Encounter Data System

Test Case Specifications

Encounter Data PACE test case specifications related to the 837 Health Care Claim: Institutional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X223A2

Test Case Specifications: 2.0
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Preface

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

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

REVISION HISTORY

Version	Date	Organization/Point of Contact	Description of Changes
1.0	08/20/12	ARDX	Base Document
2.0	08/28/12	ARDX	TC02-Capitated was removed from the Test Case Specifications and the total number of test cases has been modified to reflect a total of eight (8) test cases.

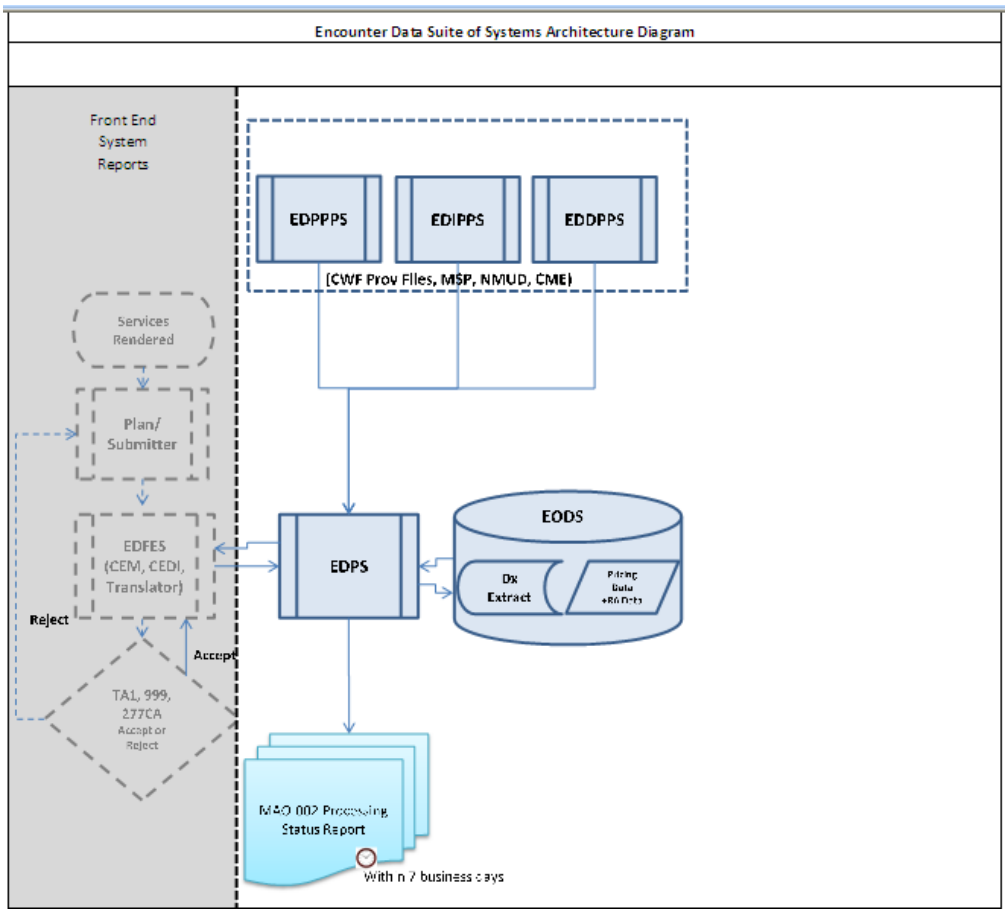
Table of Contents

1.0 Overview

This document may be used in conjunction with the business case examples referenced in the EDS 837 Institutional Transaction Companion Guide.

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

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



2.0 Introduction

CMS has provided the submission guidelines for end-to-end testing to include test cases necessary for PACE testing. PACE testing is intended to allow PACE organizations the ability to determine system performance based on the submission claims based encounters, which are collected on an inpatient or outpatient Institutional claim form. **Institutional encounter testing begins 9/1/2012 and ends 11/15/2012.**

2.1 Institutional End-to-End Testing

The 837-I certification files are submitted in two (2) files. The first file includes all unlinked test cases (7) and the second file includes the duplicate test case (1). All test cases included in the first file must be completely accepted as indicated on the MAO-002 report before the second file is submitted. PACE organizations must receive a 95% acceptance rate to be deemed certified.

The first test file must include the 14 encounters (2 encounters per test case) otherwise EDS will reject the file. Rejected files must be corrected and resubmitted until all 14 encounters pass translator and CEM editing at 100% before it can be processed in the EDPS. PACE organizations must use the following guidance when preparing all unlinked (14) and the duplicate (2) test cases:

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

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

2.2 Test Case Summary

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

I. Beneficiary Eligibility
   a. New MA Member

II. Data Validation
   a. Atypical Provider
   b. Ambulance
   c. Coordination of Benefits (COB)
   d. Hospital-Outpatient
   e. Hospital-Inpatient
   f. Outpatient Rehab

III. Processing
   a. Duplicate

Note: Submitters must exclude, from all test cases, the following Type of Bill (TOB) codes:
Skilled Nursing Facility (SNF): TOB 210-280 and 21A-28Z
Home Health: TOB 320-349 and 32A-34Z
Hospice: TOB 810-829 and 81A-82Z
Swing Bed: 18X

CMS will provide further guidance for the submission of these TOBs in the future.

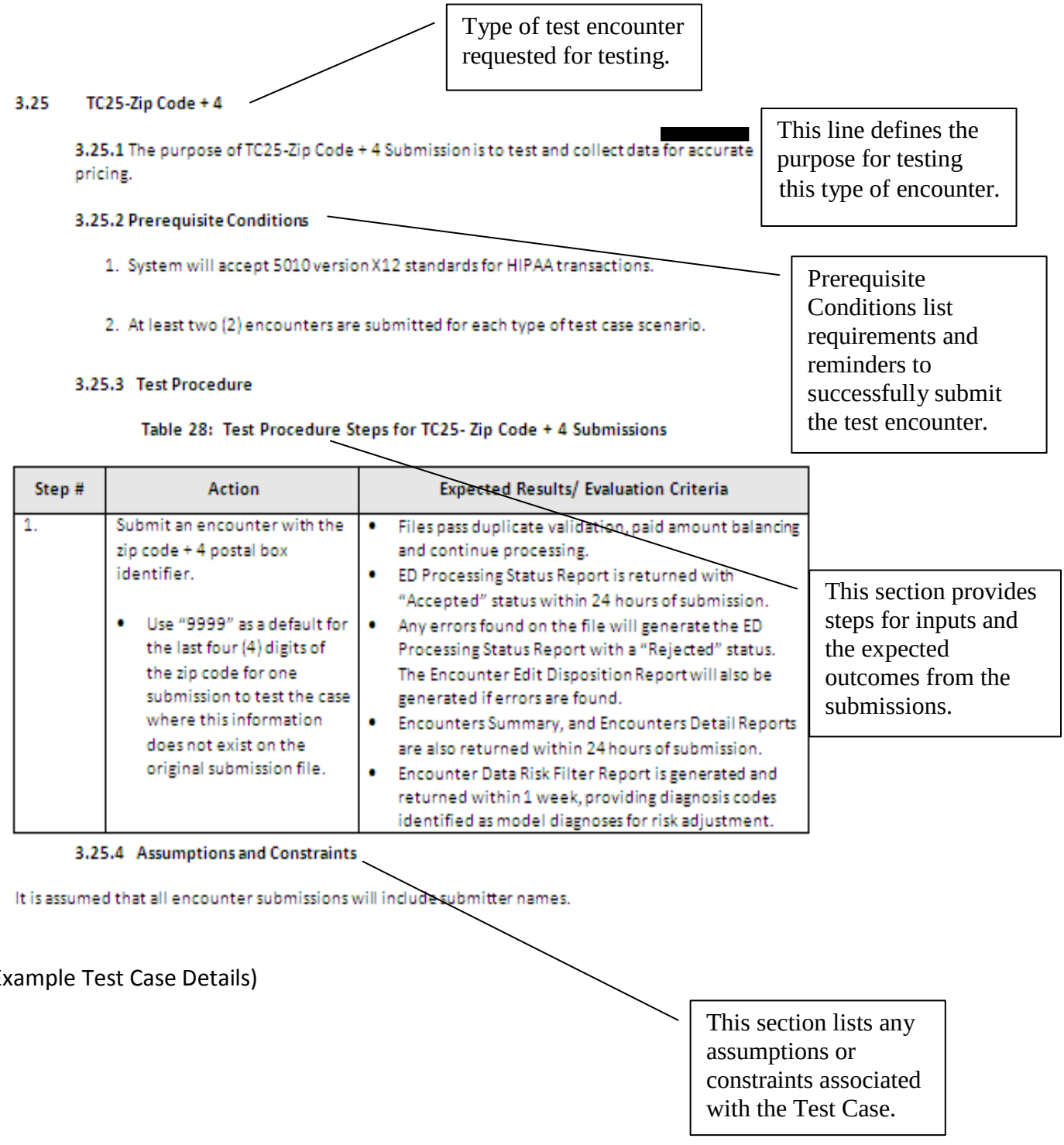
Test Case Summary Table

Test Case/Script Identifier	Test Case/Script Title
Beneficiary Eligibility	TC01- New MA Member
Data Validation	TC02-Atypical Provider
Data Validation	TC03-Ambulance
Data Validation	TC04-Coordination of Benefits
Data Validation	TC05-Hospital-Outpatient
Data Validation	TC06-Hospital- Inpatient
Data Validation	TC07-Outpatient Rehab
Processing	TC08-Duplicate

Note: Submitters must exclude, from all test cases, the following Type of Bill (TOB) codes:
Skilled Nursing Facility (SNF): TOB 210-280 and 21A-28Z
Home Health: TOB 320-349 and 32A-34Z
Hospice: TOBs 810-829 and 81A-82Z
Swing Bed: 18X

CMS will provide further guidance for the submission of these TOBs in the future.

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



(Example Test Case Details)

3.0 Test Case Details

3.1 TC01-New MA Member

3.1.1 Purpose

The purpose of TC01-New MA Member is to test eligibility rules on a new member encounter submission.

3.1.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

3.1.3 Test Procedure

Table 1: Test Procedure Steps for TC01-New MA Member

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a new Medicare Advantage member enrolled in 2011 with effective in 2012.	The 999A and 277CA Reports are returned within 48 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount ED Processing Status Report is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within seven (7) business days of submission

3.1.4 Assumptions and Constraints

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

3.2 TC02-Atypical Provider

3.2.1 Purpose

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

3.2.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

3.2.3 Test Procedure

Table 2: Test Procedure Steps for TC02-Atypical Provider

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an atypical provider 837-I file using the following default codes: NPI-1999999976 EIN-199999997 ICD-9 diagnosis code - '78099'-Other General Symptoms Loop 2300, NTE01='ADD', NTE02='NO NPI ON PROVIDER CLAIM NO EIN ON PROVIDER CLAIM'	The 999A and 277CA Reports are returned within 48 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount ED Processing Status Report (MAO-002) is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the MAO-002) with a "Rejected" status within seven (7) business days of submission.

3.2.4 Assumptions and Constraints

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

3.3 TC03- Ambulance

3.3.1 Purpose

The purpose of TC03-Ambulance is to test editing, processing, appropriate pricing, and storage of ambulance encounter submissions.

3.3.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

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

3.3.3 Test Procedure

Table 3: Test Procedure Steps for TC03-Ambulance

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a Medicare participating provider using the ambulance Fee Schedule located online at http://www.cms.gov/AmbulanceFeeSchedule/02_afspuf.asp#TopOfPage. Tip: Select the CY 2012 zip file and then use the ambfspuf_2012_ext_final.xlsx file to submit a valid ambulance HCPCS code. In Loop 2400, data element SV204='UN' and SV205 must be populated with the ambulance mileage. Applicable type of bill codes for ambulance are '13', '22','23','83', and '85'.	The 999A and 277CA Reports are returned within 48 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount ED Processing Status Report (MAO-002) is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the (MAO-002) with a "Rejected" status within seven (7) business days of submission.

3.3.4 Assumptions and Constraints

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

3.4 TC04- Coordination of Benefits

3.4.1 Purpose

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

3.4.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

3. Submit an original transaction to a primary payer.

3.4.3 Test Procedure

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

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a true coordination of benefits submission using the following guidance: **1st iteration of COB loops** – MAO information (**Primary Payer)** Loop 2320 AMT01='D', AMT02=MAO Paid Amount Loop 2330B – MAO Information Loop 2430 – MAO Service Line Adjudication Information SVD – Service Level Payment Amount CAS – Service Level Amount NOT Paid	The 999A and 277CA Reports are returned within 48 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount ED Processing Status Report (MAO-002) is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the MAO-002 with a "Rejected" status within seven (7) business days of submission.

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

3.4.4 Assumptions and Constraints

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

3.5 TC05- Hospital-Outpatient

3.5.1 Purpose

The purpose of TC05-Hospital-Outpatient is to test editing, processing, appropriate pricing and storage of submissions.

3.5.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

3.5.3 Test Procedure

Table 5: Test Procedure Steps for TC05-Hospital-Outpatient

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an outpatient hospital, type of bill code '13X' in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	The 999A and 277CA Reports are returned within 48 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount ED Processing Status Report (MAO-002) is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the MAO-002 with a "Rejected" status within seven (7) business days of submission.

3.5.4 Assumptions and Constraints

Outpatient hospital encounters will be priced based on the Outpatient Prospective Payment System (OPPS), with separate pricers for providers billed separately using the Medicare Physician Fee Schedule (MPFS) located online using the Physician Fee Schedule search tool http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

3.6 TC06- Hospital-Inpatient

3.6.1 Purpose

The purpose of TC06-Hospital-Inpatient is to test editing, processing, appropriate pricing, and storage of submissions.

3.6.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

3.6.3 Test Procedure

Table 6: Test Procedure Steps for TC06-Hospital-Inpatient

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an inpatient hospital, type of bill code '11X' in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	Validation on the file for a unique encounter is based on the following data fields: o Admit Date o Patient Status Code The 999A and 277CA Reports are returned within 48 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount ED Processing Status Report (MAO-002) is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the MAO-002 with a "Rejected" status within seven (7) business days of submission.

3.6.4 Assumptions and Constraints

Inpatient hospital encounters will be priced based on the Inpatient Prospective Payment System (IPPS).

3.7 TC07 - Outpatient Rehab

3.7.1 Purpose

The purpose of TC07 - Outpatient Rehab is to test editing, processing, appropriate pricing and storage of submissions.

3.7.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

3.7.3 Test Procedure

Table 7: Test Procedure Steps for TC07- Outpatient Rehab

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an outpatient rehab, type of bill code '74X', '75X' in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	The 999A and 277CA Reports are returned within 48 hours of submission. Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount ED Processing Status Report (MAO-002) is returned with "Accepted" status within seven (7) business days of submission. Any errors found on the file will generate the MAO-002 with a "Rejected" status within seven (7) business days of submission.

3.7.4 Assumptions and Constraints

Outpatient rehab encounters will be priced based on the Medicare Physician Fee Schedule (MPFS) located online using the Physician Fee Schedule search tool http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

3.8 TC08-Duplicate

3.8.1 Purpose

The purpose of TC08-Duplicate is to ensure information is not duplicated and stored for pricing and risk adjustment in EODS.

3.8.2 Prerequisite Conditions

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

2. Two (2) encounters are submitted for each type of test case scenario.

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

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

3.8.3 Test Procedure

Table 8: Test Procedure Steps for TC08-Duplicate

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a duplicate 837-I encounter to the EDFES with duplicate data in all of the following fields: o Beneficiary HICN o Beneficiary Last Name o Date of Service o Type of Bill o Revenue Code o Procedure Code o Billing Provider NPI o Paid Amount	The 999A and 277CA Reports are returned within 48 hours of submission. The file is rejected due to duplicate data contained in EODS. Any errors found on the file will generate the ED Processing Status Report (MAO-002) with a "Rejected" status within seven (7) business days of submission.

3.8.4 Assumptions and Constraints

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

1. ACRONYMS

CMS	Centers for Medicare & Medicaid Services
EDFEC	Encounter Data Front End Contractor
EDFES	Encounter Data Front End System
EDIPPS	Encounter Data Institutional Pricing and Processing System
EODS	Encounter Data Operational Data Store
EDIPPS	Encounter Data Institutional Pricing and Processing System
EDPS	Encounter Data Processing System
EDPSC	Encounter Data Processing System Contractor
EDS	Encounter Data System
IPPS	Inpatient Prospective Payment System
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MPFS	Medicare Physician Fee Schedule
OPPS	Outpatient Prospective Payment System
PPS	Prospective Payment System
SNF	Skilled Nursing Facility
TOB	Type of Bill