI as Billing Provider in Loop 2010BB and the Individual Rendering Provider NPI in Loop 2420A

Processing Edits – Scenario 2

Paul Brown is admitted to Old Dominion Regional Hospital due to abdominal pain and receives an x-ray (CPT 70422) from Dr. Rogers. The claim for the x-ray is submitted to Greenville Health Plan and includes a procedure code for cheiloplasty (CPT 40702) instead of the x-ray performed. Greenville Health Plan adjudicates the claim, converts it to an encounter, and submits it to EDS. The encounter passes EDFES edits and an MAO-002 report is returned to Greenville Health Plan for the encounter with a reject status.

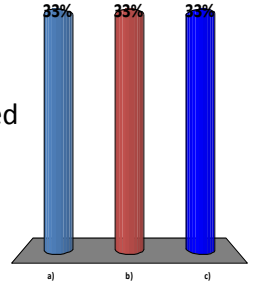
Processing Edits – Scenario 2 (continued)

What is the edit generated on the MAO-002 report received by Greenville Health Plan?

a) Edit 18270 – l:Revenue Code and HCPCS Code Required on Outpatient

b) Edit 03102 Provider Type or Specialty Not Allowed to Bill for Procedure

c) Edit 18140 - Diagnosis – Principal Diagnosis Is An E-Code



Institutional Processing Edits
(continued)

- The most common validation edits generated for encounter data:

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

Institutional Processing Edits
(continued)

- Edit 17590 – Value Code – Code 05 Not Present or Conflicts With Dollar Amount occurs when Value Code 05 is not present; or 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
  - When HI01-1 = 'BE' and HI01-2 = '05', the value code dollar amount must be more than the sum of revenue codes 960, 962, 963, 964, 969, 970-989 and 98X

Institutional Processing Edits
(continued)

- Edit 17285 – Billed Lines Require Charges (Few Exceptions) occurs when a charge amount is not provided for a service line; or when a charge amount is not required for a capitated encounter

  - If the encounter is submitted with a billed amount of 0.00, there must be an associated capitated encounter indicator
    - Loop 2300, CN101='05'
  - Ensure that all non-capitated encounters submitted include billed lines greater than 0.00'

Institutional Processing Edits
(continued)

- Edit 17310 – Surgical Revenue Code 036X Requires Surgical Procedure Code occurs when 036X is submitted with TOB 11X, 18X and 21X but the surgical procedure code or surgical procedure code date is not populated
  - Include both the surgical procedure code and the surgical procedure date
  - If the surgical procedure was canceled, the appropriate diagnosis code must be populated (V641, V642, or V643)

Institutional Processing Edits (continued)

- Edit 20505 - Accurate Ambulance HCPCS and Revenue Code Required occurs when Revenue Code 0540 is present but does not include an appropriate ambulance HCPCS code and HCPCS mileage code, or the units associated do not equal 1
  - For ambulance services using TOBs 12X, 13X, 22X, 23X, 83X, or 85X and Revenue Code 0540, HCPCS codes must include: A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434
  - An appropriate mileage HCPCS code must be included
  - The encounter must also reflect a unit of one (1) for each HCPCS code

Special Considerations

- Some submissions require special considerations in order to allow the encounters to pass EDFES and EDPS edits:
  - Ambulance
  - Capitated Submission
  - Default NPIs
  - Atypical Provider
  - Paper Claim
  - 4010 Submission
  - Chart Review
  - Correct/Replace
  - Void/Delete
  - Modification to Provider's Original Claim

Ambulance

- Ambulance Pick-Up ZIP Code is required
- Include appropriate ambulance revenue code(s) and HCPCS
  - 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

Ambulance (continued)

- **Note:** If an ambulance procedure code is submitted to the Encounter Data System with a QL modifier, it is not required to populate the ambulance pick-up ZIP code in the value code field
  - QL = *patient pronounced dead after ambulance called*
  - Any edits for the pick-up ZIP code in HI01 are bypassed when the QL modifier is included on the encounter with the appropriate ambulance HCPCS code

Ambulance Scenario 1

USA Health received a claim for ambulance services, which included revenue code 0540 and one (1) unit of HCPCS code 0425, as well as the Pick-Up ZIP Code of 34568999.9. USA Health Plan adjudicated the encounter and submitted it to the EDS.

EDS returned the encounter to USA Health with an edit stating "Accurate Ambulance HCPCS and Revenue Code Required". USA Health Plan has verified that the submitted revenue code and HCPCS are valid.

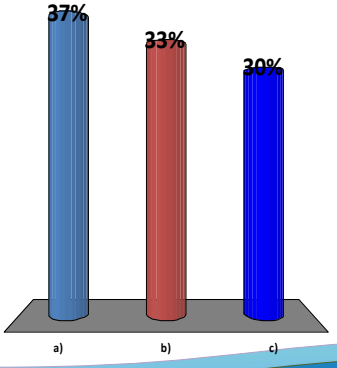
Ambulance Scenario 1 (continued)

Why was the encounter returned to USA Health?

a) The encounter should not have been returned

✓ b) HCPCS mileage and unit were missing

c) The Pick-up ZIP Code was not formatted correctly



Ambulance Scenario 2

Spangle Health Plan received a claim from Cox Hospital for ambulance services for Jennifer Rodriguez, who expired after a car accident and prior to the ambulance arrival. The claim included procedure code A0429, ambulance services, basic life support (BLS), emergency transport, with a QL modifier (Patient pronounced dead after ambulance called). Spangle Health Plan submitted the encounter without populating HI01-1='BE', HI01-2='A0', and HI01-5 = ZIP Code + 4. The EDS requirement for ambulance services states that this information is required, but the encounter passed the EDIPPS edits.

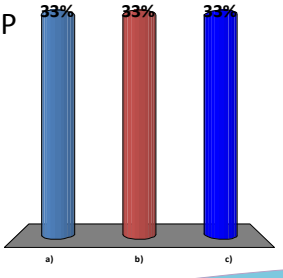
Ambulance Scenario 2 (continued)

How did this encounter successfully pass the editing process?

a) 837-I format doesn't allow for a Pick-up ZIP code

b) The HCPCS code did not require a Pick-up ZIP code

✔c) The HCPCS included a QL modifier



Capitated Submission

- For capitated arrangements, '0.00' is submitted **only** if billed and/or payment amount is not available
- Indicator must be used to identify the encounter as capitated
  - Loop 2300, CN101='05'
  - May only be populated at the claim level

- Capitated encounters must comply with EDFES balancing edits

Default NPIs

- CMS has provided a default NPI ***when the provider has not been assigned an NPI***

SYSTEM	PAYER ID	DEFAULT NPI VALUE
Institutional	80881	1999999976

- Potential exceptions requiring the use of a default NPI
  - Atypical Provider Submissions
  - Paper Claim Submission
  - 4010 Submission
- A valid/true EIN must be used

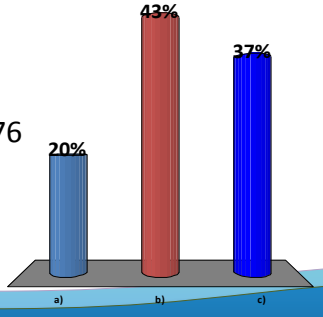
Default NPIs – Atypical Provider

- Atypical Provider - Providers who are not considered health care providers and do not provide health care services
- The default EIN provided by CMS may be used for Atypical Provider submission ***only*** and only in the instance that a valid EIN is not available
  - Loop 2010BB
    - REF01 = 'EI'
    - REF02 = 199999999 (default EIN)

Default NPIs – Atypical Provider (continued)

Your Health Plan received an invoice for Smith Massage Therapy services provided in the hospital, with an EIN but not an NPI. In order to submit this invoice as an encounter to the EDS, an NPI must be populated. How will Your Health Plan reconcile this encounter for submission to EDS?

a) Use any valid NPI
✔b) Populate the default NPI of 1999999976
c) Return the invoice to the massage therapist



Default NPIs – Paper Claim

- Paper Claim Indicator
  - Loop 2300
    - PWK01 = 'OZ'
    - PWK02 = 'AA'

- **Note**: PWK must be populated or the encounter will be processed as an atypical provider submission

Default NPIs – Paper Claim Scenario

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 default NPI value and the required minimum data elements.

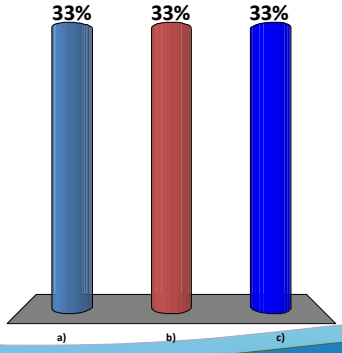
Default NPIs – Paper Claim Scenario (continued)

What are the required values that Happy Health Plan must use to accurately identify this encounter as a Paper Claim submission to EDS?

a) Default NPI 1999999976 and PWK01 = '09'

b) Default NPI 9999999999 and PWK01 = 'OZ'

✓ c) Default NPI 1999999976 and PWK01 = 'OZ'



Default NPIs – 4010

- 4010 Indicator
  - Loop 2300
    - PWK01='PY'
    - PWK02='AA'
- **Note**: PWK must be populated or the encounter will be processed as an atypical provider submission

Chart Review

- Chart Review Indicator
  - Loop 2300
  - PWK01 = ’09’
  - PWK02 = ‘AA’
- May be used to:
  - Add diagnoses to a full encounter
  - Delete diagnoses from a full encounter
  - Replace one chart review with another chart review
  - Add and delete diagnoses on a single full encounter

Chart Review – Exercise 1

A-One Health performed a quarterly medical record review at Virginia Mountain Hospital and discovered diagnosis 402.10 – Benign Hypertensive Heart Disease without Heart Failure was not included on the original encounter (ICN 37293848292) for Gwendolyn Nguyen. A-One Health 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.

Chart Review – Exercise 1
(continued)

Loop	Data Element	Required Value
2300	CLM05-3	**1**
2300	PWK01	**09**
2300	PWK02	**AA**
2300	REF01	**F8**
2300	REF02	**37293848292**
2300	HI01-1	**BK**
2300	HI01-2	**402.10**

Chart Review – 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.

Chart Review – Exercise 2
(continued)

Loop	Data Element	Required Value
2300	CLM05-3	1
2300	PWK01	09
2300	PWK02	AA
2300	REF01	F8
2300	REF02	72739283929
2300	HI01-1	BK
2300	HI01-2	429.3
2300	REF01	EA
2300	REF02	8

Chart Review – Exercise 3

Fresh Perspective Health 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 provided. Fresh Perspective also noted that diagnosis 403.90 – Kidney Disease due to Hypertension was omitted from the original encounter. Fresh Perspective 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 (new diagnosis code), REF01='EA', REF02=714.0 (deleted diagnosis code).

Chart Review – Exercise 3
(continued)

Loop	Data Element	Required Value
2300	CLM05-3	**1**
2300	PWK01	**09**
2300	PWK02	**AA**
2300	REF01	**F8**
2300	REF02	**09230293020**
2300	HI01-1	**BK**
2300	HI01-2	**403.90**
2300	REF01	**EA**
2300	REF02	**714.0**

Chart Review – 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.

Chart Review – Exercise 4
(continued)

Loop	Data Element	Required Value
2300	CLM05-3	7
2300	PWK01	09
2300	PWK02	AA
2300	REF01	F8
2300	REF02	26328373087

Chart Review – Duplicate Logic

Linked ICN Chart Review Duplicate Logic
Health Insurance Claim Number (HICN)
Date of Service
Diagnosis Code
Internal Control Number (ICN) from a previously accepted encounter

Unlinked ICN Chart Review Duplicate Logic
Health Insurance Claim Number (HICN)
Date of Service
Diagnosis Code

Chart Review – Duplicate Logic
(continued)

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.

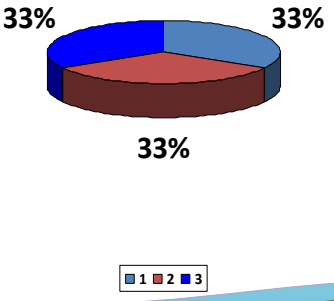
Chart Review – Duplicate Logic
(continued)

Six (6) months later, Rohring Community Health hired Riverview Medical Consultants to perform a semi-annual medical record review. Riverview Medical Consultants 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 chart review encounter and generates an MAO-002 report for the encounter with a 'reject' status.

Chart Review – Duplicate Logic (continued)

What reject edit did Rohring Community Health receive on the MAO-002 report for this chart review submission?

1. Edit 18145 – Diagnosis – Unacceptable Code
2. Edit 98325 – Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim
3. Edit 18012 – l:Gender – Inconsistency With Diagnosis Code



Correct/Replace

- Submitted for any modification to a previously accepted encounter, including but not limited to, billing or payment information, provider information, and/or diagnosis codes or procedure codes
  - Loop 2300
    - CLM05-3 = '7'
    - REF01 = 'F8'
    - REF02 = ICN of the original accepted encounter

Correct/Replace Scenario

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.

Correct/Replace Scenario (continued)

Two (2) months later, Happy Health Plan receives a claim correction from Vermont Regional Medical Center 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 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'.

Void/Delete

- Void/delete encounters will supersede previously accepted encounters
- Submitted when a previously submitted and accepted encounter must be voided from the EDS
  - Loop 2300
    - CLM05-3 = '8'
    - REF01 = 'F8'
    - REF02 = ICN of the original accepted encounter
  - All other information on the void/delete encounter must match the original encounter submission

Void/Delete (continued)

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, 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 contacted 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'.

Proxy Data Information

- All encounters must match the provider's original claim after adjudication
- In some instances, submission of proxy data information is required for successful processing through the EDS
  - Alteration of DOS from 2011 to 2012
  - Anesthesia modifier
  - Removal of rejected lines
  - Medicaid Service lines

Proxy Data Information (continued)

- Proxy Data Indicator

Loop 2300

NTE01 = 'ADD'

NTE02 =

for DOS = CLAIM CHANGE DUE TO 2011 DOS DURING EDS IMPLEMENTATION PERIOD
for Modifier = CLAIM CHANGE DUE TO EDS ACCEPTABLE ANESTHESIA MODIFIER

Proxy Data Information
(continued)

- Proxy Data Indicator

Loop 2300

NTE01 = 'ADD'

NTE02 =

for Rejected Lines = CLAIM CHANGE DUE TO REJECTED LINE EXTRACTION

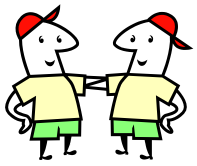
for Medicaid = CLAIM CHANGE DUE TO MEDICAID SERVICE LINE EXTRACTION

Proxy Data Information
(continued)

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. NTE02 = 'REJECTED LINES CHANGE DUE TO REJECTED LINE EXTRACTION'.

EDIPPS Duplicate Logic

- The following values are the minimum values used for Institutional duplicate logic:



Beneficiary Demographic • HICN • Last Name	Revenue Code(s)
	Procedure Code(s)
Date of Service	Billing Provider NPI
Type of Bill (TOB)	Paid Amount*

* The amount paid by the MAO or other entity populated in Loop ID-2320, AMT02

Summary

- Submission and processing requirements data were provided
- Acceptable Type of Bills (TOBs) and the associated services were detailed
- Top beneficiary, provider, and validation edits were provided, including prevention and resolution strategies
- Special considerations were identified and operational guidance was provided

Evaluation

Please take a moment to complete the evaluation form for the following module:

Institutional Submission

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

Encounter Data

DME Submission

Purpose

To specify the data collection, submission, and processing principles for DME encounter data in accordance with CMS requirements

Learning Objectives

- 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

DME Services

- DME "Incident to"
  - Submitted for service(s) provided during a physician or institutional visit
- DMEPOS Supplier
  - Submitted for supplies provided by a DME Supplier entity (non-physician/non-institution) under a Medicare agreement

DMEPOS Supplier Guidelines

- DMEPOS must be submitted separately from non-DME and DME "incident to" services and meet the following conditions:
  - Can withstand repeated use
  - Used to serve a medical purpose
  - Not useful in the absence of an illness or injury
  - Appropriate for use in the home
- All conditions must be met before an item can be considered durable medical equipment
- Parenteral and Enteral Nutrition and supplies are considered prosthetics and must be provided by a DME supplier

DME Fee Schedule HCPCS Codes

- DME "incident to" and DMEPOS Supplier determinations are made according to the NPI for the provider or supplier and the associated HCPCS codes
- HCPCS codes listed on the DMEPOS Fee Schedule are categorized in the in the following manner:
  - "D" = DMEPOS Supplier HCPCS code only
  - "J" = DMEPOS Supplier HCPCS code or DME "incident to" HCPCS code
  - "L" = DME "incident to" HCPCS code only

DME Fee Schedule HCPCS Codes
(continued)

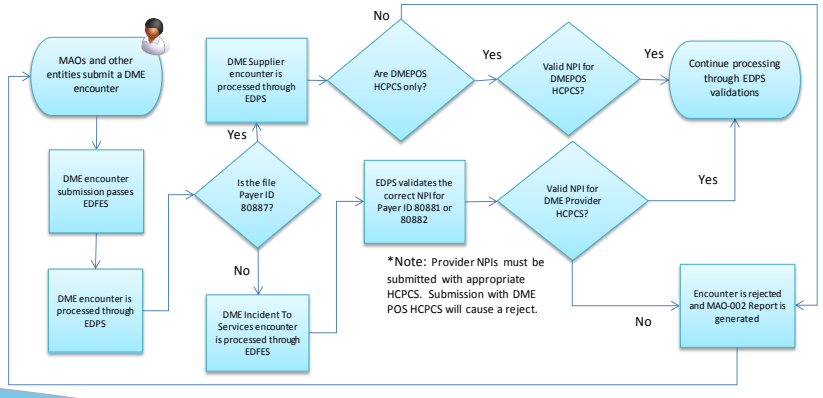
A	B	C	D	E	F
Durable Medical Equipment,					
Prosthetics, Orthotics, and Supplies					
(DMEPOS)					
Revised 2012 Fee Schedule					
HCPCS	Mod	Mod2	JURIS	CATG	Ceiling
L8485			D	PO	$13.68
L8500			D	PO	$811.94
L8501			D	PO	$148.62
L8507			D	PO	$46.31
L8509			L	PO	$120.72
L8510			D	PO	$279.33
L8511			J	PO	$80.40
L8512			J	PO	$2.41

DMEPOS Supplier Only

DME "incident to" Only

DMEPOS Supplier or DME "incident to"

DME Submission



DME "Incident to" Submission

- Must be submitted on the 837-P or 837-I with the appropriate Payer ID for DME encounters that are "incident to" a professional service
- Claims for implanted DME, implanted prosthetic devices, replacement parts, accessories, and supplies for the implanted DME , when considered "incident to", are part of the encounter
- The NPI on the encounter must be for a provider/physician or institution and not for a DMEPOS Supplier

DME "Incident to" Submission (continued)

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

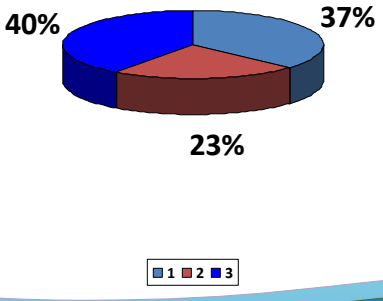
DME "Incident to" Submission
(continued)

Yellow Health Plan submitted an encounter using a provider NPI for a DME Supplier (Med Emporium was the supplier), a Payer ID (Institutional), and a HCPCS code with a HCPCS code identifier of "D" were used. The encounter was rejected by the EDS and returned to Yellow Health Plan.

DME "Incident to" Scenario

Using the DMEPOS HCPCS Code Worksheet provided, identify the Payer ID and HCPCS code for this scenario that would cause this encounter to reject.

1. Payer ID 80881 and HCPCS Code E0193
2. Payer ID 80887 and HCPCS Code A7505
3. Payer 80887 and HCPCS Code A6254



DME "Incident to" Submission
(continued)

Dr. Jones provides Sally Jane with crutches during an office visit. 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 ", as identified on the DMEPOS Fee Schedule.

DMEPOS Supplier Submission

- DMEPOS Supplier services must be indicated on a separate 837-P:
  - ISA08 (Interchange Receiver ID) = 80887
  - GS03 (Application Receiver Code) = 80887
  - Loop 1000B, NM109 (Receiver Identifier) = 80887
  - Loop 2010BB, NM109 (Payer Identifier) = 80887
- DMEPOS Supplier NPI must be used
- DMEPOS HCPCS codes identified as "D" or "J" on the DMEPOS Fee Schedule are acceptable

DMEPOS Supplier Submission (continued)

DME HCPCS 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, wound filler, dry form, sterile, per gram
K0040	D	Adjustable angle footplate

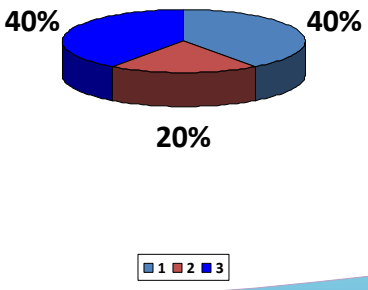
DMEPOS Supplier Scenario 1

ABC Health Plan submitted an encounter using a Billing Provider NPI for Dr. Brown of Brown's Private Practice and a HCPCS code with a HCPCS Code identifier of 'J'. The encounter was rejected and returned to ABC Health Plan.

DMEPOS Supplier Scenario 1
(continued)

Using the DMEPOS HCPCS Code Worksheet provided, identify the Payer ID and HCPCS code for this scenario that would cause this encounter to reject.

1. Payer ID 80882 and HCPCS Code E0781
2. Payer ID 80882 and HCPCS Code A7040
3. Payer ID 80887 and HCPCS Code A6403



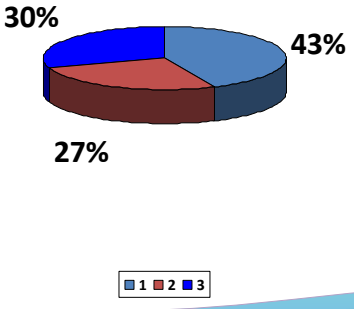
DMEPOS Supplier Scenario 2

Happy Health Plan received a claim from Med Health Store with an NPI categorized as a DMEPOS Supplier and an 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 of _____.

DMEPOS Supplier Scenario 2 (continued)

What is appropriate Payer ID for this submission?

1. 80881
2. 80887
3. 80882



DMEPOS Supplemental Forms

- DME supplemental forms, such as a Certificate of Medical Necessity (CMN) or Oxygen Certification, must not be submitted to the EDS
- Indicate that the forms are available and can be retrieved, if necessary
  - Loop 2400, PWK01 = 'CT' (Certificate)
  - Loop 2400, PWK02 = 'NS' (Not Specified)
- Minimum data elements and other relevant data must be populated for each DMEPOS Supplier service line

DMEPOS Supplemental Forms – Scenario

American Health Plan received a claim from a DMEPOS 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.

DMEPOS CEM Edits

- Several CEM edits will be permanently deactivated to ensure that syntactically correct encounters pass 837-P DMEPOS Supplier EDFES editing
- The Proposed 5010A1 Edits CEDI column in the CEM Edits spreadsheet applies to DMEPOS Supplier services and must be referenced for DMEPOS edits and EDFES report reconciliation

ccept/Re ject	Disposition / Error Code	Proposed 5010A1 Edits Part B	Proposed 5010A1 Edits CEDI
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.	
R	IK304 = I6: "Implementation Dependent Segment Missing"		2400.PWK with PWK01 = "CT" must be present when 2400.CR3 is present.
R	IK304 = 5: "Segment Exceeds Maximum Use"		Only one iteration of 2400.PWK with PWK01 = "CT" is allowed.

DMEPOS End-to-End Testing

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

Note: DMETC02 must include Payer ID 80881 or 80882 and DMEPOS HCPCS codes with a "JURIS" identifier of "D".

DMEPOS End-to-End Testing
(continued)

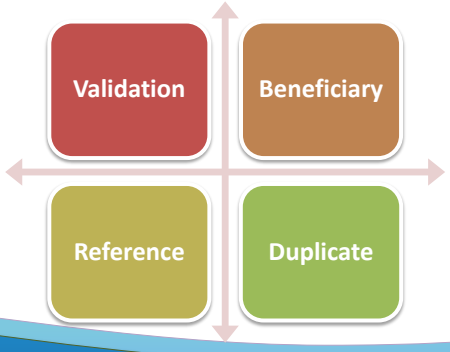
File 1
- 2012 DOS only
- Test cases that **do not** require linking (5 test cases – 10 encounters)
- TC indicator in Loop 2300, CLM01 (e.g., CLM01=TC01)
- *If this file contains less than or greater than the ten (10) encounters defined in the Test Case Specifications document, the file will be returned without processing*

File 2
- 2012 DOS only
- "Incident to" Provider services test case only (1 test case – 2 encounters)
- TC indicator in Loop 2300, CLM01 (e.g., CLM01=DMETC02)
- *If this file contains less than or greater than the two (2) encounters defined in the Test Case Specifications document, the file will be returned without processing*

File 3
- 2012 DOS only
- Duplicate test case only (1 test case – 2 encounters)
- TC indicator in Loop 2300, CLM01 (e.g., CLM01=TC07)
- Submit using a duplicate of TC01, TC03, TC04, TC05, or TC06 (File 1 test cases)
- *If this file contains less than or greater than the two (2) encounters defined in the Test Case Specifications document, the file will be returned without processing*

EDDPPS Logic

- The EDDPPS contains edits that are applied to each encounter submission and organized into four different categories:



EDDPPS Edits - Scenario

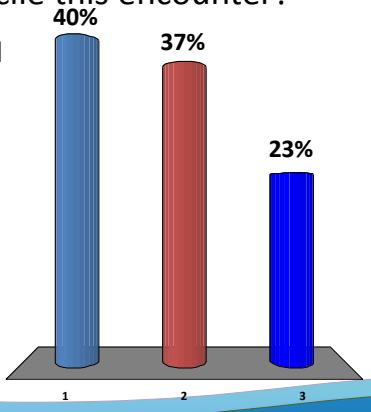
Medical Supply Company submitted a claim to Lamb Health Plan, with two (2) service lines. Both service lines were for a breast prosthesis – mastectomy bra, unilateral – for the same beneficiary on the same date of service using the same HCPCS code – L8001 with modifier LT.

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 data cannot be submitted relating to more than one (1) service line within an encounter.

EDDPPS Edits – Scenario
(continued)

How will Lamb Health Plan reconcile this encounter?

1. Delete the duplicate service line and resubmit the encounter.
2. Contact Medical Supply Company to correct the encounter and resubmit with the appropriate data
3. Remove the LT modifier from one of the service lines and resubmit the encounter



DMEPOS Special Considerations

- Some submissions require special considerations in order to allow the encounters to pass EDFES and EDDPPS edits
  - Default NPIs
  - Atypical Provider

Default NPIs

- CMS has temporarily provided a default NPI ***when the provider has not been assigned an NPI***

SYSTEM	PAYER ID	DEFAULT NPI VALUE
DME	80887	1999999992

- A valid/true EIN must be used

Atypical Provider

- Atypical Provider - not considered health care providers and do not provide health care services
- When the EDPS receives an encounter, it reads the atypical provider NPI and bypasses all other edits
  - Default EIN **199999999** may be used with ***atypical provider*** submissions, if the provider EIN is not available
- Diagnoses captured from atypical provider types will not be stored for risk adjustment calculation

DMEPOS Duplicate Logic

- The following values are the minimum values used for DMEPOS duplicate logic:

Beneficiary Demographic • HICN • Last Name	Procedure Code(s) and 4 modifiers
Date of Service	Rendering Provider NPI
Place of Service (2 digits)	Paid Amount*
Type of Service **	

** the amount paid by the MAO or other entity populated in Loop ID-2320, AMT02*
*** not submitted on the 837-P but derived from data captured*

Summary

- Submission and processing requirements data were provided
- Acceptable DME "incident to" and DMEPOS Supplier services were detailed
- Top beneficiary, provider, and validation edits were provided, including prevention and resolution strategies
- Special considerations were identified and operational guidance was provided

Evaluation

Please take a moment to complete the evaluation form for the following module:

DME Submission

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

Encounter Data

EDFES Acknowledgement Reports

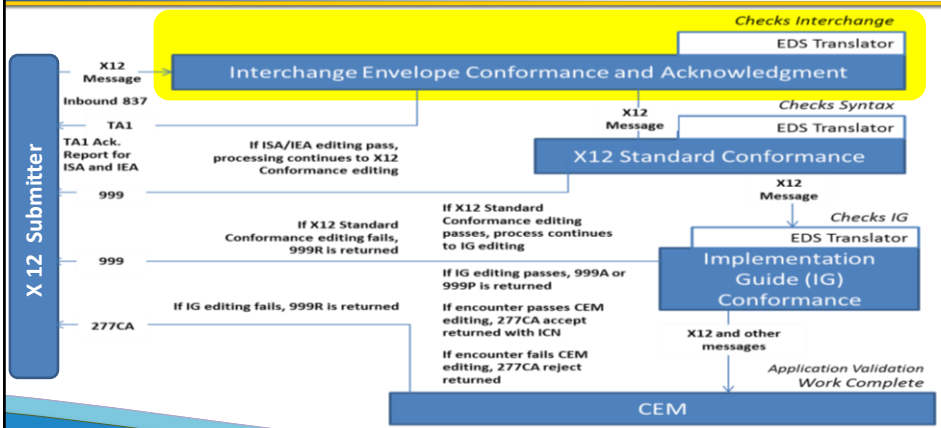
Purpose

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

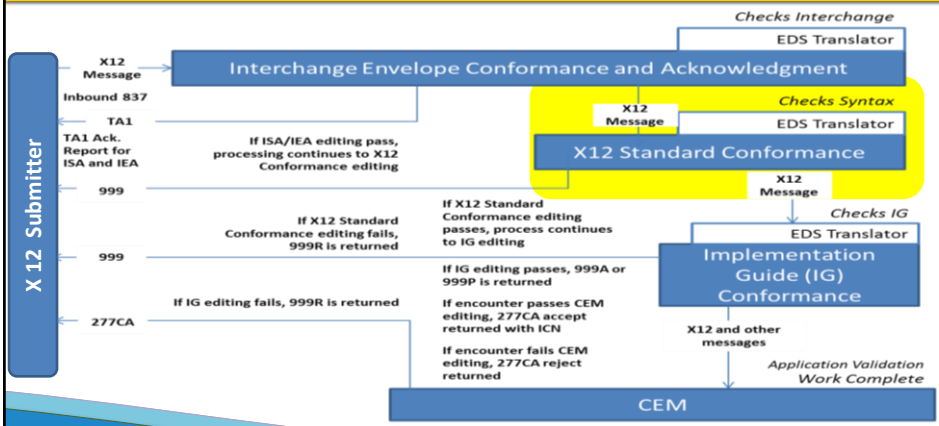
Learning Objectives

- 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

Process Overview – EDFES Edits and Flow



Process Overview – EDFES Edits and Flow (continued)



EDFES Acknowledgement Reports
2012 Regional Technical Assistance

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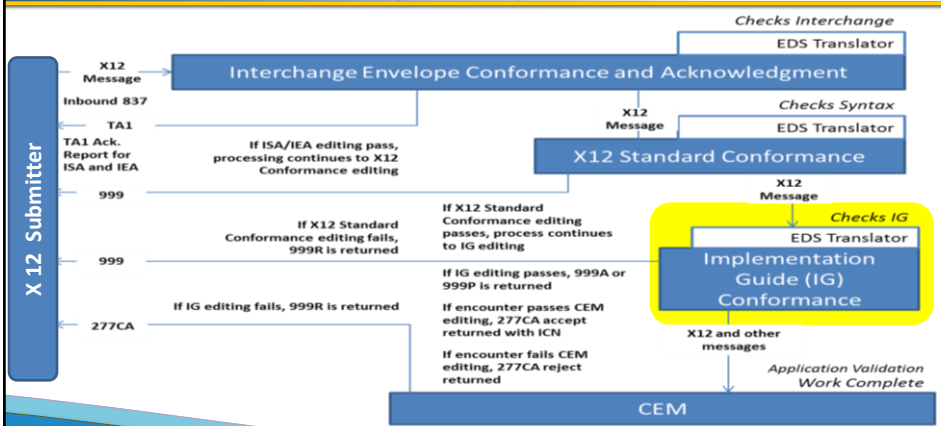
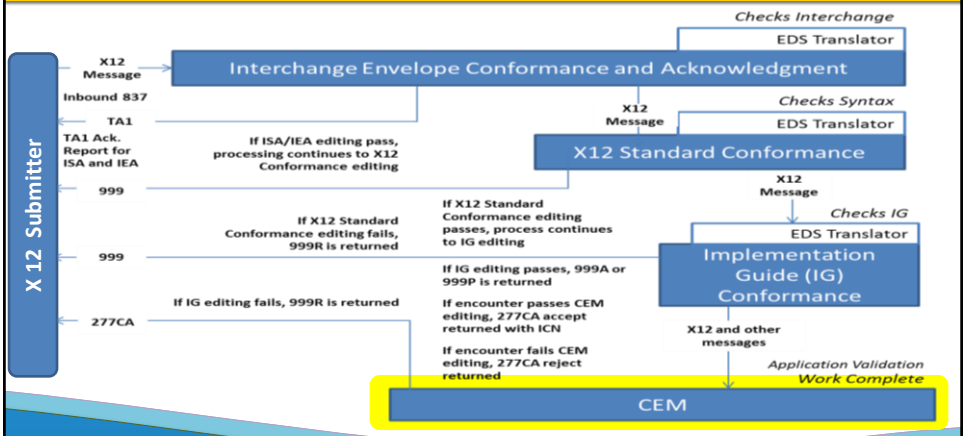
Process Overview – EDFES Edits and Flow (continued)



EDFES Acknowledgement Reports
2012 Regional Technical Assistance

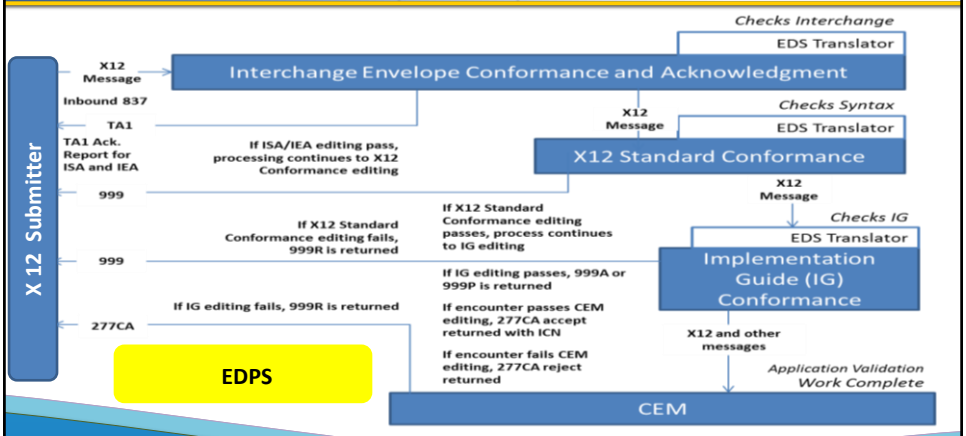
6

Process Overview – EDFES Edits and Flow (continued)



EDFES Acknowledgement Reports
2012 Regional Technical Assistance

Process Overview – EDFES Edits and Flow (continued)



EDFES Acknowledgement Reports
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Acknowledgement Report File Naming Convention

- EDFES acknowledgement reports are sent to MAOs and other entities within 48 hours of submission
- The naming conventions were developed to allow MAOs and other entities the ability to identify reports distributed

Acknowledgement Report File Naming Convention (continued)

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

Acknowledgement Report File Naming Convention (continued)

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

Acknowledgement Report File Naming Convention (continued)

DESCRIPTION of the file name components

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

TA1 Acknowledgement Report

- Provides the status of a received Interchange header (ISA) and trailer (IEA) after being processed by the translator
- Informs MAOs and other entities of their Interchange status
- Notifies the sender of problems that were encountered within the Interchange control structure

TA1 Acknowledgement Report (continued)

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

1. If requested in the ISA14 of the 837 transaction
2. If the transaction is rejected

For EDS processing, a TA1 is produced only when there is a rejection

TA1 Acknowledgement Report (continued)

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

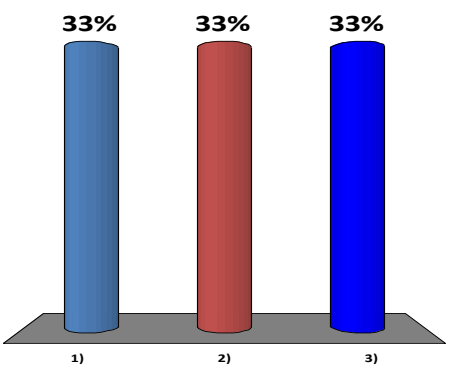
- Edits the ISA/IEA for consistency with the data they contain
- Errors found in this stage will cause the entire X12 Interchange to be rejected with no further processing

The entire ISA/IEA Interchange (837X file) must be resubmitted after corrections are made.

Scenario

You have a returned TA1 report, which of the following is the reason your TA1 report was returned?

1) Your claim level information is not valid
2) Your ISA/IEA is consistent
3) Your ISA/IEA is inconsistent



TA1 Acknowledgement Report (continued)

Three (3) TA1 edit examples from the 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.

TA1 Acknowledgement Report (continued)

- ISA13 data element (Interchange Control Number) maps to TA101 data element

ISA*00* *00* *ZZ*ENH9999 *ZZ*80882 *120430*1144*^*00501*200000031*1*P*:~

– The ISA13 data element has a value of "200000031"

TA1*200000031*120425*1217*R*024~

– The TA01 data element has a value of "200000031"

Interpreting the TA1 Acknowledgement Report

This string will allow MAOs and other entities to identify the Interchange error

```
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~
```

The file with an Interchange control number of 000000003 was rejected because the Interchange header (ISA) and trailer (IEA) control numbers do not match

Reconciling the TA1 Acknowledgement

Resolution steps for Error 001, provided in data element TA105:

Steps	Description
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 Edit Spreadsheet
3	Locate the error on the edit spreadsheet
4	Access the 837 file with the Interchange control number of 000000003
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

999 Acknowledgement Report

- Reports on the adherence to IG level edits and CMS standard syntax errors as depicted in the CMS edit spreadsheet. **Three** (3) possible acknowledgement values are:
  - **"A" – Accepted**
  - **"R" – Rejected**
  - **"P" – Partially Accepted (at Least One Transaction Set was Rejected)**

999 Acknowledgement Report Responses

One (1) 999 edit example from the spreadsheet, "Proposed 5010A1 Edits Part B" and the associated reason for the failure

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

Reading the 999 Acknowledgement

- This report is composed of segments that report information on the 837X file received:

IK3 error identification	Reports a segment error
CTX appears after the IK3 segment	Describes the context within the segment
IK4 data element	Reports 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
IK5 and AK9 segments are present always	Notes the transaction set and/or the functional group's accept or reject status

Reading the 999 Acknowledgement (continued)

- 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)

  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

Reading the 999 Acknowledgement (continued)

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 acknowledgment 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

Interpreting the 999A Functional Group with One (1) Transaction Set Accepted

```
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~
```

Both the Functional Group and Transaction Set passed 999 editing and were accepted

Interpreting the 999A Functional Group with One (e Transaction Set Accepted (continued)

999A Acknowledgment Report – Functional Group & 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

Interpreting the 999A

999A Acknowledgment 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 elements represent the ST/SE Control numbers

Interpreting the 999R

999R Acknowledgment Report Example

```
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~
   AK2*837*000020860*005010X222A1~
   IK3*SVD*31*2430*8~
```

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Interpreting the 999R Rejected Transaction Set

999R Acknowledgment Report Example

```
16 IK4*2**7*000000000015~
17 IK5*R*I5~
18 AK2*837*000020860*005010X222A1~
19 IK3*SVD*31*2430*8~
20 CTX*CLM01:P2752560~
21 IK4*1**2*H9999~
22 CTX*SITUATIONAL TRIGGER***2330~
23 IK5*R*I5~
24 AK9*R*2*1*0~
25 SE*16*26654001~
26 GE*1*3026654~
   IEA*1*003038950~
```

EDFES Acknowledgement Reports
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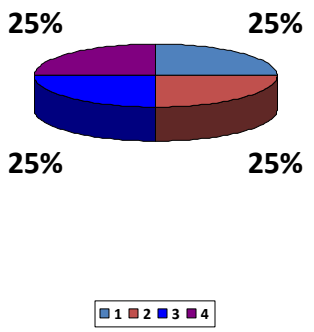
Scenario

When viewing the 999 report, MAOs and other entities should navigate to the _____ and _____ segments to identify if the file was accepted or rejected.

1. IK5 and AK9 segments
2. IK3 and IK4 segments
3. IK6 and AK9 segments
4. AK9 and AK5 segments



999R Reject Transaction Set Resolution Steps

1. Locate errors for Transaction Set **000000133 (4 Errors in Transaction Set)**
   a. Look at the data string for encounter **20120203999900522TC11**

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

   b. Look at the data string for encounter **20120307999900224TC11**

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

999R Reject Transaction Set Resolution Steps (continued)

2. Locate errors for Transaction Set **000020860 (1 Error in Transaction Set)**

   a. Look at the data string for encounter P2752560

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

277CA Acknowledgement Report

- Provides the status of each encounter as either accepted or rejected
  - Accepted encounters are assigned an EDS Internal Control Number (ICN)
  - Rejected encounters will not receive an ICN
- Unsolicited acknowledgement report from CMS to MAOs and other entities
  - 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

277CA Acknowledgment Report (continued)

Performs 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

277CA Acknowledgment Report (continued)

Reconciliation Steps:

- Recognize rejected encounters, the business rule error that occurred, and address problems using billing/claims processing experts
- Correct the rejected encounters based on the error reported
- Recognize accepted encounters

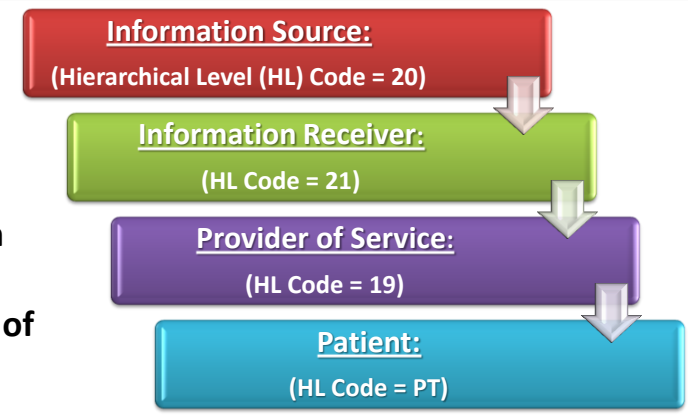
277CA Failure Reasons

277CA Edit example from CMS edit spreadsheet

Edit Reference	Segment or Element	Description	TA1/ 999/ 277CA	Accept /Reject	Disposition / Error Code	Proposed 5010A1 Edits Part B
X222.351. 2400.SV10 5.010	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

Reading the 277CA Acknowledgement

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



Reading the 277CA Acknowledgement (continued)

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

The BHT03 data element has the value of "000090028

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

Interpreting the 277CA Acknowledgement Report – Submitter Level Accepted

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~
```

Interpreting the 277CA Acknowledgement Report – Provider and Encounter Level Accepted

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~
```


Interpreting the 277CA Acknowledgement Report – Encounter Level Rejection

277CA Acknowledgement Report Example – Encounter Level Rejection

```
1  HL*21*2*19*1~
2  NM1*85*2*DR JOHN M. DOE*****XX*123456788~
3  TRN*1*0~
4  STC*A1:19:PR**WQ*41.61~
5  QTY*QC*1~
6  AMT*YY*41.61~
7  HL*22*21*PT~
8  NM1*QC*1*SMITH*TESTER*A***MI*123456789A~
9  TRN*2*PP2728937TC05~
10 STC*A7:164:IL*20120403*U*41.61~
11 REF*D9*PP2728937TC05~
12
```

Provider of Service Level
- **Status "WQ" Indicates the provider level is accepted**

Patient/Encounter Level
- **Status "U" indicates this encounter level is rejected**
- **The reject reason is A7:164:IL**

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

Multiple ST/SE Rejections

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~

First, ST/SE Segment Failed at the Information Receiver Level (HL=21)

Interpreting the 277CA Acknowledgement Report – Multiple ST/SE Rejections (continued)

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

BHT*0085*08*12094*20120403*02344200*TH~
HL*120*1~**
NM1*PR*2* PALMETTO GBA SOUTH CAROLINA*****46*80882~
TRN*1*808822012040300000 1~
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~

Second, ST/SE Segment Failed at the Information Receiver Level (HL=21)

277CA Acknowledgement Report Resolution Steps

Rejection Steps:

Step	Description	Step	Description
1	Access the current version of the CMS Edit Spreadsheet	5	Edit X222.121.2010BA.NM109.020 was found on the CMS Edit Spreadsheet providing the error reason
2	Access the WPC Health Care Claim Status Category Code (CSCC) list	6	Look at the proposed edit column for the resolution
3	Access the Claim Status Code (CSC) list	7	Enter a valid subscriber number value using the correct format for the NM109 data element
4	Obtain the description of the error code(s)	8	Resubmit the encounter

277CA Acknowledgement Report Resolution Steps (continued)

Rejection Steps:

Steps	Descriptions	Steps	Description
1	Access the current version of the CMS Edit Spreadsheet	5	Edit X222.351.2400.SV105.010 was found on the CMS Edit Spreadsheet providing the error reason
2	Access the WPC Health Care Claim Status Category Code (CSCC) list	6	Look at the proposed edit column for the resolution
3	Access the Claim Status Code (CSC) list	7	Enter a valid Place of Service code in Loop 2400, segment SV1, data element SV105
4	Obtain the description of the error code(s)	8	Resubmit the encounter

277CA Acknowledgement Report Resolution Steps (continued)

Rejection Steps:

Steps	Description
1	Access the current version of the CMS Edit Spreadsheet
2	Access the WPC Health Care Claim Status Category Code (CSCC) list
3	Access the Claim Status Code (CSC) list
4	Obtain the description of the error code(s)
5	Per Palmetto, to resolve this type of error, MAOs and other entities must follow validated processes

EDFES Notifications

- Provides the reason the submitted file was not sent to the EDPS
- Does not replace the TA1, 999, or 277CA

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

EDFES Notifications (continued)

Positions	Item
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)

EDFES Notifications (continued)

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
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

Summary

- ISA, GS, ST, and BHT segments were identified when submitting 837X file
- TA1, 999, and 277CA error identification segments are found using the 837X file details
- TA1 report indicates Interchange level rejections
- 999 report indicates accepts/rejections at the Functional Group and Transaction Set levels
- 277CA report indicates accepts/rejections at the submitter, billing provider, encounter, and line levels

2012 Regional Technical Assistance

Evaluation

Please take a moment to complete the evaluation form for the following module:

EDFES Acknowledgement Reports

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Encounter Data

EDPS Reports

ARDX A. Reddix & Associates

Purpose

To provide MAOs and other entities with strategies that will assist in reconciliation of data submitted against the data stored in the CMS databases

Learning Objectives

- 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

EDPS Reports Overview

- EDPS reports were developed to communicate the disposition of encounters throughout processing and risk adjustment filtering
- EDPS reports design supports various business needs
- Submitters are to access the EDPS reports in two (2) separate layouts:
  - Data file
  - Format

EDPS Reports Overview (continued)

- Through 2012, EDPS will continue to implement enhancements that will allow for a more expedited 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

EDPS Reports

- CMS has developed reports to provide MAOs and other entities with the disposition of encounters submitted

Report Number	Report Name
MAO-001	Encounter Data Duplicates Report
MAO-002	Encounter Data Processing Status Report
MAO-004*	Encounter Data Risk Filter Report
MAO-005*	Encounter Summary Report
MAO-006*	Edit Disposition Summary Report
MAO-007*	Encounter Detail Report

***Will be provided in a future release**

MAO Report File Naming Convention

- EDPS reports are distributed through CMS approved connectivity methods
  - Connect:Direct (NDM)
  - Gentran
  - FTP
- Files are tracked by the Submission Interchange Number, which includes:
  - Interchange Sender ID (ISA06)
  - Interchange Control Number (ISA13)
  - Interchange Date (ISA09)

Testing File Naming Convention

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

Connect:Direct (NDM) users' reports file naming conventions are user defined

Production File Naming Convention

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

Connect: Direct (NDM) users' reports file naming conventions are user defined

File Naming Convention (continued)

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'

Report Layout

- The MAO reports are delivered to the submitter's EDS mailbox in two (2) forms:
  - Flat file
  - Formatted reports
- Reports are sorted by Submitter ID values:
  - Contract ID
  - Plan ID (CCN)
  - Encounter ICN
  - Line Number

MAO-001 Encounter Data Duplicates Report

- Provides detailed information for encounters that receive edit 98325 – Exact Duplicate of a Service Line within this Claim or a Previously Priced Claim
- Edit 98325 is generated for one 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

MAO-001 Encounter Data Duplicates Report (continued)

837-I (Institutional)	837-P (Professional)
Beneficiary HICN	Beneficiary HICN
Beneficiary Last Name	Beneficiary Last Name
Date of Service	Date of Service
Type of Bill	Place of Service (2-digit)
Revenue Code(s)	Type of Service
Procedure Code(s)	Procedure Code(s) and 4 modifiers
Billing Provider NPI	Rendering Provider NPI
Paid Amount	Paid Amount

MAO-001 Flat File Layout

- Distributed as a delimited text file
- The report provides beneficiary HICN and DOS as verification of the encounter submitted for a specific beneficiary
- Provides the specific lines that cause the duplicate error

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

MAO-001 Flat File Layout (continued)

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

MAO-001 Flat File Layout (continued)

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

MAO-001 Formatted Report Layout

Encounter Data Duplicate Report
Report Run Date 07/09/2012 12:51 PM
Medicare Advantage Contract ID: H9999
PROD

Page 1

Submission Interchange Number: ENH290600000001320120705
Report Date: 07/09/2012
Transaction Date: 07/08/2012

Report ID: MAO-001

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	25090615390028	001	567185299	06/15/2012
PRO	231181790	2509061539013	002	222186398	25090615390047	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

EDPS Reports
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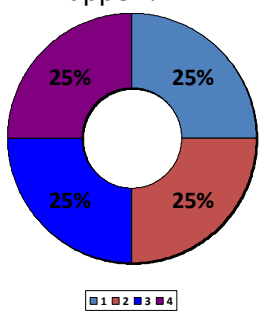
Scenario

Blue Health Plan submitted an 837-P encounter to EDS with five (5) service lines. Three (3) of the service lines on the encounter included HCPCS A4259 with modifier KL. As a result, what will happen?

1. An MAO-001 report is generated
2. The Submission Tracking Number is issued to MAOs and other entities
3. Edit 98325 is determined to be the cause
4. All of the above



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MAO-002 Encounter Data Processing Status Report

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

MAO-002 Flat File Format

- Distributed as a delimited text file
- Provides the overall number of encounter processing errors:
  - Rejected
  - Accepted
- Provides a total count summary of lines that are:
  - Submitted
  - Rejected

MAO-002 Flat File Format (continued)

HEADER RECORD (There is only one header per record per file.)				
Position(s)	**Item**	**Notes**	**Length**	**Format**
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

MAO-002 Flat File Format (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
11-15	Medicare Advantage Contract ID	Medicare Contract ID assigned to the MA Plan	5	Alpha Numeric
16	Delimiter		1	Uses the * character value
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

MAO-002 Flat File Format (continued)

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.

MAO-002 Formatted Report Layout

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: ENC00450000000742012070 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	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

MAO-002 Edit Logic

- EDPS edits are used for validation of 837-I and 837-P files
- Encounter data files are validated for accuracy of:
  - Beneficiary information
  - Provider information
  - Reference and limitation factors
  - NCCI coding
  - Duplicate and pricing factors

MAO-002 Edit Logic (continued)

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: ENC00350000007320120703
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

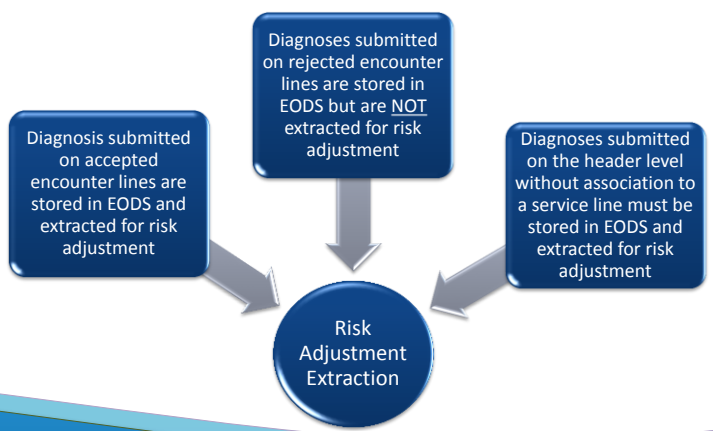
TOTALS:

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

MAO-004 Encounter Data Risk Filter Report

- Risk Filter Report identifies ICD-9 diagnosis codes that are eligible for risk adjustment
- Diagnosis codes and descriptions on the Risk Filter report are associated with accepted encounter and service lines
- The current risk adjustment filtering logic includes:
  - Date of service within the payment year
  - Facility/Provider included in the risk adjustment acceptable sources list
  - Risk adjustment eligible diagnosis codes

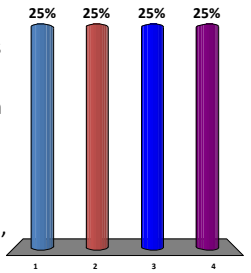
Risk Filtering Logic



Scenario

Happy Health Plan submits an encounter with two (2) service lines. Service line one (1) points to a diagnosis code that is included in the 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. How should Happy Health Plan proceed?

1. Resubmit the encounter and receive an MAO-004 report that reflects the diagnosis code as eligible for risk adjustment
2. Resubmit the encounter to correct service line one (1) and receive an MAO-002 report after both service lines are accepted
3. Resubmit the diagnosis code and receive an MAO-002 report once the diagnosis code is accepted
4. Receive MAO-001 and MAO-002 reports. Once corrections are made, the service lines will be accepted



MAO-004 Flat File Layout

- The MAO-004 flat file layout is distributed as a delimited text file
  - Displays ICD-9 diagnosis codes acceptable for risk adjustment
  - Allows up to 12 additional diagnoses per Professional encounter
  - Allows up to 25 additional diagnoses per Institutional encounter

MAO-004 Flat File Layout (continued)

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

MAO-004 Flat File Layout (continued)

DETAIL RECORD				
Position(s)	**Item**	**Notes**	**Length**	**Format**
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
222-226		Additional Diagnoses – up to 25 for Institutional and 12 for Professional	5	Alphanumeric, with decimal

MAO-004 Flat File Layout (continued)

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.

MAO-004 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

Summary

- EDPS reports were identified
- Information was provided to identify the various EDPS reports and how they may be used for error reconciliation
- MAOs and other entities were informed how to determine diagnoses that are accepted for risk adjustment calibration based on MAO-002 report interpretation

2012 Regional Technical Assistance

Evaluation

Please take a moment to complete the evaluation form for the following module:

EDPS Reports

Your Feedback is Important!
Thank you!

2012 Regional Technical Assistance

Encounter Data

Special Considerations

Purpose

Provide PACE organizations, Cost Plans, and Special Needs Plans (SNPs) with guidance regarding encounter data submissions

Learning Objectives

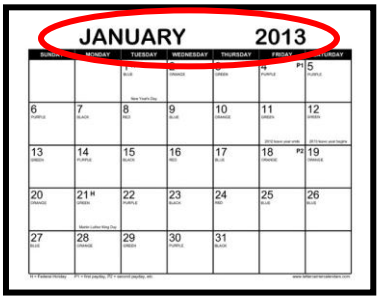
- Determine the PACE implementation timeline
- Describe types of encounter data Cost Plans will be required to submit
- Identify encounter data requirements for dual-eligible SNPs

Overview of PACE Services

- **The Program of All-Inclusive Care for the Elderly (PACE)**
- PACE services allow beneficiaries to stay in the community, rather than in a nursing home or other facility.
- Provide services/items not typically covered by Medicare or Medicaid, but necessary for PACE beneficiaries.
- PACE organizations also provide other non-PACE day care center services.

PACE Submission

- PACE organizations will be required to submit only claims-based encounters
- Required to follow instructions included in Professional, Institutional, and DME Companion Guides



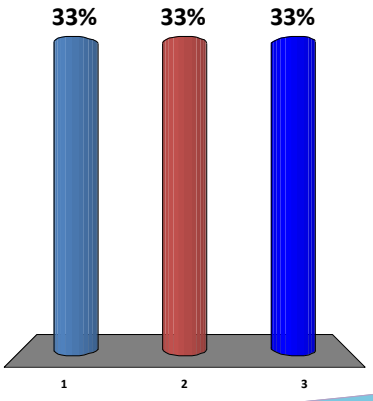
Scenario

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 was submitted to EDS.

Scenario (continued)

Using the TR3, what element should be populated in Loop 2010AA, REF02?

1. NPI – 1453673442
2. ✓ EIN – 123487345
3. CPT – 71260



PACE Testing

- Certification will be required on two (2) levels:
  1. Encounter Data Front-End System (EDFES)
  2. End-to-End
- PACE organizations must submit two (2) files to receive EDFES certification:
  1. One Institutional
  2. 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**

PACE Testing (continued)

Certification Timeline

TESTED SYSTEM	TESTING BEGINS	TESTING REQUIREMENTS	TESTING ENDS/DEADLINE FOR CERTIFICATION
Front-End Testing	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

Overview of Cost Plans

- CMS required §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
- §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

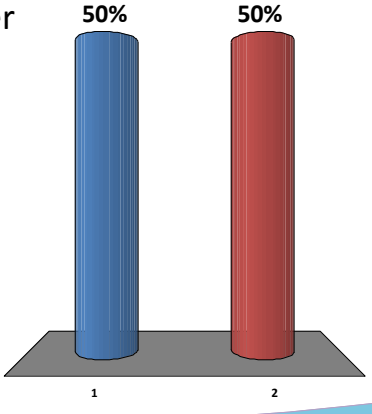
Cost Plans Submission

- 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.

Scenario

<u>True or False:</u> MAOs and other entities must not extract the Medicaid service lines from the encounter submission.

1. True
2. False ✔



Special Needs Plans

- Obtain full beneficiary utilization from MAOs and other entities
- Medicare Modernization Act of 2003 (MMA)
- Special consideration for SNPs (Special Needs Plans) services is required

Special Needs Plans (continued)

Types of SNPs

Special Needs Plans	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 Conditions	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

Dual Eligible SNPs Submission

- Dual eligible beneficiaries receive most acute care services from Medicare and most long-term-care services from Medicaid
- Typically providers file dual eligible claims with Medicare as the primary payer

Dual Eligible SNPs Submission (continued)

- States then submit the encounter data to CMS
- 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

Summary

- PACE organization, Cost Plan, and SNP submission requirements were provided
- Key provisions, validations, and data necessary for encounter data collection were identified

2012 Regional Technical Assistance

Evaluation

Please take a moment to complete the evaluation form for the following module:

Special Considerations

Your Feedback is Important!
Thank you!