Encounter Data System
User Group

June 7, 2012
Agenda

• Introduction
• Session Guidelines
• CMS Updates
• EDPS Updates
  – Medicare Beneficiary Edits
  – EDS Incident Tracking
  – True COB Submissions – Institutional
  – Professional Production Data Submission “Catch-up” Plan
  – DME Edits and Testing
• Questions and Responses
• Closing Remarks
Introduction

The purpose of this session is to provide Medicare Advantage Organizations (MAOs) and other entities with information on policy and operational guidance on testing and submitting production data to the Encounter Data System (EDS)
MAOs and Other Entities

- CMS requires the following types of organizations to submit encounter data:
  - Medicare Advantage (MA) Plans
  - Medicare Advantage-Prescription Drug (MA-PD) Plans
  - Health Maintenance Organizations (HMOs)
  - Special Needs Plans (SNPs)
  - Local Preferred Provider Organizations (PPOs)
  - Regional PPOs
  - Employer Group Health Plans
  - Programs of All-Inclusive Care for the Elderly (PACE) Plans
  - Cost Plans (1876 Cost HMOs/CMPs and 1833 HCRRPs)
  - Medical Savings Account (MSA)
  - Private Fee-for-Service Plans (PFFS)
  - Religious Fraternal Benefit Plans (RFBs)
  - Provider Sponsored Organizations (PSO)
Session Guidelines

• This is a one (1) hour Encounter Data User Group for MAOs and other entities

• If time allows, we will respond to questions
CMS Updates
End-to-End Testing Status

Certification Status as of 06/05/2012 *

<table>
<thead>
<tr>
<th></th>
<th>Professional</th>
<th>Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Submitters</td>
<td>224</td>
<td>224</td>
</tr>
<tr>
<td>Number of Submitters Certified</td>
<td>156</td>
<td>1</td>
</tr>
<tr>
<td>Certified MAOs and Other Entities Represented</td>
<td>426</td>
<td>1</td>
</tr>
</tbody>
</table>

*These figures do not include PACE Plans
End-to-End Testing / Certification Timeline

<table>
<thead>
<tr>
<th>Encounter Data</th>
<th>Testing Begins</th>
<th>EDPS Testing</th>
<th>Testing Ends/Deadline for Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Encounters</td>
<td>1/4/12</td>
<td>Test cases only</td>
<td>5/31/12</td>
</tr>
<tr>
<td>Institutional Encounters</td>
<td>4/30/12</td>
<td>Test cases only</td>
<td>6/30/12</td>
</tr>
<tr>
<td>DME Encounters</td>
<td>6/15/12</td>
<td>Test cases only</td>
<td>7/30/12</td>
</tr>
</tbody>
</table>

- CMS will not begin compliance measures without advance notice; however, the End-to-End Testing/Certification timeline has not changed.
- MAOs and other entities that have not completed end-to-end testing should do so immediately.
Tier 2 Testing

- Tier 2 testing has been extended to allow for submission of Professional and Institutional data.
- Currently, CMS has not identified a Tier 2 testing deadline. CMS will notify MAOs and other entities two (2) weeks prior to ending the Tier 2 testing capabilities.
- As of June 5, 2012:
  - 302 Professional Tier 2 test files were processed.
  - 43 Institutional Tier 2 test files were processed.
Tier 2 Testing

- End-to-end certified MAOs and other entities must begin submitting production data based on the submission timelines previously established.
- MAO-002 reports are returned within seven (7) business days for test file submissions and within five (5) days for production file submissions.
EDPS Updates
Frequent EDPPPS Edits

• Edit 98325 – Claim is an Exact Duplicate of a Previously Priced Claim
  – The ISA13 field must be populated with a unique Interchange Control Number for a rolling 12-month period per Submitter ID
  – Use new and unique encounter data for each test case scenario

• Edit 02240 – Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service
  – Ensure that member status is effective during the date of service
  – Do not submit encounters for members with a date of death prior to the Date of Service
Frequent EDPPPS Edits

- **Edit 02256** – Beneficiary Not Part C Eligible for Date of Service
  - Submitters should verify the beneficiary’s eligibility status using MARx

- **Edit 02110** – Beneficiary Health Insurance Carrier Number (HICN) Not on File
  - Submitters must use the beneficiary’s HICN that is active for 2012
  - EDPS system issues have been identified and are being resolved

- **Edit 98370** – Anesthesia vs Anesthesia Same Code
  - Submitters are using TOS code ‘7’ on multiple service lines
Frequent EDIPPS Edits

- **Edit 98325** – Claim is an Exact Duplicate of a Previously Priced Claim
  - The ISA13 field must be populated with a unique Interchange Control Number for a rolling 12-month period per Submitter ID
  - Use new and unique encounter data for each test case scenario

- **Edit 17825** – Billed Lines Require Charges (Few Exceptions)
  - If Revenue and HCPCS codes are present, a charge is required
  - If there is no charge, submitters should use a billed amount of $0.00
Frequent EDIPPS Edits

- **Edit 20505** – Accurate Ambulance HCPCS and Revenue Code Required
  - Submitters must not use HCPCS codes A0425 and A0380 when Revenue Code 540 is present

- **Edit 17310** – Surgical Revenue Code 036X Requires Surgical Procedure Code
  - Submitter must submit encounter with a surgical procedure code and surgical procedure code date

- **Edit 17110** – TOB 74X or 75X Requires HCPCS and Revenue Code
  - When using TOB 74X with Revenue Code 0274 or 75X with Revenue Code 0275, submitters must use HCPCS file fee indicator of ‘R’
EDPS Bulletin Schedule Update

- CMS has revised the distribution schedule for the EDPS Bulletin
- The EDPS Bulletin will be posted to the CSSC Operations website bi-weekly on the weeks alternate to scheduled User Group sessions at http://csscoperations.com/internet/cssc.nsf/docsCat/CSSC~Encounter%20Data~EDPS%20Bulletins?open&cat=CSSC~Encounter%20Data~EDPS%20Bulletins
- The next EDPS Bulletin will be posted on Wednesday, June 13, 2012
Medicare Beneficiary Edits
Medicare Beneficiary Edits

- CMS has completed review of beneficiary edits 02110, 02240, 02256, and 02125
- System upgrades have been implemented to ensure accuracy of these edits
- If these edits are still occurring on the returned MAO-002 reports, submitters should verify, using the MARx UI, that the beneficiary was active for the date of service submitted on the encounter
Medicare Beneficiary Edits

• After verifying the beneficiary status, if the beneficiary data did not match the MARx UI, submitters may update the beneficiary information and resubmit.

• If after MARx UI analysis the beneficiary is found to be correct, the submitter should submit an EDS Incident report in the tracking tool.
EDS Incident Tracking
Incident Tracking Tool

• As of June 2, 2012, 180 incident inquiries have been received
  – 88% of these incidents have been resolved
  – Remaining incidents are pending analysis or investigation

• Many of the remaining incidents are related to the following edits, which are under further investigation and analysis:
  – 98325 – Claim is an Exact Duplicate of a Previously Priced Claim
  – 03102 – Provider Type or Specialty Not Allowed to Bill Procedure

• MAOs and other entities are encouraged to submit incident reports when these edits are received on the returned MAO-002 reports
Incident Tracking Tool

- Common or related incidents can be compiled and submitted in one (1) incident report, which will allow the EDS Team to quickly identify, review and assess the issues.

- Protected Health Information (PHI) must not be submitted through the Incident Tracking Tool.

- Submitters are asked to provide the ICN and include in the description the line number and edit associated with the issue.
True Coordination of Benefits Submission - Institutional
True COB - Institutional

- TC05 – True Coordination of Benefits
  - MAOs and other entities must populate the DTP segment (Claim Check or Remittance Date)
  - The DTP segment will be included in the True COB Business Case in the next version release of the Companion Guide
True COB - Institutional

• TC05 – True Coordination of Benefits (cont’d.)
  – The following Institutional CEM edits have been temporarily deactivated to allow this test case to process through the EDS

<table>
<thead>
<tr>
<th>CEM Level Edit</th>
<th>Edit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X223.143.2300.CLM02.080</td>
<td>CSCC A7: &quot;Acknowledgement/Rejected for Invalid Information&quot;</td>
</tr>
<tr>
<td></td>
<td>CSC 400: &quot;Claim is out of Balance&quot;</td>
</tr>
<tr>
<td></td>
<td>CSC 672 &quot;Payer's payment information is out of balance&quot;</td>
</tr>
<tr>
<td>X223.424.2400.SV203.060</td>
<td>CSCC A7: &quot;Acknowledgement/Rejected for Invalid Information&quot;</td>
</tr>
<tr>
<td></td>
<td>CSC 400: &quot;Claim is out of balance:&quot;</td>
</tr>
<tr>
<td></td>
<td>CSC 583: &quot;Line Item Charge Amount&quot;</td>
</tr>
<tr>
<td></td>
<td>CSC 643: &quot;Service Line Paid Amount&quot;</td>
</tr>
</tbody>
</table>

– Once a permanent resolution is determined, CMS will provide additional guidance to MAOs and other entities, if required
Professional Production Data Submission
“Catch-up” Plan
Professional Production Data Submission “Catch-up” Plan

• MAOs and other entities are categorized by beneficiary membership volume as large, medium or small, as follows:

<table>
<thead>
<tr>
<th>Number of Medicare Enrollees</th>
<th>Category of MAOs and Other Entities</th>
<th>Number of MAOs and other entities in Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 100,000</td>
<td>Large</td>
<td>41</td>
</tr>
<tr>
<td>50,000 – 100,000</td>
<td>Medium</td>
<td>55</td>
</tr>
<tr>
<td>Less than 50,000</td>
<td>Small</td>
<td>655</td>
</tr>
</tbody>
</table>

• MAOs and other entities should begin submission of production data

• CMS is examining the production submissions to determine a viable catch-up plan
EDDPPS Edits
EDDPPS Edits

- CMS will distribute the Proposed Edits Comments tool and the list of proposed Encounter Data DME Processing and Pricing (EDDPPS) Edits to MAOs and other entities for review and comment.

- MAOs and other entities are asked to provide comments/feedback to the proposed EDDPPS edits no later than 5:00PM ET on June 13, 2012.

- CMS will analyze the comments and incorporate the updates in the final EDDPPS Edits documentation.
## Proposed EDDPPS Edits – Reject

<table>
<thead>
<tr>
<th>EDDPPS Edit#</th>
<th>EDDPPS Edit Category</th>
<th>EDDPPS Edit Disposition</th>
<th>EDIPPS Edit Error Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>00010</td>
<td>Validation</td>
<td>Reject</td>
<td>From Date of Service is Greater than TCN Date</td>
</tr>
<tr>
<td>00012</td>
<td>Validation</td>
<td>Reject</td>
<td>Date of Service Less Than 01.01.2012</td>
</tr>
<tr>
<td>00025</td>
<td>Validation</td>
<td>Reject</td>
<td>To Date of Service is After Date of Claim Receipt</td>
</tr>
<tr>
<td>00265</td>
<td>Validation</td>
<td>Reject</td>
<td>Adjustment or Void ICN Not Found in History</td>
</tr>
<tr>
<td>00699</td>
<td>Validation</td>
<td>Reject</td>
<td>Void Submission Must Match Original Encounter</td>
</tr>
<tr>
<td>00761</td>
<td>Validation</td>
<td>Reject</td>
<td>Unable to Void Due to Different Billing Provider on Void From Original</td>
</tr>
<tr>
<td>02110</td>
<td>Beneficiary</td>
<td>Reject</td>
<td>Beneficiary Health Insurance Carrier Number (HICN) Not on File</td>
</tr>
<tr>
<td>02112</td>
<td>Beneficiary</td>
<td>Reject</td>
<td>DOS is After Beneficiary Date of Death</td>
</tr>
</tbody>
</table>
## Proposed EDDPPS Edits – Reject

<table>
<thead>
<tr>
<th>EDDPPS Edit#</th>
<th>EDDPPS Edit Category</th>
<th>EDDPPS Edit Disposition</th>
<th>EDIPPS Edit Error Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>02125</td>
<td>Beneficiary</td>
<td>Reject</td>
<td>Beneficiary Date of Birth Mismatch</td>
</tr>
<tr>
<td>02240</td>
<td>Beneficiary</td>
<td>Reject</td>
<td>Beneficiary Not Enrolled in Medicare Advantage Organization for Date of Service</td>
</tr>
<tr>
<td>02255</td>
<td>Beneficiary</td>
<td>Reject</td>
<td>Beneficiary Not Part A Eligible for Date of Service</td>
</tr>
<tr>
<td>02256</td>
<td>Beneficiary</td>
<td>Reject</td>
<td>Beneficiary Not Part C Eligible for Date of Service</td>
</tr>
<tr>
<td>03101</td>
<td>Validation</td>
<td>Reject</td>
<td>Invalid Gender for Procedure Code</td>
</tr>
<tr>
<td>30055*</td>
<td>Validation</td>
<td>Reject</td>
<td>Duplicate Within Claim – Suppliers are Equal</td>
</tr>
<tr>
<td>31610*</td>
<td>Validation</td>
<td>Reject</td>
<td>Duplicate Billing for the Same HCPCS Code(s) on a Home Health Claim</td>
</tr>
<tr>
<td>98325</td>
<td>Duplicate</td>
<td>Reject</td>
<td>Claim is an Exact Duplicate of a Previously Priced Claim</td>
</tr>
</tbody>
</table>

* Denotes DME specific edits
# Proposed EDDPPS Edits - Informational

<table>
<thead>
<tr>
<th>EDDPPS Edit#</th>
<th>EDDPPS Edit Category</th>
<th>EDDPPS Edit Disposition</th>
<th>EDIPPS Edit Error Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>01045</td>
<td>Validation</td>
<td>Informational</td>
<td>Referring/Ordering Provider Name Mismatch</td>
</tr>
<tr>
<td>02106</td>
<td>Beneficiary</td>
<td>Informational</td>
<td>Invalid Beneficiary Last Name</td>
</tr>
<tr>
<td>02120</td>
<td>Beneficiary</td>
<td>Informational</td>
<td>Beneficiary Gender Mismatch</td>
</tr>
<tr>
<td>03015</td>
<td>Reference</td>
<td>Informational</td>
<td>DOS Spans Procedure Code Effective/End Date</td>
</tr>
<tr>
<td>30135*</td>
<td>Reference</td>
<td>Informational</td>
<td>Diagnosis – Gender Mismatch</td>
</tr>
<tr>
<td>30261*</td>
<td>Validation</td>
<td>Informational</td>
<td>Referring Physician NPI is Required</td>
</tr>
<tr>
<td>30262*</td>
<td>Validation</td>
<td>Informational</td>
<td>Invalid Modifier</td>
</tr>
<tr>
<td>31000*</td>
<td>Validation</td>
<td>Informational</td>
<td>Certain HCPCS Codes Require LT or RT Modifiers</td>
</tr>
<tr>
<td>31100*</td>
<td>Validation</td>
<td>Informational</td>
<td>Invalid Diagnosis Codes for Procedure Codes</td>
</tr>
<tr>
<td>31105*</td>
<td>Validation</td>
<td>Informational</td>
<td>Modifier AY and AX Combination is Invalid</td>
</tr>
<tr>
<td>31305*</td>
<td>Validation</td>
<td>Informational</td>
<td>DMEPOS Items With Service Dates That Overlap Inpatient Stay</td>
</tr>
<tr>
<td>31360*</td>
<td>Validation</td>
<td>Informational</td>
<td>IRP Item Rental Payments Can Not Exceed the Cost of the Item</td>
</tr>
<tr>
<td>31680*</td>
<td>Validation</td>
<td>Informational</td>
<td>All Claims Must Have a Diagnosis in the Detail Claim Line</td>
</tr>
</tbody>
</table>

* Denotes DME specific edits
DME Testing
DME Testing

- MAOs and other entities must be front-end certified in order to submit end-to-end test cases for DME encounter data.

- MAOs and other entities must achieve a 95% acceptance rate on all required test cases and receive notification of certification for DME end-to-end testing in order to submit production data.
DME Testing Guidance

CMS requires that DME test cases be submitted in **three (3) separate** files.

**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” Physician Services test case only (1 test case – 2 encounters)
- TC indicator in Loop 2300, CLM01 (e.g., CLM01=TC02)
- *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.*

**File 1 and File 2 must be completely accepted before submitting File 3.**

**File 1 and File 2 may be submitted simultaneously.**
# DME Test Cases Overview

<table>
<thead>
<tr>
<th>TC File #</th>
<th>Test Case / Script Title</th>
<th>Test Case / Script Identifier</th>
<th>Test Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>New MA Member</td>
<td>Beneficiary Eligibility</td>
<td>TC01</td>
</tr>
<tr>
<td>1</td>
<td>DMEPOS</td>
<td>Data Validation</td>
<td>TC03</td>
</tr>
<tr>
<td>1</td>
<td>Purchased DME</td>
<td>Pricing</td>
<td>TC04</td>
</tr>
<tr>
<td>1</td>
<td>Capped Rental</td>
<td>Pricing</td>
<td>TC05</td>
</tr>
<tr>
<td>1</td>
<td>Oxygen</td>
<td>Pricing</td>
<td>TC06</td>
</tr>
<tr>
<td>2</td>
<td>Incident to Physician Services</td>
<td>Data Validation</td>
<td>TC02</td>
</tr>
<tr>
<td>3</td>
<td>Duplicate</td>
<td>Processing</td>
<td>TC07</td>
</tr>
</tbody>
</table>
• TC01 – New MA Member
  – Submit a DME encounter for a new Medicare Advantage member enrolled in 2011 with an effective date in 2012
  – Include the DME Payer ID: 80887
• **TC03 – DMEPOS**
  - Submit a DMEPOS HCPCS code selected from the DME Fee schedule

• **TC04 – Purchased DME**
  - Submit a DMEPOS HCPCS code selected from the DME Fee schedule
  - Select any HCPCS code with a 1st Modifier code of ‘NU’
DME Test Cases – File 1

• TC05 – Capped Rental
  – Submit a DMEPOS HCPCS code selected from the DME Fee schedule Select any HCPCS code with the 1\textsuperscript{st} modifier code of ‘RR’ and category code of ‘CR’

• TC06 – Oxygen
  – Submit a DMEPOS HCPCS code selected from the DME Fee schedule
  – Select any HCPCS code with a category code of ‘OX’
DME Test Cases – File 2

• TC02 – “Incident to”
  – Submit a DME encounter incident to a physician or institutional service with a HCPCS code selected from the DME Fee schedule
  – Select any HCPCS code with a category ‘IN’ or ‘SD’ where there is no modifier listed on the spreadsheet
  – Include the Payer ID: 80881 or 80882

Note: This file must reject and will not count against the 95% encounter testing failure rate
DME Test Case – File 3

• TC07 – Duplicate

  – Submit a duplicate 837-P encounter accepted in File 1 to the EDFES with duplicate data in all of the following fields:

<table>
<thead>
<tr>
<th>Beneficiary HICN</th>
<th>Beneficiary Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service</td>
<td>Place of Service</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Procedure Code</td>
</tr>
<tr>
<td></td>
<td>(and 4 modifiers, as appropriate)</td>
</tr>
<tr>
<td>Rendering Provider NPI</td>
<td>Paid Amount</td>
</tr>
</tbody>
</table>
DME Test Cases

• The DME Test Case Specification document is located on the CSSC Operations website at:

• The DME Business Case Scenarios will be published in the upcoming DME Companion Guide
Questions & Answers
Resources

- Encounter Data Outreach Registration: www.tarsc.info
- CMS: www.cms.gov
- EDS Inbox: eds@ardx.net
Resources (cont’d)


• Washington Publishing Company: http://www.wpc-edi.com/content/view/817/1
REMINDER:

• The next User Group is scheduled for Thursday, June 21, 2012 from 3:00 PM – 4:00 PM ET
2012 Regional Technical Assistance

Registration Is Now Open!

August 6 – 9, 2012  Baltimore, MD

Las Vegas session is cancelled.

Attendance also available by live webcast.

Session Topics

Encounter Data  Risk Adjustment
Enrollment        Payment
Prescription Drug Event

Please remember to reserve your accommodations
Closing Remarks