Medicare Advantage General Supplemental Services Submission Guide

Standard Companion Guide for Supplemental Benefit Services

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Standard Companion Guide for Supplemental Benefit Services

2.12.1. Introduction

The purpose of this document is to provide Medicare Advantage (MA) organizations with instructions specific to populating and submitting encounter data records (EDRs) for supplemental benefit services.[1] This document, the *Medicare Advantage General Supplemental Services Submission Guide*, is accompanied by two separate appendices (Appendix 2.12 B and Appendix 2.12 C) that provide additional details on requirements for successful submission of supplemental benefits on EDRs.

CMS notes that some of the information within these documents duplicates information in the *Encounter Data Submission and Processing Guide* and Appendix 3A, "MA Companion Guide: CMS' Supplemental Instructions for EDR & CRR Data Elements."[2] Information in the *Encounter Data Submission and Processing Guide* and Appendix 3A is only superseded by specific instruction provided herein. MA organizations are responsible for referencing these other documents for general EDR submission needs.

Please note that the information contained in this document will be incorporated into a future version of the *Encounter Data Processing and Submission Guide.* The numbering of the sections in this document begins with 2.12 as this is the current section in Chapter 2 of the *Encounter Data Processing and Submission Guide* that provides information on submission of encounter data for supplemental benefits.

For unusual scenarios, challenges faced, or any other questions related to the requirements discussed in this document, contact RiskAdjustmentOperations@cms.hhs.gov. Please specify "Supplemental Benefits Submission" in the subject line.

[1] This document builds upon general instructions for submitting EDRs published in the February 21, 2024, Health Plan Management System (HPMS) memo, "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records."
[2] Available at: https://www.csscoperations.com/

2.12.2. Overview

2.12.2.1 Statutory and Regulatory Background

CMS requires organizations providing services or items to Medicare beneficiaries to submit data that characterize the context and purpose of each item and service provided to a Medicare beneficiary, as described in regulation at 42 CFR 422.310. The regulation at 422.310(b) states, "Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization."

In 2008, CMS revised 42 CFR 422.310(d) to further clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee to fulfill the requirements provided at 422.310(b).[3] Consistent with that authority, CMS began collecting encounter data with 2014 dates of service.

The requirements and authorities codified at 42 CFR 422.310 apply not only to Medicare Part A and B covered items and services, but also extend to supplemental benefits offered by MA organizations, i.e., MA organizations are required to submit encounter data for supplemental benefits provided to their enrollees. While MA organizations have always been able to submit some supplemental benefits to the Encounter Data System (EDS), not all MA organizations have regularly submitted the supplemental benefits that could be submitted. Further, a number of these benefits could not be submitted because certain data elements required for EDS to accept the data did not exist and, in some situations, CMS has not provided specific instructions for the submission of supplemental benefits.

In this document, CMS provides instructions on how to submit encounter data records (EDRs) for supplemental benefits into the EDS. These instructions include information that addresses challenges MA organizations have faced in submitting EDRs for supplemental benefits, such as when an MA organization lacks certain required data elements for non-medical supplemental services.

2.12.2.2 General Information for Supplemental Benefits Reporting

CMS understands that MA organizations may lack a diagnosis code, procedure code, and/or revenue code for many non-medical supplemental benefits (such as non-urgent transportation, meals, or gym memberships) because such data is not typically collected in the billing for these services, MA organizations may have had difficulty to submit EDRs for such benefits. For all supplemental benefits for which there does not exist sufficient data to populate an X12 837

[3] Final 2009 inpatient prospective payment system (IPPS) rule, 73 Fed. Reg. 48434 (August 19, 2008). https://www.federalregister.gov/documents/2008/08/19/E8-17914/medicare-program-changes-to-the-hospital-inpatient-prospective-payment-systems-and-fiscal-year-2009

Version 5010 record, CMS has developed default codes, discussed in section 2.12.3.2 of this document and Appendix 2.12 C, which may be used to populate the required data fields.

Additionally, we understand that certain types of supplemental benefits do not produce the same types of utilization data that are associated with a medically related service, medical encounter, or traditional items being furnished; therefore, the utilization of these services cannot be easily enumerated for EDR reporting purposes. For example, gym memberships may be paid for quarterly or annually, and are not paid for on a per-visit basis. Because approaches to payment can vary across types of supplemental benefits and across MA plans, and because supplemental benefits have purchasing arrangements and/or utilization that differ from typical medical services, we have developed these technical instructions to identify the most appropriate unit of service to be reported, or instance of utilization to be recorded, for different types of benefits and how to populate the EDR.

When considering how utilization of supplemental benefits should be reported on an EDR, MA organizations should use the guiding principle that a record of utilization should be submitted for every individual instance when an enrollee uses the benefit. In certain circumstances in which per-utilization reporting is not practicable (e.g., each time an enrollee uses a physical fitness membership to visit a fitness center or a pre-funded card for over-the-counter (OTC) items is used at a participating retailer), MA organizations should instead report when the enrollee first has access to the benefit and is able to use it or at the end of the benefit period to include the portion of an allowance used. MA organizations should apply these general principles when submitting supplemental benefits beyond the examples provided in these instructions.

Please see the following general examples:

- If reimbursements are paid on a fee-for-service basis, such as for worldwide travel coverage or different levels of hearing aids, and the unit of service being provided is enumerable, then report each individual instance of utilization for each item or service and provide the actual date of service for each individual use.
- CMS strongly encourages MA organizations to report each use of an allowance or payment card and the items or services being paid for with that allowance or payment card. However, submitters are permitted to report the amount of an allowance used, based on card periodicity, when per-utilization reporting is not practicable.[4] For example, if an OTC pre-funded card is distributed and paid for quarterly, then an EDR should be submitted at the end of each quarter and include the amount of the available allowance that was used per period.
    - When allowance amounts on pre-funded cards span multiple categories of supplemental benefits (e.g., a single allowance for OTC items and healthy

[4] CMS expects that utilization of most supplemental benefits, including dental, vision, and hearing services, is enumerable and will be reported on a per-utilization basis. This applies regardless of the purchasing arrangements or payment mechanisms in place (e.g., individual claims processing or an allowance on a pre-funded card).

groceries), MA organizations must separate out spending by service category and submit an EDR for each category in which there was utilization.

- When there is a payment for a membership that allows an enrollee to access services, such as a gym membership, submit EDRs for each period when the membership was active, depending on how payment is made for a membership. For instance, if membership is paid monthly and an enrollee activates the gym membership in January and ends it in March, an EDR should be submitted for each month (January, February, and March). If membership is activated and paid for annually, quarterly, or on another periodic basis, an EDR should correspondingly be submitted annually, quarterly, or on another periodic basis. The "from" date of service would be the first of the month, or the first of the first month in the time period, being paid for. The "through" date of service would be the last day in that time period.

More specific examples are provided in section 2.12.4 of this document.

2.12.3. Technical Instructions for Supplemental Benefits Reporting

CMS requires that MA organizations and other submitters use the X12 837 5010 format for submitting supplemental benefit EDRs. Version 5010 of the 837 transaction set establishes the 837I (Institutional), 837P (Professional), and 837D (Dental). CMS requires the 837I for institutional encounters and the and 837P for professional and/or DME encounters. See section 2.12.3.5 below for additional information on the 837D.

2.12.3.1 Identification of Supplemental Benefits Using PWK fields

CMS has developed a Supplemental Benefits Indicator to identify supplemental benefits on encounter data submissions using existing fields on the 837 format, specifically the Paperwork (PWK) fields. The general purpose of the PWK fields is to allow submitters to provide additional documentation, and these fields have a variety of uses depending on the payer; CMS has repurposed these fields at the line level to provide indicators about a service. The PWK fields that should be populated for submission of supplemental benefits and the associated values are provided below. The use of the Supplemental Benefits Indicator will enable CMS to distinguish between items and services covered under Medicare Part A or Part B and those that are supplemental benefits. In addition, to standardize reporting across various supplemental benefits data collection efforts, the Supplemental Benefits Indicator will include a Supplemental Benefit Services Category (SBSC) Code, which aligns with supplemental benefit categories from the PBP software (see Appendix 2.12 B).

The Supplemental Benefits Indicator was created to identify all supplemental benefits offered by an MA organization. The Supplemental Benefits Indicator comprises the following four data elements within the 2400 Loop (line level) with the following values:

- PWK01 = IR
- PWK02 = EM
- PWK05 = AC

- PWK06 (Identification Code) = SBSC Code

The first three values are static values, and the last value (PWK06) is to be populated with the appropriate value as provided in Appendix 2.12 B. Each service line should only contain one occurrence of the Supplemental Benefits Indicator and should be reported in the first iteration of the PWK segment.

For example:

- Routine Foot Care: PWK01 = IR, PWK02 = EM, PWK05 = AC, PWK06 = 7f
- Fluoride Treatment: PWK01 = IR, PWK02 = EM, PWK05 = AC, PWK06 = 16a3

2.12.3.1.1 Reporting Combined Supplemental Benefits

When MA organizations are submitting EDRs for supplemental benefits that are part of a combined supplemental benefits package (as described in their plan benefit package (PBP)), the MA organization must separate utilization by service category and submit a separate EDR for each service category in which there was utilization.

In addition, MA organizations must report the distinct category that is being utilized in the PWK06 field followed by a 'zz' ('zz'). For example:

- If an MA plan offers a combined supplemental benefits package that covers 15 total supplemental chiropractic and acupuncture visits, and the MA organization is reporting enrollee utilization of a single supplemental routine chiropractic visit, the PWK06 field should be populated with 7b1zz
- If an MA organization is reporting utilization of $250 for contact lenses on a pre-funded card that is part of a single allowance spanning vision and hearing benefits, the MA organization would populate field PWK06 with 17b1zz

2.12.3.1.2 Chart Review Records

CMS is aware that two of the PWK fields described in section 2.12.3.1 are also used to identify chart review records (CRRs). Because supplemental benefits must be submitted on EDRs, there should be no conflict in using these fields. Submission of supplemental benefits as line-level items or services on a CRR will result in a rejected record, as described in section 2.12.5.2. When submitting supplemental benefits as EDRs or on EDRs that also contain non-supplemental benefit services, the PWK data fields must be completed for the supplemental benefits at the line-level as outlined in the section 2.12.3.1.

2.12.3.2 Default Values

For all supplemental benefits for which there does not exist sufficient data to populate an X12 837 Version 5010 record, CMS has developed default codes, provided below, which may be used to populate the respective required data fields. These default codes are only to be used for submitting supplemental benefits data to the EDS when diagnosis, procedure, or revenue code

data do not exist for the MA organization to obtain for a given item or service (e.g., reporting OTC benefit utilization that does not have an associated diagnosis code). In all other circumstances, CMS expects MA organizations to obtain from the provider or vendor the specific codes necessary for submission.

- Default Procedure code: SBSP1
- Default Diagnosis code: SBSD1
- Default Revenue code: 1111

When reporting items and services from atypical providers (defined as an individual or business that bills for services rendered but does not meet the definition of a health provider at 45 CFR 160.103), who are not eligible to obtain an National Provider Identifier (NPI), MA organizations and other submitters are instructed to follow the default NPI and Employer Identification Number (EIN) guidance in Chapter 3 of the *Encounter Data Submission and Processing Guide*.

In additional to the values described above, please refer to Appendix 2.12 C (Supplemental Benefits Minimum Data Elements and Default Data) to complete the EDR.

2.12.3.3 Dates of Service, Quantity, and Units

Dates of service are populated in the Service Date (Professional/Institutional Loop 2400 – DTP01 = 472, DTP02 = D8 or RD8, and DTP03 = date or date range).

- If the actual date of service is not known, use the first day of the month.
- Future dates are not accepted. Encounters should be held until after the 'through' date of service, so that complete information about the service, including the *through* date, can be reported.
- Populate the actual date an item is delivered or installed (e.g., home modifications, wigs after chemo, Personal Emergency Response System (PERS)).
- For allowances on pre-funded cards, populate the "from" date of service as the first day in the period for which utilization is being reported, and populate the "through" date of service as the last day of the period for which utilization is being reported.

Populate the Quantity (Professional Loop 2400 – SV104, Institutional Loop 2400 – SV205) with the count of the appropriate unit. EDR submission frequency should reflect the periodicity of the benefit (e.g., a quarterly fitness benefit should be submitted with a quantity of one (1), and an EDR should be submitted for each quarter in which the fitness benefit is active).

2.12.3.4 Supplemental Benefits Provided as Allowances

For items that are provided through an allowance or with a maximum plan benefit coverage per period (e.g., an annual allotment for vision services or a quarterly pre-funded card for OTC purchases), MA organizations should populate the total allowance on the Line Item Charge Amount (Professional Loop 2400 – SV102, Institutional Loop 2400 – SV203), and then populate

the amount used by the beneficiary in the Service Line Paid Amount (Professional/Institutional Loop 2430 – SVD02).[5] The Line Item Charge Amount cannot be left blank.

If an unused allowance amount that, based on the plan benefit design, carries over to the next period, MA organizations should continue to populate the Line Item Charge Amount with the base maximum plan benefit coverage amount per period. For example, if an MA plan offers a $100 per period OTC benefit and the enrollee uses $90, when reporting OTC utilization for the subsequent period, the Line Item Charge Amount would remain $100, not $110.

2.12.3.5 Submission of Dental Benefits

Medicare-covered dental services must continue to be submitted using the 837P for dental services that are Part B benefits or the 837I for dental services that are Part A benefits. Supplemental dental benefits cover preventive and comprehensive dental services outside of Medicare-covered dental services; the context and purpose of these benefits are best captured via a dental-specific format. As such, supplemental dental benefits are to be reported using the X12 837D Version 5010 claims format. CMS will notify submitters when the EDS begins accepting dental encounters using the 837D format; we expect that this will be around June 2024. At that time, we expect that MA organizations will begin to submit supplemental dental benefits for dates of services beginning January 1, 2024, and we expect submissions (notwithstanding runout) to be caught up by the end of 2024. If MA organizations don't want to wait to submit supplemental dental services, or are already submitting supplemental dental services on the 837P, you may continue to submit supplemental dental services using the 837P format and the appropriate Healthcare Common Procedure Coding System (HCPCS) D-codes and, when CMS is ready to begin accepting the 837D, begin submitting dental supplemental services using the 837D. Alternatively, MA organizations can wait and submit all dental supplemental services beginning January 1, 2024 on the 837D once CMS begins accepting that format. We understand that some submitters employ capitated or allowance types of payment arrangements in which the submitter does not receive claims data for dental services. CMS expects that, in these circumstances, MA organizations will work with their vendors to gather the data necessary to populate an 837D.

2.12.4. Examples

The examples provided below are illustrative and intended to help MA organizations submit complete and accurate EDRs for supplemental benefits.

All supplemental benefits submissions require use of the PWK fields as outlined in section 2.12.3.1 of this document. Because the PWK01, PWK02, and PWK05 fields have static values for submission of supplemental benefits, the examples below only provide the PWK06 field (which must align with the appropriate SBSC code as provided in Appendix 2.12 B). As described in section 2.12.3.1.1, EDRs that report utilization of supplemental benefits that are part

[5] This applies regardless of the benefit mode of delivery (e.g., debit card, catalogue purchase, claims processing, etc.)

of a combined benefit package must include a suffix ‘zz’ after the SBSC code in the PWK06 field.

2.12.4.1 Additional Days for Inpatient Hospital – Acute

In this example, in addition to Medicare-covered hospital stays, the MA offers unlimited additional acute inpatient days. An enrollee has an extended hospital stay and uses 7 days beyond the base Medicare-covered stay. The MA organization would report the additional inpatient days as follows:

- The actual NPI, diagnosis code, procedure code(s), and revenue code should all be populated just as they would for a stay that is part of the basic Medicare benefits in accordance with information received from the provider
- To specify additional days are being submitted, populate the Unit or Basis for Measurement Code (Professional Loop 2400 – SV103, Institutional Loop 2400 – SV204) with DA
- The actual count of additional days should be populated in the Quantity (Professional Loop 2400 – SV104, Institutional Loop 2400 – SV205)
- PWK06 = 1a1

2.12.4.2 Skilled Nursing Facility (SNF) – Waive Hospital Stay, 3 Days

In this example, an MA plan waives the typical Medicare-required three-day hospital stay prior to a SNF admission. An enrollee has a two-day acute inpatient stay related to a fall and is discharged to a SNF for rehabilitation. The acute inpatient stay and the SNF admission are Medicare-covered benefits and should be submitted as EDRs using the standard processes and values. In addition, the MA organization should submit a supplemental benefit EDR for the waiver of the three-day hospital stay requirement, as follows:

- The actual NPI, diagnosis code, procedure code(s), and revenue code should all be populated in accordance with information received from the provider
- PWK06 = 2-4

2.12.4.3 Worldwide Emergency Coverage

In this example, and MA plan offers worldwide emergency care coverage. An enrollee is traveling and seeks emergency care in an international setting on April 1, 2024. When they return home, the enrollee submits a request for direct member reimbursement for their emergency visit. The MA organization would report this as outlined below. If the documentation provided by the enrollee includes a valid diagnosis code, the actual code should be submitted (not the default diagnosis code).

- NPI (default) = 1999999984
- Procedure code (default) = SBSP1
- Diagnosis code (default) = SBSD1

- Revenue code (default) = 1111
- Date of service = 04/01/2024
- PWK06 = 4c1

2.12.4.4 Outpatient Blood Services – Three (3) Pint Deductible Waived

In this example, an MA plan waives the typical three-pint deductible for outpatient blood services. An enrollee has a health condition that requires an outpatient blood transfusion. The MA organization should submit a supplemental benefit EDR for the waiver of the three-pint deductible, as follows:

- The actual NPI, diagnosis code, procedure code(s), and revenue code should all be populated in accordance with information received from the provider
- PWK06 = 9d

2.12.4.5 Over-the-Counter (OTC) Pre-Funded Card

In this example, an MA plan offers an OTC benefit on a pre-funded card with a $250 quarterly allowance to be used at participating retail locations. Any unused portion of the allowance does not rollover to the subsequent period. The enrollee is mailed the card at the beginning of the plan year; in the first quarter of the year, they use the card to purchase $190 of covered OTC items. The OTC card vendor does not report diagnosis, procedure, or revenue codes as part of their billing process. At the end of the first quarter, the MA organization would report the first quarter OTC utilization on an EDR as outlined below.

- NPI (default) = 1999999984
- Procedure code (default) = SBSP1
- Diagnosis code (default) = SBSD1
- Revenue code (default) = 1111
- “From” date of service = 01/01/2024
- “Through” date of service = 03/31/2024
- PWK06 = 13b
- Line Item Charge Amount = $200.00
- Service Line Paid Amount = $190.00

2.12.4.6 Combined OTC and Food and Produce Benefit

In this example, an MA plan offers a Special Supplemental Benefits for the Chronically Ill (SSBCI) combined benefits package that covers OTC items and food and produce (e.g., healthy groceries). This benefit is provided as a monthly allowance of $100 via a debit card. Any unused portion of the allowance rolls over to the subsequent period. In June 2024, the enrollee has an unused amount of $17 that carried forward from May. The enrollee uses $105 of this allowance on healthy groceries and the remaining $12 on OTC items. The MA organization would submit two separate EDRs for this benefit utilization, as outlined below.

OTC Items:

- NPI (default) = 1999999984
- Procedure code (default) = SBSP1
- Diagnosis code (default) = SBSD1
- Revenue code (default) = 1111
- "From" date of service = 06/01/2024
- "Through" date of service = 06/30/2024
- PWK06 = 13bzz
- Line Item Charge Amount = $100.00
- Service Line Paid Amount = $12.00

Food and Produce:

- NPI (default) = 1999999984
- Procedure code (default) = SBSP1
- Diagnosis code (default) = SBSD1
- Revenue code (default) = 1111
- "From" date of service = 06/01/2024
- "Through" date of service = 06/30/2024
- PWK06 = 13i1zz
- Line Item Charge Amount = $100.00
- Service Line Paid Amount = $105.00

CMS is aware that some retail locations may provide both OTC and food items in a single transaction (e.g., an enrollee visits a grocery store and uses their pre-funded card in a single encounter to purchase both food and first aid supplies), which may be a barrier to reporting separate OTC and food supplemental benefits utilization. CMS expects MA organizations to work with their vendors to obtain the information necessary to report separately by service category.

2.12.4.7 Physical Fitness Benefit

In this example, an MA plan offers a monthly physical fitness benefit that consists of a quarterly gym membership. The vendor does not collect or report diagnosis, procedure, or revenue codes as part of their billing process. The enrollee activates the membership in January. The MA organization would report this utilization as follows:

- NPI (default) = 1999999984
- Procedure code (default) = SBSP1
- Diagnosis code (default) = SBSD1
- Revenue code (default) = 1111
- "From" date of service = 01/01/2024
- "Through" date of service = 01/31/2024
- PWK06 = 14c4-1

2.12.4.8 Personal Emergency Response System (PERS) Benefit

In this example, an MA plan offers an annual PERS benefit, in which an enrollee can receive a one-time installation of a PERS device. The enrollee calls to request the benefit in March, and the vendor installs the device on March 15, 2024. The vendor submits information to the MA organization that contains diagnosis code Z91.81 (history of falling) and procedure code S5160 (PERS installation). The MA organization would report this utilization as follows:

- The actual diagnosis and procedure code should be populated in accordance with information received from the provider or vendor
- NPI (default) = 1999999984
- Revenue code (default) = 1111
- Date of service = 03/15/2024
- PWK06 = 14c11

The PERS benefit comes with a monthly monitoring service while the device is active. The MA organization receives a monthly update from the vendor for April 2024 that includes diagnosis code Z91.81 (history of falling) and procedure code S5161 (emergency response system; service fee, per month (excludes installation and testing)). The MA organization would report this as follows:

- The actual diagnosis and procedure code should be populated in accordance with information received from the provider or vendor
- NPI (default) = 1999999984
- Revenue code (default) = 1111
- Date of service = 04/01/2024
- PWK06 = 14c11

2.12.4.9 Combined Vision/Hearing Benefit

In this example, an MA plan offers a combined supplemental vision and hearing benefit, with a maximum plan benefit coverage amount of $2,000 per year. Services provided under this benefit are reported to the MA organization via claims processing or an encounter-based reporting. The enrollee visits and audiologist and receives a single outer ear hearing aid on June 1, 2024, with a total cost of $1,800. The MA organization would report this utilization as follows:

- The actual NPI, diagnosis code, procedure code, revenue code, and date of service should all be populated in accordance with information received from the provider
- PWK06 = 18b3zz
- Line Item Charge Amount = $2,000.00
- Service Line Paid Amount = $1,800.00

2.12.5. Encounter Data Processing System (EDPS) Edits

Edit codes are used throughout encounter data processing to indicate invalid or unacceptable data submitted in an encounter data file. This section focuses on edit codes specific to submission of EDRs for supplemental benefits. MA organizations should also refer to Chapter 6 of the *Encounter Data Submission and Processing Guide* for additional information on EDPS edits. The EDPS Edit Code Look-Up Tool is updated regularly, and it is the responsibility of MA organizations to ensure submissions comply with all editing and validation steps.

Section 2.12.5.1 describes five (5) new edits for supplemental benefits; section 2.12.5.2 describes updates to nine (9) existing edits.

2.12.5.1 New Edits for Supplemental Benefits

Edit 19000 "Invalid Supplemental Benefit Submission" is a new service line level reject edit applicable for professional, institutional, and durable medical equipment (DME) encounters. This edit validates that the SBSC code submitted in PWK06 is a valid code. The 2024 SBSC reference code list is provided in Appendix 2.12 B.

Edit 19000 will post when:

- Service Line on the encounter contains PWK01= 'IR' and PWK02= 'EM' and PWK05= 'AC' and
- PWK06 is not matching with SBSC reference data stored in EDPS and
- The service line 'from' date is on or after 01/01/2024.

Edit 19005 "Missing Supplemental Benefit Details" is a new service line and header level reject edit applicable for professional, institutional, and DME encounters. This edit validates that the supplemental benefits indicator is submitted when any of the default diagnosis (header level), procedure, or revenue codes are also submitted on a service line. If this edit is posted at the header level, the entire record will be rejected, and the edit will not also post at the line for the same encounter.

Edit 19005 will post on professional and DME encounters at the line level when:

- Service line contains a default procedure code of 'SBSP1'
  or service line points to a header-level default diagnosis code of 'SBSD1' and
- Service line does not contain the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The service line 'from' date is on or after 01/01/2024.

Edit 19005 will post on professional and DME encounters at the header level when:

- Encounter contains a default diagnosis code of 'SBSD1' and

- None of the service lines contain the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The statement 'from' date is on or after 01/01/2024.

Edit 19005 will post on institutional encounters at the line level when:

- Service line contains a default procedure code of 'SBSP1' or a default revenue code of '1111' and
- Service line does not contain the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The service line 'from' date is on or after 01/01/2024.

Edit 19005 will post on institutional encounters at the header level when:

- Encounter contains a default diagnosis code of 'SBSD1' and
- None of the service lines contain the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The statement 'from' date is on or after 01/01/2024.

Edit 19010 'Supplemental Service on CRR Not Allowed' is a new line and header level reject edit applicable for professional, institutional, and DME chart review records. Since supplemental benefit services are only to be submitted on encounter data records, this edit will validate and reject chart review records that include the Supplemental Benefits Indicator on any of the lines or when any of the default diagnosis, procedure, or revenue codes for use with supplemental benefits are submitted. Edit 19010 will either be posted to the encounter at the header or the line level. If this edit is posted at the header, the entire record will be rejected, and the edit would not post at the line level for the same encounter.

Edit 19010 will post on the professional and DME chart review records at the line level when:

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- The service line contains the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The service line 'from' date is on or after 01/01/2024.

OR

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- The service line contains a default procedure code of 'SBSP1' and
- The service line 'from' date is on or after 01/01/2024.

Edit 19010 will post on the professional and DME chart review record at the header level when:

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- All service lines contain the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The statement 'from' date is on or after 01/01/2024.

OR

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- CRR contains a default diagnosis code of 'SBSD1' and
- The statement 'from' date is on or after 01/01/2024.

Edit 19010 will post on the institutional chart review record at the line level when:

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- The service line contains the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The service line 'from' date is on or after 01/01/2024.

OR

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- The service line contains a default procedure code of 'SBSP1' or default revenue code of '1111' and
- The service line 'from' date is on or after 01/01/2024.

Edit 19010 will post on the institutional chart review record at the header level when:

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- All service lines contain the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The statement 'from' date is on or after 01/01/2024.

OR

- The current encounter is a linked or unlinked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- CRR contains a default diagnosis code of 'SBSD1' and
- The statement 'from' date is on or after 01/01/2024.

Edit 19015 'Not a Valid Code for DOS' is a new line and header level reject edit applicable for professional, DME, and institutional encounters. The edit validates that the default procedure, revenue code, and diagnosis codes created for use while submitting supplemental benefits is used for DOS starting January 1, 2024. Edit 19015 will either be posted to the encounter at the header or the line level. If this edit is posted at the header, the entire record will be rejected, and the edit would not post at the line for the same encounter.

Edit 19015 will post on professional and DME encounters at a line level when:

- The service line contains a default procedure code of 'SBSP1' and
- The service line 'from' date is before 01/01/2024.

Edit 19015 will post on professional and DME encounters at the header level when:

- Encounter contains a default diagnosis code of 'SBSD1' and
- The statement 'from' date is before 01/01/2024.

Edit 19015 will post on an institutional encounter at the line level when:

- The service line contains default procedure code of 'SBSP1' or default revenue code of '1111' and
- The service line 'from' date is before 01/01/2024.

Edit 19015 will post on an institutional encounter at the header level when:

- Encounter contains a default diagnosis code of 'SBSD1' and
- The statement 'from' date is before 01/01/2024.

Edit 19020 'CRR Linked to Supplemental Services' is a new header level reject edit that validates when a linked chart review record is submitted and linked to an accepted supplemental benefits encounter data record (i.e., when all services lines on the linked encounter contain the Supplemental Benefits Indicator). This edit is applicable to professional, institutional, and DME encounters.

Edit 19020 will post when:

- The encounter being submitted is a linked chart review record (PWK01 = '09'/PWK02 = 'AA') and
- Parent encounter is in accepted status
- All service lines in the parent encounter contain the Supplemental Benefits Indicator (PWK01= 'IR', PWK02= 'EM', PWK05= 'AC', and PWK06 = SBSC code) and
- The statement 'from' date is on or after 01/01/2024.

2.12.5.2 Updates to Existing Edits

To facilitate the collection of supplemental benefits on the same encounters as traditional Part A / Part B services, we reviewed all existing EDPS edits. The outcome of our review indicated the need for additional edit bypass conditions for the edits below:

- 98325 - Service Line(s) Duplicated
- 32070 - Non-DME HCPCS Code
- 22340 - ESRD Diagnosis Code Missing
- 22320 - Missing ASC Procedure Code
- 98300 - Exact Inpatient Duplicate Encounter
- 21953 - SNF Claim Missing Revenue Code 0022
- 22100 - Rev Code 0023 Missing/Invalid for DOS'
- 22470 - HH Claim Missing Skilled Services
- Preliminary RA Flag reported on the MAO-002

Edit 98325 - Service Line(s) Duplicated - Service lines containing the Supplemental Benefits Indicator will not be validated against previously submitted service lines, including previously submitted service lines containing the Supplemental Benefits Indicator. A bypass condition is added when service line contains the Supplemental Benefits Indicator**.**

Edit 32070 – Non-DME HCPCS Code – This DME informational edit validates that the submitted HCPCS/CPT code on the encounter is not present on the DMEPOS, DMEPEN, or ASP fee schedules for the service line from date of service. A bypass condition is added to the edit logic when the service line contains the supplemental benefits indicator.

Edit 22340 – ESRD Diagnosis Code Missing – This institutional reject edit ensures that an ESRD diagnosis code is submitted with Type of Bill (TOB) 72x (End Stage Renal Disease), given the corresponding dates of service. A bypass condition is added to the edit logic when all service lines contain Supplemental Benefits Indicator.

Edit 22320 – Missing ASC Procedure Code – This professional and institutional informational edit validates the submitted ASC procedure code is present on the appropriate fee schedule. This edit is applicable for institutional encounter service lines when TOB 83X is present. This edit is applicable for professional encounter service lines when the billing provider's NPI submitted on the encounter corresponds to the provider specialty '49' and place of service is '24'. A bypass condition is added to the edit logic when the service line contains the Supplemental Benefits Indicator.

Edit 98300 – Exact Inpatient Duplicate Encounter – This institutional reject edit validates that a previous inpatient encounter was not submitted with the same beneficiary, date of service, type of bill, and billing provider NPI. A bypass condition is added to the edit logic when all service lines contain Supplemental Benefits Indicator.

Edit 21953 - SNF Claim Missing Revenue Code 0022 – This institutional informational edit validates that revenue code 0022 is submitted with the correct TOB. A bypass condition is added to the edit logic when all service lines contain the Supplemental Benefits Indicator.

Edit 22100 – Rev Code 0023 Missing/Invalid for DOS – This institutional informational edit validates that the revenue code 0023 is submitted with the appropriate TOB and statement and service line from dates of service. A bypass condition is added to the edit logic when all service lines contain the Supplemental Benefits Indicator.

Edit 22470 – HH Claim Missing Skilled Services – This institutional informational edit validates that home health (HH) TOB 0327 or 0329 and specific revenue codes are not present. A bypass condition is added to the edit logic when all service lines contain the Supplemental Benefits Indicator.

Preliminary RA Flag – the MAO-002 report will report a 'RA Flag' of blank and Reason Code of blank when Type of Bill is 11x (Hospital Inpatient) or 41x (Religious Nonmedical (Inpatient)) and all service lines contain the Supplemental Benefits Indicator.

Appendix 2.12 A - American Hospital Association (AHA) Copyright Notice and Disclaimer

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