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Center for Consumer Information and Insurance Oversight (CCIIO)

EDGE Server Business Rules

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1 Purpose

The External Data Gathering Environment (EDGE) Server Business Rules (ESBR) document supplements the EDGE server Interface Control Document (ICD) by providing EDGE server file processing rules to facilitate successful submission of enrollment, pharmacy claims, medical claims, and Supplemental Diagnosis Code files by issuers, Third Party Administrators (TPAs) and support vendors.

2 Overview

As part of the Patient Protection and Affordable Care Act (PPACA), two (2) programs, Risk Adjustment (RA) and Reinsurance (RI), mitigate the impact of adverse selection of plans and provide stability for issuers. States have the option to operate the RA and RI programs themselves or have the Department of Health and Human Services (HHS) operate the programs on their behalf.

- Section 1343 of the PPACA created the RA program to better spread the financial risk borne by health insurance issuers, in order to stabilize premiums and enable issuers to offer a variety of plans to meet the needs of a diverse population. Under the RA program, payments are transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered Individual and Small Group Market plans, irrespective of whether they are a part of the Exchange, submit risk adjustment data (claims and enrollment data) that is used to determine individual-level risk scores and plan average actuarial risk and associated payments and charges.
- Section 1341 of the PPACA established the RI program as a temporary three-year program starting in 2014. Reinsurance provides funds to issuers that incur high costs for claims in the Individual Market. In accordance with 45 CFR § 153.230, reinsurance payments are based on a coinsurance rate or proportion of an issuer's claims costs that are above an attachment point and below a reinsurance cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for reinsurance payments. The reinsurance cap is the dollar limit at which point an issuer is no longer eligible for reinsurance payments. The attachment point, coinsurance rate, and reinsurance cap are applied to an issuer's total costs for an individual enrollee in a given calendar year. Individual Market plans, irrespective of whether they are part of the Exchange, submit reinsurance data (claims and enrollment data) that is used to determine if an Individual Market plan issuer is eligible for reinsurance.

The Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf) grants HHS the authority to collect data from issuers when HHS is operating risk adjustment on behalf

of a state. The HHS Notice of Benefit and Payment Parameters for 2014 Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf) grants HHS the authority to collect data for reinsurance. HHS uses a distributed data collection approach to collect this data for both programs. The Centers for Medicare & Medicaid Services (CMS)/Center for Consumer Information and Insurance Oversight (CCIIO) implements the data collection approach for these HHS-operated programs. During initial evaluation of possible models, HHS determined that a distributed data collection model is most effective for the collection and processing of data received from issuers. Specifically, the distributed data collection model ensures all of the following:

- Issuer proprietary data remains resident within the issuer environment and not transmitted to CMS,
- Minimal transfer of protected health information (PHI) to decrease privacy and data security risks,
- Standardization of business processes, timing and rules.

Issuers in states where HHS operates an RA and/or RI program are required to submit enrollment, pharmaceutical claims and medical claim information on enrollees from issuers' proprietary systems to an issuer-distributed data collection server (also known as an EDGE server). An EDGE server runs HHS-developed software designed to verify submitted data, execute RA and RI processes and submit summary reports to CMS.

Issuers have the option to own, operate and maintain an EDGE server or have a TPA host an EDGE server. Issuers, or TPAs on their behalf, may establish either an Amazon Cloud EDGE server (AWS) or an EDGE server in their own environment (On-Premise server [OPS]). The technical specifications and details for these options are available through webinars. The presentation slides and other supporting documents are published in the Registration for Technical Assistance Portal (REGTAP) Library, available at https://www.regtap.info/. Under either option, issuers load the necessary software to perform file processing, risk adjustment and reinsurance. Required data elements are identified in the Interface Control Document (ICD), published in the REGTAP Library.

An EDGE server stores detailed claims, enrollment and Supplemental Diagnosis Code data, detailed file processing metrics, detail and summary reports and program calculation data. Only plan summarized data, file processing metrics and summary reports will be sent back to CMS. CMS uses the same data collection method for risk adjustment and reinsurance, thereby limiting the data collection burden on issuers or submitters on their behalf. The HHS Notice of Benefit and Payment Parameters for 2014, published on March 11, 2013, finalized the requirement (45 CFR § 153.700) that issuers must establish dedicated secure data environments (EDGE server) when HHS is operating either program on behalf of a State, for CMS to access claims and enrollment information and run CMS-developed software. In addition, the rule requires issuers to use a masked enrollee identification number when loading enrollee-level plan enrollment data, enrollee claims data and enrollee encounter data to issuers' EDGE servers (45 CFR § 153.720).

EDGE server issuers are required to retain all original data stored in their MySQL data tables for a period of 10 years. Additionally, in accordance with CFR § 153.620 of the Federal Regulation, three (3) years of data must be retained on an active EDGE server to comply with any risk adjustment or reinsurance program initiatives or activities identified by CMS, as needed.

3 Introduction to File Processing Business Rules

Table 1 provides a legend to the symbols and formatting used in this document.

Table 1: Legend of Symbols and Formatting

Symbol or Formatting	Significance
Italics	Indicates important information.
Bolded Blue	Indicates a data element present on the inbound submission file. Please see the ICD for data element descriptions along with technical field/element characteristics.
	Indicates an important rule. If this guidance is not followed, it may impact file ingest or calculations.
	Indicates information an issuer should note. Although the information may not impact file ingest or calculations, it requires attention.

This document guides issuers on the business rules that CMS applies to enrollment, pharmacy, medical claims, and Supplemental Diagnoses Code files submitted to an issuer's EDGE server, as well as recommendations for data management. These rules are not intended to change standard billing practices and issuer contractual arrangements with their providers who submit claims to issuers for payment processing. Issuers retain the right to develop and communicate with providers the policies and procedures that support the issuer's business needs for claim and enrollment processing.

Issuers should use this document as a reference guide to assist them with submitting medical and pharmacy claims, enrollment and supplement files to the EDGE server. Prior to submission to the EDGE server, issuers must modify some post-adjudication claim data to conform to requirements for data submission to the EDGE server. Issuers are permitted to modify claims extracted from their payment systems to meet EDGE submission requirements, but should retain traceability of such changes in the event of audit. Information about necessary modifications is provided throughout this document.

The ESBR document provides file processing business rules based on five (5) categories (general rules, enrollment, pharmacy claims, medical claims and supplemental diagnosis files). There is also a section on how plan data is loaded and

applied on the EDGE server and an overview of claim selection for the RA and RI program. Specific information about how calculations are performed for the RA and RI programs are not included in this document. Issuers should visit the REGTAP Library and review information found under the RA and RI program areas for program specific information.

Section 4: General File Processing

Section 4 describes the rules pertaining to all file types, including general processing rules, general verification rules and general rules that apply to each eXtensible Markup Language (XML) segment (i.e., header, issuer and plan) within a file.

Section 5: Enrollment File Processing Rules

Section 5 describes the rules for EDGE Server Enrollment Submission (ESES) file processing rules, including enrollment file term definitions, enrollment file specific rules that apply to each XML segment (i.e., header and issuer) within a file, enrollee/Subscriber ID dependencies and premium changes.

Section 6: Pharmacy File Processing

Section 6 describes the rules for EDGE Server Pharmacy Claim Submission (ESPCS) file processing, including pharmacy file term definitions, pharmacy file specific rules that apply to each XML segment (i.e., header, issuer and plan) within a file, duplicate checks, and voiding and replacing claims and derived amounts.

Section 7: Medical File Processing

Section 7 describes the rules for EDGE Server Medical Claim Submission (ESMCS) file processing, including medical file term definitions, medical file specific rules that apply to each XML segment (i.e., header, issuer and plan) within a file, duplicate checks with exceptions, voiding and replacing claims, derived amounts, processing institutional claims, including interim bills, late charges and mother/baby claims.

Section 8: Supplemental Diagnosis File Processing

Section 8 describes the rules for EDGE Server Supplemental Diagnosis File Submission (ESSFS) file processing, including definitions, file specific rules that apply to each XML segment (i.e., header, issuer and plan) within a file, duplicate checks, adds, deletes and voids.

Section 9: Plan Reference Data

Section 9 describes the rules for EDGE Server Plan Reference Data, including table definitions, data sources, data integration and identifying missing plan data.

Section 10: Risk Adjustment and Reinsurance Calculations

Section 10 provides reference material on how claims are selected by the RA and RI programs for calculations.

Section 11: Assistance with Business Rules

Section 11 identifies resources for additional assistance with file processing rules.

Appendices

Appendices provide revision details, terms and definitions, acronyms, examples for additional assistance with any file processing rules outlined within the ESBR and queries to identify missing plan data.

4 General File Processing

This section describes general file processing rules for enrollment, pharmacy claims, medical claims and Supplemental Diagnosis Code files.

Table 2 provides a legend to the symbols and formatting used in this document.

Table 2: Legend of Symbols and Formatting

Symbol or Formatting	Significance
Italics	Indicates important information.
Bolded Blue	Indicates a data element present on the inbound submission file. Please see the ICD for data element descriptions along with technical field/element characteristics.
	Indicates an important rule. If this guidance is not followed, it may impact file ingest or calculations.
	Indicates information an issuer should note. Although the information may not impact file ingest or calculations, it requires attention.

4.1 General File Structure – XML Levels

Files submitted and produced on the EDGE server are created in XML. Issuers are required to extract claims and enrollment data from their proprietary systems and convert that data into XML files prior to submission to the EDGE server. Outbound files will also be sent to issuers in XML. XML files are segmented by levels of data. This document refers to these levels as header level, issuer level, plan level, enrollee level, enrollment period level, pharmacy claim level, medical header claim level, and medical claim line level.

All files have a header and issuer level. Table 3 identifies all applicable levels and the corresponding file type to which they apply. An ‘X’ indicates the level is required for that file type.

Table 3: XML Levels by File Types

Level	All Files	Enrollee File	Pharmacy Claims File	Medical Claims File	Supplemental Diagnosis File
Header	X	X	X	X	X
Issuer	X	X	X	X	X
Plan			X	X	X
Enrollee		X			
Enrollment Period		X			
Pharmacy Claim			X		
Medical Claim Header				X	
Medical Claim Line				X	
Supplemental Diagnosis File Detail Record					X

4.2 General File Processing Definitions

See Appendix B: Terms and Definitions for enrollee file definitions.

4.3 General File Processing Rules

Once an EDGE server is registered and provisioned, issuers will need to utilize an extract, transform and load (ETL) process to prepare and submit files. Issuers should extract the necessary data elements from their proprietary systems, transform those elements into an XML, and load the file either through the EDGE server user interface (UI) or via a secure file transfer protocol (SFTP), as outlined in the EDGE server ICD and in accordance with the business rules outlined within this document.

4.3.1 EDGE Zones

The EDGE server includes three (3) zones: test, validation and production. Table 4 describes the differences in these zones and the appropriate use of each.

Table 4: Processing Zone Descriptions

Processing Zone	Description
Production Zone	• The production zone is where enrollment, pharmacy claims, medical claims, and supplemental diagnosis data will be submitted, verified, and stored for the RA and RI programs. • Only data submitted to the production zone is used to produce reports used by CMS to perform RA payments and charges and RI payments. • The production zone is not intended to be used for issuers to test their submission processes. Issuers should only submit data to the production zone that they feel is accurate, at the time of submission, for program calculations. • The production zone is blacked out, meaning no data can be submitted, at the end of business ET (Eastern Time) on April 30th, or the first business day thereafter. The blackout is lifted after final reports are produced and delivered to issuers.
Test Zone	• The test zone tables and software are identical to the production zone and therefore will produce the same results as data submitted to the production zone. • The test zone is available for issuers to test files *prior* to data submission to the production zone. CMS encourages issuers to submit their files to the test zone and evaluate the results of the detail reports to limit the amount of rework necessary once data is submitted to production. • CMS does not receive summary data from the test zone and will not use any program-specific reports produced in this zone. • The test zone is available for issuers during the production blackout period to test new data files with one (1) notable limitation: o Once the production blackout is in effect, issuers cannot submit claim data to the test zone for a benefit year that has closed or is in the process of being finalized. • Issuers may submit enrollment for prior years, cross-year claims where the statement coverage end date is in the new benefit year, and supplemental records associated with claims for the new benefit year.
Validation Zone	• The validation zone is a pre-test and pre-production zone for CMS to deploy new software versions for data processing, RA and RI calculations, changes in table structures, updates to reference data and new or updated reports. • The validation zone is intended for issuers to utilize, *upon the direction of CMS*, to test upcoming releases prior to deployment to the test and production zones, which only house the current software version and table structures. • CMS will initially select a group of “beta” testers to conduct testing on changes deployed to the validation zone. Once the beta testers have confirmed the accuracy of the release, all issuers will be permitted to utilize the validation zone for testing. CMS will communicate the timing of these activities prior to each release.

4.3.2 Timely Data Submission and Data Integrity

Issuers must submit files to the production zone no less than quarterly. CMS recommends monthly submissions, but issuers have the option to submit as frequently as their business requires.

Each benefit year, CMS publishes deadlines and other important dates related to EDGE server data submission, command deployment and maintenance updates. Issuers should refer to this published guidance in the REGTAP Library at https://www.regtap.info/.

CMS requires that issuers submit complete and accurate data to the EDGE server. The test and validation zones allow issuers to validate that their data extract and submission process works correctly prior to submitting data to the production zone on the EDGE server. Issuers should thoroughly test their ETL process and review the outbound error file reports to identify and correct any issues in their submission process.



Note: Issuers should submit all final claims, Supplemental Diagnosis Codes and enrollment data, as well as corrections to any data records, by April 30th following the applicable benefit year, or if the April 30th deadline falls on a weekend, the following business day. Additional data and corrections to previously submitted and rejected records *will not* be accepted after this date. Issuers will be required to certify the accuracy of data submission after the submission window closes for the applicable benefit year.

4.3.3 EDGE Server File Ingest Processing

This section explains how the EDGE server verifies files once a file is submitted for processing.

Table 5 identifies the steps the EDGE server takes to verify and process files.

Table 5: EDGE Server Verification and Processing Steps

#	Step
1	The EDGE server verifies that the basic structure and elements are present upon submission, as outlined in Section 4.4. • This first verification step determines if the file can proceed to header level verification. • Once a file passes the file type verification process, the EDGE server assigns a Job ID. • If the file does not pass, no Job ID will be created and the issuer will receive a System Error (SE) report.

#	Step
2	Once the file structure is verified, the file moves to header level verification. • A file that passes all header level verifications is archived and continues through the process. • A file that fails any header level verification is not archived and is rejected. • For every file submitted, an EDGE Server File Accept Reject (ESFAR) Report is produced, indicating whether the file header passed or failed.
3	Files that pass header level verifications continue processing through each subsequent XML segment. • At each segment of the XML, the EDGE server confirms required fields, performs face validity, validates and applies logical edits. • The EDGE server stores accepted data for use in future processing, and maintains a minimum number of data elements associated with the rejected records in order to communicate the error.
4	After a file has completed processing, the EDGE server produces outbound XML files and sends them to the issuer and to CMS. • Outbound XML files, sent to issuers, include both a detailed report of accepted and rejected records and a summary report of counts for each file submitted. Outbound reports can be found in the ICD, available on REGTAP (https://www.regtap.info/). • CMS receives outbound data files, which are limited to aggregated, summarized data. No individual enrollee level RA or RI data is provided to CMS. • *Accepted records are the only records eligible for RA and RI program-specific calculations. Therefore, it is important for issuers to review and reconcile their rejected record reports on a regular basis and resubmit corrections timely and as needed.*

Table 6 identifies the general rules for the submission and replacement of enrollment, pharmacy, medical and supplemental diagnosis files.

Table 6: General File Submission and Replacement Rules

#	Rule	Notes
1	All enrollment, pharmacy, medical and supplemental files should include enrollees in the Individual and Small Group Market, both inside and outside the Exchange.	N/A
2	Issuers must submit enrollment and claim files no less than quarterly. Enrollment files are full replacement file submissions. Pharmacy claims, medical claims and supplemental diagnosis files are incremental file submissions.	CMS recommends issuers submit enrollment files monthly.

4.4 File Type Verification Rules

All files submitted to an EDGE server must pass a file verification process. Table 7 identifies the four (4) rules that must be met for a file to move to file processing.

Table 7: File Type Verification Rules

#	Rule	Notes
1	The file must be in XML.	Any other file type submitted to the EDGE server will be rejected.
2	The file must include an acceptable file type at the file header level. Valid file types include: • E = Enrollment • P = Pharmacy • M = Medical • S = Supplemental Diagnosis	Any other file type submitted will result in the entire file being rejected.
3	The file must include an acceptable Execution Zone. Valid Execution Zones include: • T = Test • V = Validation • P = Production	Any other file Execution Zone submitted will result in the entire file being rejected.
4	A file that fails as the result of an issuer's EDGE server technical limitation (for example, processing speed or size) will also be rejected.	N/A

4.5 Verification Edits – Required, Face Validity, Reference and Logical

All data elements included on submitted enrollment, pharmacy claims, medical claims and supplemental diagnosis XML files undergo verification edits. Table 8 identifies the verification edits for each data element. See the ICD for specific verification edits applied to each data element.

Table 8: Verification Edits

Data Element	Verification Edits
XML Data Tag Requirement	All XML data element tags are required. Population of specific data within the data tag is optional for some data elements (such as Subscriber ID and claim modifiers). Refer to the ICD to determine the requirements for each data element.

Data Element	Verification Edits
Required/ Situational/Not Required	• Required – Verifies that a data value, other than a null value, is included with the data tag. • Situational – Verifies that under the specified conditions, a data value, other than a null value, is included with the data tag. • Not Required – No verification. A null value may be used with the submitted data tag. Please see the ICD for specific edits.
Face Validity	Verifies that the data element conforms to the specified data type and restrictions. Please see the ICD for specific edits.
Referential Check	Verifies that the data element value matches a value in the common reference data table set. Please see the ICD for specific edits.
Logical Check	Verifies that the data value meets the defined business logic. Please see the ICD, and sections throughout this document, for specific edits and requirements.

File processing on an EDGE server is designed to evaluate as many data elements as possible before rejecting a file or record. Verification edits are performed in two (2) stages:

1. Required and face validity verifications
2. Referential and logical checks

Without required and face validity verifications, referential and logical verifications cannot be conducted.

All data elements proceed through required and face validity verifications. The EDGE server applies a status of accept or reject to each data element. Table 9 identifies verification edit rules.

Table 9: Verification Edit Rules

#	Rule	Notes
1	Any data element that fails the required or face validity verification step will not proceed to the referential and logical checks.	N/A
2	Data elements that pass the required and face validity verification step will proceed to the referential and logical checks.	N/A
3	Outbound data files will include the specific reject code(s) and description(s) for each data element that failed verification.	N/A

A list of Error Codes (i.e., reject codes) and descriptions are posted in the REGTAP Library.

This list will be updated periodically as file processing edits are updated. Issuers will receive notification of any changes through the REGTAP system and the Release Management process.



Note: Table 10 is an abridged version of the header level verifications, as listed in the ICD. Review the full table in the ICD for all data elements for each file type and the applicable verifications.

Table 10: Verifications for the Header Level

XML Element Names	Business Data Element	Required/ Situational/Not Required	Face Validity	Referential Check	Logical Checks
fileIdentifier	File ID	Required	N	Y	Y (if a file is accepted, each **File ID** must be unique within an execution zone)
executionZoneCode	Execution Zone	Required	Y	N	N
submissionTypeCode	Report Type	Required	N	Y	N

4.6 Header Level Rules for Enrollment, Pharmacy, Medical and Supplemental Diagnosis Files

All file types (EDGE Server Enrollment Submission, EDGE Server Pharmacy Claims Submission, EDGE Server Medical Claims Submission and EDGE Server Supplemental File Submission files) include a file header. The specific data elements, definitions and processing rules are outlined in the ICD. Table 11 identifies header level rules.

Table 11: Header Level Rules for All File Types

#	Rule	Notes
1	Data elements at the header level must pass *all* verifications for the file to be archived and to proceed to the next level of verification.	N/A
2	If *any* data element fails any header level data element verification, the file will be rejected and will not be saved.	N/A

#	Rule	Notes
3	**File IDs** must be unique to each file submitted. Duplicate **File IDs** will be rejected. • A duplicate **File ID** is an identical **File ID** previously submitted and accepted *to the same execution zone*. • If a file was rejected, the same **File ID** can be reused.	N/A
4	The final status of the header level verification will be communicated to the submitter through an outbound ESFAR file.	N/A
5 	The **Allowed Amount** reported at the header must be greater than $0. • Under regulation, issuers must not submit denied claims. The EDGE server software identifies a $0 **Allowed Amount** as a denied claim and will therefore reject claims with a $0 **Allowed Amount**.	Please see Section 6.9 and Section 7.14 for more information.

Please see Section 5.3, Section 6.3, Section 7.6, and Section 8.5 for verification rules for data elements in the header level relevant to ESES, ESPCS, ESMCS and ESSFS files, respectively.

All file types (ESES, ESPCS, ESMCS and ESSFS files) include **Record IDs**, which begin at the issuer level of the XML.

A **Record ID** is defined as a unique identifier for each record (i.e., XML element 'recordIdentifier') in a submitted file. Table 12 identifies **Record ID** rules.

Table 12: Record ID Rules for All File Types

#	Rule	Notes
1	**Record IDs** begin at the issuer level and must continue sequentially throughout each subsequent level of the file.	N/A
2	**Record IDs** must be in ascending order, with each subsequent record being one (1) greater than the preceding **Record ID**, regardless of the level in the file.	If **Record IDs** are not contiguous and sequential, the file will be rejected.
3	The count of the number of records is compared to the last **Record ID** in the file.	N/A
4	If the count of the number of records does not equal the reported count at the header level, then the file is rejected.	N/A

Please see the XML samples published in the REGTAP Library for **Record ID** sequencing.

4.7 Issuer Level Verification Rules

All file types (ESES, ESPCS, ESMCS, and ESSFS files) must include an issuer level. All issuer level data elements are defined in the ICD.

An **Issuer ID** is a unique identifier for an insurance issuer assigned through the Health Insurance Oversight System (HIOS). Table 13 identifies issuer level rules.

Table 13: Issuer Level Rules for All File Types

#	Rule	Notes
1	Each file may contain only one (1) **Issuer ID**.	N/A
2	An issuer record that passes required and referential checks will only be rejected if a subsequent level in the file completely fails verification.	For example, the subsequent level, to the issuer level, in an enrollment file is the enrollee level. If all enrollees fail for a given issuer, then the issuer record will be rejected.

Please see Section 5.3, Section 6.3, Section 7.6, and Section 8.5 for enrollment, pharmacy, medical claims and supplemental diagnosis files data elements rules at the issuer level.

4.8 Plan Level Verification Rules

Only pharmacy, medical claims and supplemental diagnosis files include a plan level. These rules apply only to those file types. All plan level data elements are defined in the ICD.

A **Plan ID** is a 16-digit unique identifier for an insurance plan offered by an issuer, either on or off the Exchange, under which an insured enrollee is covered. The **Plan ID** is issued through HIOS. Table 14 identifies plan level rules.

Table 14: Plan Level Rules for Pharmacy, Medical and Supplemental Files

#	Rule	Notes
1	Each pharmacy, medical claim and supplemental diagnosis file must contain at least one (1) plan, but may contain more than one (1) plan.	N/A
2	Plans are restricted to non-grandfathered, Small Group and Individual Market plans, both inside and outside the Exchange.	Plans outside the Small Group and Individual Market will be rejected.
3	A plan that passes the required and referential checks will only be rejected if a subsequent level completely fails verification.	For example, in a pharmacy and medical claim file, the claim level follows the plan level. If all claims fail for a given plan, the plan record will be rejected.

Please see Section 6.3, Section 7.6, and Section 8.5 for pharmacy claims, medical claims and supplemental diagnosis files data elements rules at the plan level.

5 Enrollment File Processing Rules

This section defines enrollment file processing rules. An enrollment file contains four (4) levels of data: header, issuer, enrollment and enrollment period. Please see the ICD for specific required formatting, reference and logical verifications of enrollment XML files.

Table 15 provides a legend to the symbols and formatting used in this document.

Table 15: Legend of Symbols and Formatting

Symbol or Formatting	Significance
Italics	Indicates important information.
Bolded Blue	Indicates a data element present on the inbound submission file. Please see the ICD for data element descriptions along with technical field/element characteristics.
	Indicates an important rule. If this guidance is not followed, it may impact file ingest or calculations.
	Indicates information an issuer should note. Although the information may not impact file ingest or calculations, it requires attention.

5.1 Enrollee File Definitions

See Appendix B: Terms and Definitions for enrollee file definitions.

5.2 General Enrollment File Processing Rules

This section describes enrollment file requirements and general processing rules.

According to 45 CFR § 153.700, enrollment files must be submitted quarterly. Issuers must continue to submit the prior year's enrollment data until CMS releases official notification to cease such submissions. In addition, each benefit year, CMS publishes baseline and submission deadlines in order to monitor and evaluate all issuers' enrollment and claims data submissions. Issuers will receive notifications of enrollment submission and submission deadlines through the REGTAP portal at https://www.regtap.info/.

Table 16 identifies rules for enrollment file processing.

Table 16: Enrollment File Processing

#	Rule	Notes
1	The initial enrollment file must be a cumulative file of all enrollees and enrollment periods.	Initial records that successfully pass all verifications at the enrollee and enrollment period level will be stored as "active" in an enrollment data table.
2	Issuers must submit at least two (2) years of enrollment records for each enrollee every benefit year.	Prior benefit year enrollment is necessary for the inclusion of cross year claims. Issuers may stop submitting enrollment that is two (2) years before the current benefit year. For example, while 2017 data is being submitted, issuers must submit 2016 and 2017 data but may stop submitting 2015 data.
3 	Subsequent enrollment file submissions must be a *complete replacement file* inclusive of all enrollees and enrollment periods. Each new enrollment file submission will result in the inactivation of all previously submitted records and storage of all newly submitted and accepted records.	Inactive enrollment records are not included in RA or RI calculations.
4	Do not submit duplicate Enrollee IDs.	A duplicate enrollee is when the same **Unique Enrollee ID** is reported at the enrollee level by a single issuer multiple times on a single enrollment file submission. Only the first **Unique Enrollee ID** will proceed to verification for acceptance or rejection. All subsequent records with the same **Unique Enrollee ID** will be rejected.
5	Submit unique enrollment period records to represent multiple plan enrollments for a single **Unique Enrollee ID**.	See examples in this section on multiple enrollment periods.
6 	Subscriber records must be submitted and accepted for an associated non-subscriber/dependent record to be accepted.	Rejection or non-submission of a subscriber record will result in a rejection of the non-subscriber/dependent record. See Section 5.4.

#	Rule	Notes
7 	Submit an enrollment period with either an initial issuance or renewal Enrollment Period Activity Indicator (EPAI) code for each enrollee *every benefit year*.	Enrollee records must include at least one (1) initial or renewal enrollment period record *for each benefit year* to ensure accuracy of risk adjustment calculations. Enrollment periods may be submitted as a calendar year (January – December) or may cross a calendar year (July – June), but in either case, the enrollment period must also include an EPAI that indicates an initial or renewal. See Section 5.6, Table 26, for EPAI rules.



Note: Issuers should *not* create a *single enrollment period for each month of annual enrollment coverage*. Creating a unique monthly enrollment period for each month of enrollment significantly increases processing time of inbound and outbound files, and increases required storage space by issuers.

5.2.1 Enrollment Start and End Dates

Enrollment Start and End Dates are reported at the enrollment period level. To prevent enrollment file failures or processing delays, issuers should not submit open-ended **Enrollment End Dates**.

Table 17 identifies rules for coverage start and end dates.

Table 17: Enrollment Start and End Dates

#	Rule	Notes
1	Submit at least one (1) enrollment period for each enrollee with either an **Enrollment Start Date** or an **Enrollment End Date** in the *current benefit year* and an EPAI of 021028 or 021041.	If there is not at least one (1) day of coverage with an EPAI of 021028 or 021041 in a benefit year, RA calculations may be affected as rerating of the enrollee will not occur. See Section 5.6, Table 26, for EPAI rules.
2	The **Plan ID** in the plan reference table must have a market year equal to the year of the **Enrollment Start Date**.	The year of the **Enrollment Start Date** is verified against the market year in the plan reference table.

#	Rule	Notes
3	Do not submit an **Enrollment End Date** that exceeds 10 years from the earliest **Enrollment Start Date**.	A large number of coverage years at the enrollment period level may cause file failure. Outbound summary reports will only produce counts for the current year and two (2) years prior.
4	If there is no **Enrollment End Date** for an enrollee, use the date the premium period ends as the **Enrollment End Date**.	N/A
5	If the **Enrollment Start or End Date** is outside the effective start and end dates of the plan, in the plan reference table, the enrollment record will be accepted.	**Enrollment End Dates** are verified against the plan reference table. When either enrollment coverage date is outside the effective start or end date of the plan, in the plan reference table, the outbound detail report will include informational code 6.5.23. However, the code is only a notification. *Enrollment Start and End Dates do not need to be modified and resubmitted*.

Note: If an issuer submits an enrollment period that begins in a prior benefit year (i.e. July 1, 2016) and ends with a year beyond the current benefit year (i.e., December 31, 2018) there will be no unique enrollment periods for the current benefit year (i.e. 2017). As a result, the enrollee *will not* be included in the Enrollee Claims Summary (ECS) Report. However, the enrollee and the associated claims, *will* be included in both RA risk score and transfer calculations.

5.2.2 Enrollee File Dependencies

The enrollment period level follows the enrollee level in the XML data file. An enrollee cannot be accepted unless all enrollment periods pass all verifications.

Table 18 identifies rules for enrollee file dependencies.

Table 18: Enrollee File Dependencies

#	Rule	Notes
1	Verification failures at the enrollee level will preclude further verifications at the enrollment period level for that enrollee.	If any data element fails verification at the enrollee level, no further verification edits are performed for the enrollee or associated enrollment periods. The enrollee record and all associated enrollment periods for that enrollee will be rejected. The system will continue processing the next enrollee in the file.
2	Verification failures of one (1) or more enrollment period(s), will result in the rejection of all of the enrollment periods as well as the enrollee's record.	N/A

The EDGE server accepts and stores all enrollees and enrollment periods that pass all verification edits in an enrollment data table as active records.

Table 19 identifies rules for enrollees no longer included on submission files.

Table 19: Enrollees No Longer Included on Submission Files

#	Rule	Notes
1	Do not remove enrollees from the enrollment file who had at least one (1) day of enrollment coverage in the benefit year.	An enrollee or associated enrollment period that is no longer included on a newly submitted enrollment file will be inactivated in the enrollment table. Inactivated enrollee records will no longer be eligible for consideration in the RA or RI programs.

5.3 Header and Issuer Level Rules Specific to Enrollment Files

Two (2) of the data elements at the header and issuer level must pass a required logical check verification for enrollment file processing to continue. Issuers must follow these rules at both the header and issuer level.

Table 20 identifies the total verifications rules for both header level and issuer level.

Table 20: Header and Issuer Level Total Verifications

#	Rule	Notes
1	The **Total Number of Enrollee Records** reported at the header and issuer level must equal the count of the total enrollee records on the file.	If the reported value at the header and issuer level does not match the total count in the file, the file will be rejected.

#	Rule	Notes
2	The **Total Number of Enrollment Period Records** reported at the header and issuer level must equal the count of the total enrollment period records on the file.	If the reported value at the header and issuer level does not match the total count in the file, the file will be rejected.

5.4 Subscriber and Non-Subscriber/Dependent Requirements

A **Unique Enrollee ID** can be designated as a subscriber or a non-subscriber/dependent with an associated subscriber, in the enrollment file.



Note: A **Unique Enrollee ID** may have one (1) or more designations (subscriber or non-subscriber/dependent), as long as each designation is reported on a unique enrollment period.

5.4.1 Subscriber Requirements

Table 21 identifies the rules for a **Unique Enrollee ID** identified as a subscriber.

Table 21: Subscriber Requirements

#	Rule	Notes
1	A subscriber record must include in the enrollment period: • An "S" for the **Subscriber Indicator** • No value for the **Subscriber ID** • The subscriber's *monthly* **Premium Amount**	A subscriber is not necessarily the party who paid the premium.
2 	If no parent or guardian is enrolled and one (1) or more child is enrolled in a plan, one (1) child must be designated as the subscriber and the other child (or children) as the non-subscriber/dependent(s).	A subscriber does not need to be a parent or guardian if the parent or guardian is not enrolled in the plan.
3	Only report premiums on the enrollment record for the subscriber and where the "S" is included in the **Subscriber Indicator** field. If the enrollment period is greater than or equal to 30 days, report a **Premium Amount** greater than $0.00.	See Section 5.8 for information about premium reporting.

Example

In Figure 1, Unique Enrollee ID B33h97 is reported as the subscriber with a monthly premium. Note the "S" in the Subscriber Indicator field.

Figure 1: Subscriber Requirements Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
23	B33h97	1968-01-17	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
24	S		21890KY001000104	2014-01-01	2014-12-31	355.00	003

5.4.2 Non-Subscriber/Dependent Requirements

Table 22 identifies the rules for a **Unique Enrollee ID** identified as a non-subscriber/dependent.

Table 22: Non-Subscriber/Dependent Requirements

#	Rule	Notes
1	A non-subscriber/dependent must be linked with another enrollee identified in the file as the subscriber.	If the subscriber is not included in the enrollment file, or fails verification and is rejected, the associated non-subscriber(s)/dependent(s) will also be rejected.
2	A **Subscriber ID** populated on the enrollment period indicates the enrollee is a non-subscriber/dependent. The **Subscriber Indicator** must be **null** and the Premium Amount must be submitted as zero (0).	The **Subscriber ID** indicates the **Unique Enrollee ID** with whom the non-subscriber/dependent is affiliated under the same plan.
3	A non-subscriber/dependent enrollment period must include: • **Enrollment Start Dates** and **Enrollment End Dates** within the subscriber's enrollment start and end dates. • The same 16-digit **Plan ID** as the subscriber. • The same **Rating Area** as the subscriber.	N/A
4	The **Enrollment Start Date** for a renewal (EPAI 021041) of a dependent **must match** the **Enrollment Start Date** of the associated subscriber renewal (EPAI 021041) enrollment period record.	See Section 5.6, Table 26, for EPAI rules.

Example

In Figure 2, **Unique Enrollee ID** J900w1 is a child reported as the subscriber. Their sibling, J900w2, is reported as the non-subscriber/dependent. Note the "S" in the Subscriber Indicator field for the subscriber J900w1. For J900w2, the Subscriber ID is populated with J900w1, as the subscriber, and the Subscriber Indicator is blank.

Figure 2: Non-Subscriber Requirements Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
4000	J900w1	2010-02-03	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
4001	S		60640IL003000101	2014-01-01	2014-12-31	355.00	001

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
4002	J900w2	2012-09-01	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
4003		J900w1	60640IL003000101	2014-06-01	2014-12-31	0.00	001

5.5 Enrollees Covered Under Multiple Plans

The following sections identify rules for enrollees who are covered under more than one (1) plan for the same time period. These enrollees are referred to as dual coverage throughout this section.

An enrollee with dual coverage *in the same 16-digit plan* will not be accepted if submitted as two (2) enrollment periods that overlap. See Section 5.5.3 for instructions on how to submit this type of dual coverage for enrollees in an off-Exchange plan.

The following dual coverage scenarios may be submitted with two (2) overlapping enrollment periods:

1. Coverage in two (2) different 16-digit plans for the same period of time, either partial or whole coverage.

   Section 5.5.2 outlines the rules for submission of dual coverage in different plans.

2. An enrollee that is both a subscriber and non-subscriber/dependent under the same 16-digit plan for the same period of time, in whole or in part.

3. A non-subscriber/dependent enrollee that is enrolled under two (2) different enrollee **Subscriber IDs** in the same plan for the same period of time, in whole or in part.

   Section 5.5.3 outlines the rules for submission of Scenarios 2 and 3 above for dual coverage in the same plan.

5.5.1 Exchange Rules Regarding Dual Coverage in the Same Plan

The following subsections describe exchange rules regarding dual coverage in the same plan.

5.5.1.1 Overlapping Coverage in a Federally-Facilitated Exchange (FFE) or State-based Exchange (SBE) Plan

Individuals enrolled in a plan offered on the Exchange, either FFE or SBE, cannot be enrolled in the same plan for overlapping enrollment periods. *Issuers who have received 834 transactions where an individual has overlapping coverage must resolve the discrepancy.*

5.5.1.2 Overlapping Coverage in an Off-Exchange Plan

Individuals enrolled in plans offered outside of the Exchange may be enrolled in the same plan for overlapping enrollment periods. See Section 5.5.3 for submission requirements for off-Exchange enrollees who have dual coverage in the same plan.

5.5.2 Dual Coverage with Overlapping Enrollment in Different Plans

Table 23 identifies the rules for overlapping enrollment periods in different plans.

Table 23: Overlapping Enrollment Periods in Different Plans

#	Rule	Notes
1	If an enrollment file contains two (2) enrollment periods, for the same **Unique Enrollee ID** with different **Plan IDs** that overlap, both enrollment periods will be accepted if they pass all enrollment period verifications.	N/A

Examples

In Figure 3, **Unique Enrollee ID** A3pw88R is enrolled as a subscriber in two (2) different plans with overlapping enrollment periods. The EDGE server will accept this submission.

Figure 3: Overlapping Enrollment Periods with Different Plan IDs Example 1

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
1104	A3pw88R	1955-04-11	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
1105	S		21890KY001000104	2014-01-01	2014-12-31	355.00	003
1106	S		30412KY007000103	2014-06-01	2014-12-31	275.00	003

In Figure 4, **Unique Enrollee ID** Z98uTT0p is a subscriber in one (1) plan and a non-subscriber/dependent of subscriber Enrollee 3JeR77ym in another plan with overlapping enrollment periods. The EDGE server will accept this submission.

Figure 4: Overlapping Enrollment Periods with Different Plan IDs Example 2

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
1104	Z98uTT0p	1955-04-11	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
1105	S		55121AL001000100	2014-01-01	2014-12-31	410.00	001
1106		3JeR77ym	56931AL002000101	2014-04-01	2014-12-31	0.00	001

5.5.3 Dual Coverage with Overlapping Enrollment in the Same Plan

Table 24 identifies the rules for overlapping enrollment periods for enrollees in the same plan.

Table 24: Overlapping Enrollment Periods in the Same Plan

#	Rule	Notes
1	An enrollee in an FFE or SBE on-Exchange plan *must not* be submitted with two (2) overlapping enrollment periods in the same 16-digit plan.	See Figure 5 for an example of this rule. If an enrollee has two (2) enrollment periods in the *same 16-digit plan*, and those enrollment periods overlap, both enrollment periods and the enrollee record will be rejected.
2	An enrollee in an off-Exchange plan with two (2) overlapping enrollment periods in the same 16-digit plan must be submitted as follows: • One (1) enrollment period for the time prior to the overlapping coverage o If a subscriber, report the *monthly* premium. • One (1) enrollment period for the time of the overlapping coverage o If a subscriber, report the *combined monthly* premium for the overlapping coverage. • One (1) enrollment period for the time after the overlapping coverage o If a subscriber, report the *monthly* premium.	See Figure 6 for an example of this rule. If an off-Exchange enrollee has two (2) enrollment periods in the *same 16-digit plan*, and the enrollment periods are not submitted as indicated, both enrollment periods and the enrollee record will be rejected.
3	If an individual enrollee is both a subscriber and non-subscriber/dependent, then: • Submit the enrollee as a subscriber in one (1) enrollment period and • Submit the enrollee as a non-subscriber/dependent in the second enrollment period.	See Figure 7 for an example of this rule. See Section 7.9 for information on submission of claims for enrollees who are both a subscriber and non-subscriber/dependent. *Claims must be combined.*
4	If an individual enrollee is a non-subscriber/dependent covered under two (2) different enrollee subscribers, then submit one (1) enrollment period for each subscriber to which the non-subscriber/dependent is linked.	See Figure 8 for an example of this rule.

Examples

In Figure 5, **Unique Enrollee ID** M11Kd04 is listed twice as a subscriber in the same plan with overlapping enrollment periods. The EDGE server will reject both the enrollment periods and the enrollee.

Figure 5: Overlapping Enrollment Periods in the Same Plan Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
8054	M11Kd04	1977-07-20	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
8055	S		21890KY001000104	2014-01-01	2014-12-31	355.00	003
8056	S		21890KY001000104	2014-06-01	2014-12-31	275.00	003

Return to Overlapping Enrollment Periods in the Same Plan rules.

In Figure 6, **Unique Enrollee ID** J2ee9R is enrolled in Plan 60640IL007000100 from 1/1 to 6/30 and from 5/1 to 8/30. They have been charged a $500 premium for each enrollment. In this example, Record 926 shows the overlapping period where the premium charged is the total combined amount for both enrollments.

Figure 6: Overlapping Coverage in an Off-Exchange Plan Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
924	J2ee9R	1964-08-01	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
925	S		60640IL007000100	2014-01-01	2014-04-30	500.00	001
926	S		60640IL007000100	2014-05-01	2014-06-30	1000.00	001
927	S		60640IL007000100	2014-07-01	2014-08-30	500.00	001

Return to Overlapping Enrollment Periods in the Same Plan rules.

In Figure 7, **Unique Enrollee ID** 4KhhT93 is both a subscriber and a non-subscriber/dependent of Subscriber B5Yen67.

Figure 7: Dual Coverage, Both a Subscriber and Non-Subscriber/Dependent Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
1104	4KhhT93	1945-08-21	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
1105	S		55121AL001000100	2014-01-01	2014-12-31	410.00	001
1106		B5Yen67	55121AL001000100	2014-04-01	2014-12-31	0.00	001

Return to Overlapping Enrollment Periods in the Same Plan rules.

In Figure 8, **Unique Enrollee ID** Rj001mq8 is a non-subscriber/dependent of both Subscribers Jtn11xR and W4jb509.

Figure 8: Dual Coverage Under Two Different Subscribers Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
648131	Rj001mq8	2000-02-04	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
648132		Jtn11xR	74005KS005000703	2014-01-01	2014-12-31	0.00	001
648133		W4bj509	74005KS005000703	2014-04-01	2014-12-31	0.00	001

Return to Overlapping Enrollment Periods in the Same Plan rules.

5.6 Enrollment Period Activity Indicators

The **Enrollment Period Activity Indicator** (EPAI) tracks enrollment changes pertinent to RA. To appropriately calculate the RA transfers, CMS requires each enrollee's age at the time of initial policy issuance and policy renewal to determine the allowable rating factor (ARF). Although the **Enrollment Period Activity Indicator** codes CMS uses for EDGE server enrollment files are also used for the 834 enrollment transaction, the 834 enrollment and maintenance process is separate from the EDGE server enrollment file.

Note: Issuers must submit an enrollment period with either an initial issuance (i.e., 021028) or renewal (i.e., 021041) EPAI code for each enrollee *every benefit year*. CMS also requires information about other enrollment changes to calculate the correct enrollee inputs at the Rating Area level for RA transfers.

CMS uses four (4) EPAI codes to capture information pertinent to RA. Table 25 describes EPAI codes. Table 26 identifies the rules for successful submission of EPAI codes. Issuers must use EPAI codes as described to submit enrollment data appropriately for RA calculations.

Table 25: Enrollment Period Activity Indicator Description

Code	EPAI Description	Notes
021028	Indicates the enrollment period is an **Initial Issuance**. This code is used for the following: • First subscriber enrollment period in a policy. • Both subscriber and non-subscriber/dependent enrollment periods.	Subscriber and non-subscriber/dependent enrollment periods with this code trigger an RA Allowable Rating Factor (ARF) age determination based on age at time of the Enrollment Start Date. In 2014 and 2015, this code was used exclusively for initial issuance of a policy. In 2016, this code may also be used to indicate a renewal.
001	Indicates the enrollment period is a **Modification** or change at the subscriber level to an existing policy. This code is used for the following: • Subscriber enrollment periods only • The addition of a new member to the subscriber's policy	Subscriber enrollment periods with this EPAI code will *not* trigger a new RA Allowable Rating Factor (ARF) determination.
021EC	Indicates the enrollment period is an **Addition** of a new member. This code is used for the following: • Non-subscriber/dependent enrollment periods only.	Non-subscriber/dependent enrollment periods with this code trigger an RA Allowable Rating Factor (ARF) age determination based on age at time of the **Enrollment Start Date**.
021041	Indicates the enrollment period is a **Renewal** to an existing policy. This code is used for the following: • Subscriber and non-subscriber/dependent enrollment periods. • When the enrollment is a renewal of an eligible plan at the 14-digit **Plan ID** level. • The renewal enrollment period, which does not require a preceding modifier.	Subscriber and non-subscriber/dependent enrollment periods with this code trigger an RA Allowable Rating Factor (ARF) age determination based on age at the time of the **Enrollment Start Date**. In 2014 and 2015, this code was used exclusively for renewals of a policy. In 2016, this code could also be used to indicate an initial enrollment.

Table 26 identifies EPAI rules.

Table 26: EPAI Rules

#	Rule	Notes
1	Subscriber *and* non-subscriber/dependent records must include a 021028 or 021041 EPAI on at least one (1) enrollment period *every* benefit year. Exception: When adding a non-subscriber/dependent after the initial enrollment or renewal of the subscriber, issuers must submit it with an EPAI of 021EC.	A new ARF must be calculated each benefit year for accurate risk scores and to ensure the accuracy of risk transfers.

#	Rule	Notes
2	A subscriber enrollment period record must include EPAI 001 if one (1) of the following condition occurs: • A change in the monthly Premium Amount • A change in the subscriber's Rating Area (if it does not result in the issuance of a new policy) • A change in the 2-digit variant of the Plan ID	Additional non-subscriber/dependent enrollment periods are not required when an issuer adds a new enrollment period to the subscriber with an EPAI of 001.
3	A subscriber enrollment period that includes an EPAI of 001 must be preceded by a 021028, 021041 or 001.	EPAI 001 will only be accepted if the preceding enrollment period includes a 021028, 021041 or 001 EPAI code. No gap in coverage may be present.
4	A subscriber enrollment period must not include an EPAI of 021EC.	EPAI 021EC is only used for non-subscriber/dependent records. Subscriber records with this EPAI will be rejected.
5	A subscriber record must include a new enrollment period with an EPAI of 001 when an issuer adds a non-subscriber/dependent to the policy during the benefit year. Subscriber records must not include an EPAI of 001 when an issuer adds a non-subscriber/dependents at the time of a subscribers initial or renewal period.	See Rule 4. EPAI 001 indicates a modification to the subscriber's policy was made. The addition of a non-subscriber/dependent is considered a modification.
6	A non-subscriber/dependent who is added *after the initial (EPAI 021028) or renewal (EPAI 021041) period of the subscriber* must include an EPAI of 021EC.	EPAI 021EC triggers an ARF for the newly added non-subscriber/dependent.
7	A non-subscriber/dependent enrollment period submitted with an EPAI of 021041 must have the same **Enrollment Start Date** as the associated subscriber renewal date.	A non-subscriber/dependent record with a renewal will only be accepted if the associated subscriber is accepted and has a renewal with the same coverage start date.
8	A non-subscriber/dependent must not include an EPAI of 001.	EPAI 001 may only be submitted on subscriber records. Non-subscriber/dependent records with this EPAI will be rejected.

#	Rule	Notes
9	Subscriber *and* non-subscriber/dependent records for a partial month that are submitted to indicate termination of coverage or disenrollment should be submitted with an EPAI that matches the prior enrollment period EPAI.	There is no EPAI value to indicate termination of coverage or disenrollment. A unique enrollment period for termination of coverage or disenrollment that occurs after a full month's coverage is not required. This rule applies only to issuers who must submit a partial enrollment period for enrollees who are terminated or disenrolled.

5.7 Enrollment Periods Crossing Calendar Years

In the Small Group Market, CMS understands that some enrollment periods may cross calendar years.

Issuers are *not* required to split the enrollment periods for either subscriber or non-subscriber/dependent enrollment periods enrolled in these plans.

The EDGE server software will correctly identify the number of member months in each benefit year if the issuer submits enrollment periods in their entirety and does not split them.

CMS recommends that issuers do not split enrollment periods that cross a calendar year. Issuers who choose to split enrollment that cross a calendar year should refer to the guidance in the sections below to understand the potential adverse effects of doing so.

5.7.1 Enrollment Periods Crossing Calendar Years for a Subscriber

As described in Section 5.6, subscriber and non-subscriber/dependent enrollment periods with an EPAI code of 021028 or 021041 trigger an RA ARF age determination based on age at the time of the Enrollment Start Date.

Subscriber records are not re-rated when an issuer uses an EPAI code of 001. Therefore, if an issuer chooses to split enrollment periods that cross calendar years, the issuer should submit the enrollment period for the new calendar year with an EPAI of 001 to prevent re-rating. See the following examples.

Example

In Figure 9 and Figure 10, Subscriber A, with a date of birth of 7/15/1984, enrolled on 6/1/2014 and had continuous coverage for one (1) year. Figure 9 reflects Subscriber A before splitting enrollment.

Figure 9: Subscriber A – Before Splitting Enrollment Example

Subscriber A	EPAI	ARF
06/01/2014 – 5/31/2015	021028	Age 29 for 12 months

Figure 10 reflects Subscriber A after splitting enrollment.

Figure 10: Subscriber A – After Splitting Enrollment Example

Subscriber A	EPAI	ARF
06/01/2014 – 12/31/2014	021028	Age 29 for 6 months
01/01/2015 – 05/31/2015	001	Age 29 for 6 months

Note: Submit the subscriber's following year enrollment period with an EPAI Code of 001 to avoid re-rating. If an issuer uses EPAI Code 021028 or 021041, re-rating of the subscriber will occur.

5.7.2 Enrollment Periods Crossing Calendar Years for a Non-Subscriber

As described in Section 5.6, issuers may only submit EPAI 001 on subscriber records. The EDGE server will reject non-subscriber/dependent records with this EPAI. Therefore, splitting enrollment across a calendar year for a non-subscriber/dependent, will result in re-rating of the non-subscriber/dependent.

Note: Re-rating will also occur for a subscriber that meets the same criteria below, if an issuer uses an EPAI code of 021028 or 021041.

Issuers should consider the following information before making a decision to split the enrollment periods of a non-subscriber/dependent that meets the following criteria:

- If the non-subscriber has a birthday during their coverage in the first year, *their ARF age for RA will be higher when they are re-rated for the second year*. This may have an impact on the RA transfer amount.

Example

In Figure 11 and Figure 12, Non-Subscriber B, with a date of birth of 11/1/2005 (age 9), was added as a dependent on October 1, 2014. Figure 11 reflects Non-Subscriber B before splitting enrollment.

Figure 11: Non-Subscriber B – Before Splitting Enrollment Example

Enrollment Period 1	EPAI	ARF
10/1/2014 – 09/30/2015	021028	Age 8 for 12 months

Figure 12 reflects Non-Subscriber B after splitting enrollment.

Figure 12: Non-Subscriber B – After Splitting Enrollment Example

Enrollment Period 1	EPAI	ARF
10/01/2014 – 12/31/2014	021028	Age 8 years for 3 months
Enrollment Period 2	EPAI	ARF
01/01/2015 – 09/30/2015	021028	Age 9 years for 9months

Note: EPAI code 001 is not permitted for non-subscribers. Therefore, CMS recommends that issuers do not split enrollment across calendar years.

5.8 Premium Amounts

The **Premium Amount** is the *monthly* total rated premium *charged*, including the Advanced Premium Tax Credit (APTC). The premium is only reported on a Subscriber record. The premium may include more than the amount billed directly to a subscriber. The non-subscriber/dependent premium must be populated with $0.00.

Note: The EDGE server will automatically prorate premiums based on a 30 day month, regardless of the number of days in a given month.

EDGE server proration calculation:

# of days of enrollment divided by 30 days = % month enrolled

% month enrolled multiplied by full monthly premium = prorated premium.

Premium Amounts may vary or change based on a mid-month enrollment or disenrollment, addition or removal of non-subscribers/dependents, or a change in the subscriber's plan.

5.8.1 Changes in Premium Amount

When a change in the **Premium Amount** occurs, the issuer must create a new enrollment period for the subscriber. Table 27 identifies the rules for changes in premium.

Table 27: Changes in Premium

#	Rule	Notes
1	If a subscriber has a change in premium, submit a new enrollment period reflecting the change.	N/A

Example

In Figure 13**,** **Unique Enrollee ID** Z98uTT0p is initially enrolled with a premium of $400.00. On July 1, 2014, the premium changes to $425.00.

Figure 13: Changes in Premium Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
660	Z98uTT0p	1977-07-20	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
661	S		55121AL001000100	2014-01-01	2014-06-30	400.00	003
662	S		55121AL001000100	2014-07-01	2014-12-31	425.00	003

5.8.2 Partial Month Premium

For the EDGE server, a month is 30 days regardless of the number of days in the actual month. Therefore, the EDGE server will use 30 days for the month when calculating the prorated premium.

Issuers must submit subscriber records with a partial month premium with a distinct enrollment period for the partial month period. Table 28 identifies the rules related to submission of partial month premiums.

Note: Issuers must not submit $0.00 premiums on subscriber records that have enrollment periods equal to or greater than 30 days or the enrollment record will be rejected.

Table 28: Partial Month Premium

#	Rule	Notes
1	When a subscriber has a partial month premium, submit the following: • A distinct enrollment period representing the partial month or $0.00 premium AND • An enrollment period(s) representing the full month premium charged	The method of calculating and reporting a partial month premium should be based on how the issuer sets rates and charges premiums. Therefore, a partial month premium could be a partial premium charged, a full premium charged, or $0.00.
2	When a subscriber is not charged a premium for a partial month enrollment, submit a $0 premium.	The enrollment period must reflect the partial month enrollment in order to include a premium of $0.00. Any subscriber enrollment periods that exceed 30 days require a premium greater than $0.00.
3	If a subscriber is charged a per-day premium, report the monthly premium that is charged by multiplying the per-day premium by thirty (30) days regardless of the number of days in a given month.	For the EDGE server, a month is 30 days regardless of the number of days in the actual month.

Note: The RA program prorates **Premium Amounts** when less than a full month is used. CMS recommends that issuers submit the full month premium when possible.

5.8.2.1 Partial Month Enrollment with a Zero Dollar Premium

Example

In Figure 14, **Unique Enrollee ID** L7n33p21 is enrolled on February 27, 2014, and is not charged a premium for February.

Figure 14: Zero Month Premiums Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
5222	L7n33p21	1994-08-11	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
5223	S		11801PA004000102	2014-02-27	2014-02-28	0.00	001
5224	S		11801PA004000102	2014-03-01	2014-12-31	225.00	001

5.8.2.2 Partial Month Enrollment with a Prorated Premium

Example

In Figure 15, **Unique Enrollee ID** B8O099w is enrolled on March 15, 2014 and is charged a prorated premium for a partial month enrollment.

Figure 15: Partial Month Enrollment with a Prorated Premium Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
910	B8O099w	1994-08-11	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
911	S		02114NY001000103	2014-03-15	2014-03-31	425.00	004
912	S		02114NY001000103	2014-04-01	2014-12-31	425.00	004

5.8.2.3 Partial Month Enrollment with Per-Day Premium

Example

In Figure 16, **Unique Enrollee ID** M13ds00 is enrolled on June 14, 2015, and is charged a per-day premium of $14.00/day.

The enrollee is enrolled for 16 days at $14.00/day for a total **Premium Amount** billed to the member of $224.00. The issuer should report the monthly total **Premium Amount** charged for the policy, which would be $420.00 ($14.00/day x 30 days).

Figure 16: Partial Month Enrollment with Per Day Premium Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Gender
2208	M13ds00	1968-01-17	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
2209	S		02114NY001000103	2015-06-14	2015-06-30	420.00	004
2210	S		02114NY001000103	2015-07-01	2015-12-31	425.00	004

5.9 Disenrollments

A disenrollment is an individual enrollee who has at least one (1) day of enrollment in a benefit year in an RA or RI-eligible plan and is then terminated from the plan. Disenrolled enrollees *are* included in RA and RI calculations.

Table 29 identifies the rules for submitting disenrollments.

Table 29: Disenrollments

#	Rule	Notes
1	When an enrollee is disenrolled, continue to submit the enrollee on the enrollment file with an **Enrollment End Date** in order for that enrollee to be considered in RA and RI.	CMS will notify issuers when enrollment for a given benefit year no longer needs to be submitted.
2	If a subscriber is disenrolled, the non-subscriber/dependent, as appropriate, must be one (1) of the following: • Disenrolled • Associated to another subscriber • Changed to a subscriber	If the non-subscriber/dependent is not associated to another subscriber or does not become the subscriber, the non-subscriber/dependent will be rejected.
3	If an enrollee is retroactively disenrolled and consequently did not have health coverage *for any period of time*, *do not* submit the enrollee's record on the enrollment file.	N/A

Example:

In Figure 17, Subscriber M11Kd04 is disenrolled on May 31, 2015. Dependent N22Le05, who was the non-subscriber/dependent of M11Kd04, becomes the subscriber.

Figure 17: Disenrollment Example

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Gender
8500	M11Kd04	1955-04-11	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
8501	S		02114NY001000103	2015-01-01	2015-05-31	450.00	004

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Gender
8502	N22Le05	1958-09-12	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
8503		M11Kd04	02114NY001000103	2015-01-01	2015-05-31	0.00	004
8504	S		02114NY001000103	2015-06-01	2015-12-31	300.00	004

5.10 Mandated Enrollment Coverage

Issuers who are required by federal or state regulation to cover a newborn or other enrollee for a defined period of time, regardless of whether a premium is collected or the individual is enrolled in a plan, should submit such enrollees and the incurred claims for consideration in RA and RI.

The information in this section is guidance that issuers can use to determine the appropriate length of enrollment coverage to submit and what claims are eligible for consideration under mandated enrollment.

5.10.1 Mandated Coverage for Enrollees Enrolled in an On-Exchange Plan

Issuers are required to maintain coverage for an enrollee for three (3) consecutive months if the enrollee has financial assistance. If the enrollee does not make full payment of all outstanding premiums by the end of the three (3) month grace period, the enrollee is terminated back to the end of the first month of the grace period.

The enrollee receives plan benefit coverage for that one (1) month, and the issuer must pay all claims for services rendered during the first month of the grace period. The issuer is not responsible for payment of claims for services rendered in months two (2) and three (3) of the grace period.

Therefore, for enrollees in Exchange plans who are receiving financial assistance, issuers should report a single month of enrollment and the claims incurred for that one (1) month period.

5.10.2 Mandated Coverage for Enrollees Enrolled in an Off-Exchange Plan

The state determines the mandated grace period. If there is a state grace period for a non-financial assistance enrollee, the amount of coverage and plan liability for claims is based on whether or not the state requires coverage for a period of time without retroactive termination.

If the enrollee is covered without retroactive termination, then the enrollee is considered to be enrolled through the end of the grace period allowed by the state, even though the issuer did not receive a premium payment.

If state law allows for a grace period and subsequent retroactive termination if the enrollee does not pay all outstanding premiums by the end of the allowed grace period, then the enrollee is not enrolled and claims for services rendered after the retroactive termination date should be reversed or rejected.

Issuers should only report periods for which the person is considered enrolled, which is one (1) month in the Exchange when financial assistance is received, and up to the state law period for members enrolled outside the Exchange.

Table 30 identifies the rules for mandated enrollment coverage.

Table 30: Mandated Enrollment Coverage

#	Rule	Notes
1	The enrollment submission requirements in the preceding sections apply to enrollees with mandated coverage.	Issuers must follow the enrollment submission rules in order to receive accurate RA and RI calculations for enrollees with mandated coverage.
2	Issuers should submit an enrollee record and enrollment period that reflects the span of coverage required under the mandate. Do not limit the enrollment period to dates that claims were incurred.	Submission of enrollment will ensure the enrollee receives a risk score, and any associated claims will be eligible for consideration in RA and RI.
3	A **Premium Amount** must be included with the enrollment period submitted as a subscriber.	The **Premium Amount** reported for mandated enrollment is the amount *that would have been charged* had the person been enrolled.

#	Rule	Notes
4	If the issuer is mandated under Exchange requirements or by state law to cover a newborn, issuers should create a unique enrollee and enrollment period record for the baby for the time of mandated coverage, even if the baby is never enrolled in the plan. • Submit the newborn as a non-subscriber/dependent if the parent or guardian is enrolled in a plan and is included in the enrollment file. • Submit the newborn as a subscriber, with a premium, if there is no associated subscriber enrolled in the plan.	For example, if mandated coverage is 60 days from the time of birth, submit an enrollee record and a 60-day enrollment period in the plan that is assigned to the newborn. By creating the enrollment information, the newborn will receive a risk score, and any associated claims will be eligible for consideration in RA and RI.

6 Pharmacy File Processing

The Risk Adjustment program will begin including pharmacy claims for Benefit Year 2018 calculations.



Note: Unlike the enrollment file, issuers should *not* submit pharmacy claim files as complete replacements, but rather as incremental files. Full replacement claims file submissions will result in claims being rejected as duplicates. For each subsequent claim file, issuers should include new processed claims and any replacements or voids of previously submitted and accepted claims. Please see Section 6.5 for information on identification of duplicate claims.

Table 31 provides a legend to the symbols and formatting used in this document.

Table 31: Legend of Symbols and Formatting

Symbol or Formatting	Significance
Italics	Indicates important information.
Bolded Blue	Indicates a data element present on the inbound submission file. Please see the ICD for data element descriptions along with technical field/element characteristics.
	Indicates an important rule. If this guidance is not followed, it may impact file ingest or calculations.
	Indicates information an issuer should note. Although the information may not impact file ingest or calculations, it requires attention.

6.1 Pharmacy Claims File Definitions

See Appendix B: Terms and Definitions for enrollee file definitions.

6.2 General Pharmacy Claims File Processing Rules

Table 32 identifies general file processing rules and ESPCS dependency rules.



Note: Issuers should correct and resubmit all claims by April 30th of the year following the benefit year. The EDGE server will not accept any new claims, or corrections to rejected claims, after April 30th. If the April 30th deadline falls on a weekend, the deadline will be extended to the next business day.

Table 32: Pharmacy Claims File Processing & Dependencies

#	Rule	Notes
1	The EDGE server will only accept paid pharmacy claims for enrollees in the Individual and Small Group Market, both inside and outside the Exchange.	The EDGE server will reject all other claims.

#	Rule	Notes
2	The **Unique Enrollee ID** reported on the pharmacy claims file *must* correspond to a **Unique Enrollee ID** on the enrollment file.	Pharmacy claims that are not matched to an enrollee will be considered *orphaned* and will not be considered during the calculation process. Issuers will receive an Enrollee Without Claims Detail (ECD) Report listing active claims that do not have an active enrollee record, as well as enrollees without claims.
3 	The **Claim ID** must be *unique* for each claim, even when an issuer submits a void or replacement claim.	If a unique **Claim ID** is not used, then the claim will be rejected. Medical claims allow for the same **Claim ID** when submitting replacements, but this is not permitted with pharmacy claims.
4	Issuers may submit all versions of a claim (an original and then an adjusted claim as a replacement claim), or submit the final version of the claim (the final adjusted claim).	If the issuer submits a final version of the claim, the **Total Allowed Cost** and **Plan Paid Amount** should reflect the aggregated amounts of all the individual claims processed.
5	If *any* data element fails verification, the EDGE server will reject the pharmacy claim.	If a claim is rejected, the issuer should resubmit the claim to be considered for RA or High Cost Risk Pool (HCRP) program-specific file processing.
6	National Provider Identifiers (NPIs) submitted to the EDGE server must meet NPI check digit logic. Issuers who have Medicaid pharmacy claims that do not have an NPI may use the state Medicaid ID. The Dispensing Provider ID Qualifier must be 99 if submitting a value other than an NPI.	The EDGE server will perform a check digit validation algorithm on the NPI submitted. See the following site for information related to the check digit algorithm: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/ The dispensing provider's NPI must be used for pharmacy claims.
7 	If an enrollee has dual coverage in the *same plan*, the issuer *must* combine and submit the claim as a *single claim* and aggregate the **Total Allowed Costs** and **Plan Paid Amounts**.	Submitting two (2) claims for the same services will result in duplicate claim rejections.

6.3 Header, Issuer and Plan Level Rules Specific to Pharmacy Claims Files

The general header, **Record ID**, issuer level, and plan level rules in Section 4.6, Section 4.7, and Section 4.8 apply to all pharmacy claim files.

Two (2) data elements at the header, issuer and plan levels are specific to pharmacy claim files, and must pass a required and logical check verification process.

Table 33 identifies the header, issuer and plan level total verifications.

Table 33: Header, Issuer and Plan Level Total Verifications

#	Rule	Notes
1	The **Total Claims** reported at the *header level* must equal the count of all claim records for the issuer on the file. The **Total Claims** reported at the *issuer level* must equal the sum of the total claim records for all plans for the issuer. The **Total Claims** reported at the *plan level* must equal the sum of the total claim records for the specific plan. If a reported value at the header, issuer or plan level *does not* match the total count for the indicated level, the EDGE server will reject that level and all associated sublevels.	For example, if the header level fails and is rejected, the issuer and plan levels will also be rejected.
2	The EDGE server will compare the **Total Plan Paid Amount on File** at the *header level* to the **Total Plan Paid Amount for Issuer** at the *issuer level*. The EDGE server will compare the **Total Plan Paid Amount for Issuer** at the *issuer level* to the sum of all **Total Plan Paid Amounts** reported at each *plan level*. The EDGE server will compare the **Total Plan Paid Amount** at the *plan level* to the sum of all **Plan Paid Amounts** for all claims associated with the plan. If a reported total does not match the associated sum of the level, the EDGE server will not reject the level. An informational error message will notify the submitter of the discrepancy.	For example, if the issuer level **Total Plan Paid Amount on File** reported sum is $525,000, but the **Total Plan Paid Amount for Issuer** is $524,500, the EDGE server will not reject the file. An informational error will notify the submitter of the discrepancy.

6.4 Data Element Clarifications

Table 34 through Table 38 clarify rules specific to ESPCS files for the following data elements: **In-Network and Out-of-Network Indicator, Prescription/Service**

Reference Number, **Product/Service ID**, **Fill Number**, **Total Allowed Costs,** and **Plan Paid Amounts**.

In-Network and Out-of-Network Indicator

The In- and Out-of-Network indicator was added to claims files for use in the Actuarial Value (AV) Calculator and data analysis. As discussed in the *2018 Payment Notice*, CMS intends to use the EDGE server claims data in the AV Calculator in future years. AV helps consumers meaningfully compare plan designs.

The AV Calculator calculates AV based on in-network cost sharing, including multi-tiered networks and is not a pricing tool.

Table 34: In-Network and Out-of-Network Indicator Rules

#	Rule	Notes
1	An In-Network and Out-of-Network Indicator is required for claims with a Fill Date of January 1, 2018 and later. The In-Network and Out-of-Network Indicator must be either "I" for In-Network or "O" for Out-of-Network.	N/A

Table 35: Prescription/Service Reference Number Rules

#	Rule	Notes
1	Issuers must submit the **Prescription/Service Reference Number** assigned by the pharmacy. A pharmacy assigns a **Prescription/Service Reference Number** to identify a unique prescription event.	Issuers submitting non-retail pharmacy claims, such as staff model plans, should create a unique number of up to 12 digits for the **Prescription/Service Reference Number**.

Table 36: Product/Service ID Rules

#	Rule	Notes
1	The **Product/Service ID** can be an NDC, a National Health Related Item Code (HRI), or the Universal Product Code (UPC) for items dispensed at a pharmacy that do not have a National Drug Code (NDC) number, such as diabetic supplies. The HRI or UPC cannot exceed 11 digits.	NDC codes will undergo a reference check during file ingest for claims with a Fill Date of January 1, 2018 and later.
2	NDC Codes must be numeric and have exactly 11 digits including leading zeroes. Non-NDC codes may be between one (1) and 11 digits and may include alpha-numeric strings.	The NDC must match a valid code as defined by the Federal Drug Administration (FDA).

#	Rule	Notes
3	A Product/ Service ID Qualifier is required for claims with a Fill Date of January 1, 2018 and later. The Product/Service ID Qualifier must be either a 01 for Non-NDC Codes (e.g., HRI or UPC) or 02 for NDC Codes.	Only claims submitted with a 02 qualifier will be considered for inclusion in RA. Claims submitted with 01 or 02 qualifier will be considered for inclusion in High Cost Risk Pool (HCRP) calculations.
4	If multiple **Product/Service IDs** are supplied under a single prescription event, the issuer should submit the highest cost **Product/Service ID**.	Issuers may aggregate costs if multiple **Product/Service IDs** are supplied.

Table 37: Fill Number and Days' Supply Rules

#	Rule	Notes
1	Issuers who do not capture a **Fill Number** may default the **Fill Number** to one (1) or sequence the **Fill Number** manually.	If multiple fills have the same **Fill Date** *and the other key elements are the same*, the EDGE server will reject the claims as duplicate.
2	Issuers must submit a **Days' Supply** value that represents only the amount dispensed for the specified **Fill Date**.	If a partial supply was dispensed use the appropriate Dispensing Status Code outlined in Table 39.

Table 38: Allowed Costs, Paid Amount and Rebates Rules

#	Rule	Notes
1	**Total Allowed Costs** and **Plan Paid Amounts** are the sum of ingredient cost, dispensing fees and sales tax, where applicable.	The issuer does not need to adjust the reported **Plan Paid Amount** to reflect manufacturer rebates.

6.5 Duplicate Pharmacy Claims

The EDGE server checks duplicate claims to ensure only one (1) active version of a claim is stored in the pharmacy claim table.

Table 39 identifies the data elements the EDGE server uses to identify duplicate claims.

Note: If the EDGE server identifies a duplicate claim, it will reject the claim.

Table 39: Duplicate Pharmacy Claims Rules

#	Rule	Notes
1	The EDGE server uses the following data elements to determine a duplicate pharmacy claim: • **Issuer ID** • **Plan ID** • **Dispensing Provider ID Qualifier** • **Dispensing Provider ID** • **Fill Date** • **Prescription/ Service Reference Number** • **Fill Number** • **Dispensing Status**	These elements are referred to as the pharmacy claim key. Issuers can run a SQL query to identify the active stored claim that caused the rejection of a new claim. Please see the EDGE Server Operations and Maintenance Manual (O&MM) available in the REGTAP Library.

Depending on the **Dispensing Status** for an *active stored claim* and the new claim, the EDGE server may accept the new claim or reject it as a duplicate.

Table 40 identifies the actions the EDGE server will take depending on the dispensing status of a previously submitted claim (active claim) and the dispensing status of the new claim. A previously submitted claim must exist as active on the pharmacy data table for these actions to apply.

Table 40: Dispensing Status Actions

Active Claim Dispensing Status	New Claim Dispensing Status Blank	New Claim Dispensing Status Partial (P) Fill	New Claim Dispensing Status Completion of a Partial Fill (C)
Blank1	Reject - Duplicate	Reject - Inconsistent	Reject - Inconsistent
Partial (P) Fill	Reject - Inconsistent	Reject - Duplicate	Accept
Completion on (C) of a Partial Fill	Reject - Inconsistent	Accept	Reject - Duplicate

6.6 Claim Processed Date Time

The EDGE server uses the **Claim Processed Date Time** data element reported at the claim level to determine processing order. Issuers should differentiate claims adjusted multiple times on the same or subsequent pharmacy claim file for appropriate processing.

[1] A blank implies a single complete fill was performed.

Note: Issuers who do not capture or populate the time component of the **Claim Processed Date Time** should carefully review these rules.

Table 41 identifies the rules for **Claim Processed Date Time**.

Table 41: Claim Processed Date Time Rules

#	Rule	Notes
1	All claims must include a date and time in the **Claim Processed Date Time** field.	Issuers may create the time component to clearly identify the order of processing when submitting multiple claims on a single file, or when submitting a void/replace claim
2	If an issuer submits multiple versions of the same claim due to void or replacement, each claim must include a unique **Claim Processed Date Time**, even if the **Void/Replace Indicator** is present.	If issuers do not provide the **Claim Processed Date Time**, or it is not unique, the EDGE server will reject all claims with the same Issuer ID and claim key because it is unable to determine the processing order of the claims.
3	The **Claim Processed Date Time** of a submitted void or replacement claim *must* be later than the most current stored active claim or the void or replacement claim will be rejected.	See Section 6.7 for information on submission of voids. See Section 6.8 for information on submission of replacements.

Examples

In Figure 18, the following submission will result in the rejection of the replacement claim since the eight (8) key elements match and the **Claim Processed Date Time** is identical.

Figure 18: Claim Processing Date Time Rules – Rejected Submission Example

Issuer ID: 99999 **Plan ID:** 99112WA001000703

Dispensing Provider ID	Fill Date	Prescription/ Service Reference Number	Dispensing Status	Void/Replace Indicator	Plan Paid Amount	Claim Processed Date Time
1234567890	2014-06-02	87654321	C		1000.00	2014-06-03T00:00:00
1234567890	2014-06-02	87654321	C	R	1200.00	2014-06-03T00:00:00

As shown in Figure 192, the EDGE server will accept both claims because each claim has a unique **Claim Processed Date Time.**

Figure 19: Claim Processing Date Time Rules – Accepted Submission Example

Dispensing Provider ID	Fill Date	Prescription/ Service Reference Number	Dispensing Status	Void/Replace Indicator	Plan Paid Amount	Claim Processed Date Time
1234567890	2014-06-02	87654321	C		1000.00	**2014-06-03T08:30:10**
1234856789	2014-06-02	87654321	C	R	1200.00	**2014-06-03T08:30:20**

6.7 Voiding Pharmacy Claims

Pharmacy claim files include a data element that allows issuers to void claims previously submitted, accepted, and stored as active. Using the value "V" as the **Void/Replace Indicator**, an issuer can change an active stored claim to an inactive status, thereby removing it from consideration in the RI calculations.

Table 42 identifies the rules for voiding pharmacy claims.

Table 42: Rules for Voiding Pharmacy Claims

#	Rule	Notes
1	Issuers should not reuse Claim IDs when voiding medical claims.	CMS makes this recommendation due to the complexity of pharmacy claim key used to identify unique claims.
2	To void a pharmacy claim, the EDGE server requires the following minimum set of data values, and will verify them according to the restrictions in the ICD: • **Record ID** • **Claim ID** • **Claim Processed Date Time** – must be later than the claim being voided • **Fill Date** • **Prescription/Service Reference Number** • **Dispensing Provider ID Qualifier** • **Dispensing Provider ID** • **Fill Number** • **Dispensing Status Code** • **Void/Replace Code** – must be "V" The EDGE server will verify any other submitted data values according to the restrictions in the ICD. The EDGE server will reject the void if any data element fails verification.	See Appendix D for required data elements when submitting a void claim.

#	Rule	Notes
3	The issuer is not required to include the **Total Allowed Cost** and **Plan Paid Amount**. If populated, the value can be a negative amount.	N/A
4	Once an issuer submits a void claim, and the EDGE server changes the original claim from active to inactive status.	An inactive claim is no longer eligible for the RA or RI program. If the claim was voided in error, the issuer may either resubmit the original claim or submit a replacement claim.
5 	Issuers should not attempt to reactivate a voided pharmacy claim by submitting a replacement claim. Instead, a new claim should be submitted with a new Claim ID.	CMS makes this recommendation due to the complexity of the pharmacy claim key used to identify unique claims.

Table 43 identifies the six (6) steps involved in voiding a previously submitted pharmacy claim.

Table 43: Steps for Voiding a Previously Submitted Pharmacy Claim

#	Step
1	The issuer submits an original claim that is accepted and stored as active.
2	The issuer submits a void and populates the "V" in the **Void/Replace Indicator** field and the pharmacy claim key elements.
3	The EDGE server identifies the void or replace by the "V" populated in the **Void/Replace Indicator** field.
4	The EDGE server uses the eight (8) key elements to find the original claim. • If a match is not found, the void claim is rejected. • If a match is found, the process continues.
5 	The EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. • If the date time passes, then the original claim is inactivated. • If the date time fails, then the original claim will *not* be inactivated and the void claim will be rejected. *When a void is processed, the EDGE server only inactivates original claims if the date time verification passes.* See Table 41 for **Claim Processed Date Time** information.
6	The EDGE server checks the remaining submitted data elements to determine if the void claim should be accepted. • If all data elements pass, the new claim is stored as inactive. • If one (1) or more data elements fail, then the new claim *is not* stored and the void claim is rejected. *Even if the void is rejected, the original claim remains inactive.*

Examples

The following examples illustrate the pharmacy claims data table before and after void submission. *For these examples, the eight (8) key elements submitted on all claims are identical for the process of matching the void to the original claim*.

In Figure 20, the pharmacy claims data table includes claim RXC555, processed on April 27, 2014. The EDGE server accepted the claim and stored it with a status of active.

Figure 20: Pharmacy Claims Data Table Before and After Void Submission – Active Claim Example

Issuer ID	*Key Elements*	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	*Key Elements*		2014-04-27T16:02:20	1735.00	Active

In Figure 21, the issuer submits a void on May 2, 2014. The EDGE server uses the eight (8) key elements to locate the active claim in the data table.

Figure 21: Pharmacy Claims Data Table Before and After Void Submission – Void Submitted Example

Issuer ID	*Key Elements*	V/R Indicator	Claim Processed Date Time	Plan Paid Amount
999887	*Key Elements*	V	2014-05-02T06:12:00	1735.00

In Figure 22, the EDGE server finds the previously submitted claim and changes the status from active to inactive. The submitted void is added to the pharmacy claim data table as inactive.

Figure 22: Pharmacy Claims Data Table Before and After Void Submission – Inactive Status Example

Issuer ID	*Key Elements*	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	*Key Elements*	V	2014-05-02T06:12:00	1735.00	Inactive
999887	*Key Elements*		2014-04-27T16:02:20	1735.00	Inactive

6.8 Replacing Pharmacy Claims

Pharmacy claims files include a data element that allows issuers to replace claims previously submitted, accepted, and stored as active. By using the value “R” as the **Void/Replace Indicator**, an issuer can replace a previously submitted claim.

Table 44: Rules for Replacing Pharmacy Claims

#	Claims Rule	Notes
1 	An issuer cannot replace a pharmacy claim if one (1) of the eight (8) key elements has changed. Instead, the issuer must void the claim. An issuer can replace a pharmacy claim if a data element other than the eight (8) key elements from the original claim is being changed (e.g., Plan Paid Amount).	N/A
2	To replace a pharmacy claim: • A value of "R" must be present in the **Void/Replace indicator** data field. • The issuer must include all data elements on a replacement claim in order for the replacement claim to be evaluated for processing. • The eight (8) key elements must match a stored claim, which may be active or inactive. • The **Claim ID** for the replacement claim *must* be unique.	N/A
3	When an issuer submits a replacement claim to account for changes in a **Plan Paid Amount**, the EDGE server inactivates the original claim and the **Plan Paid Amount** associated with the original claim.	The replacement claim should include all final paid charges for the services.
4	Issuers should not submit a negative value for the **Plan Paid Amount** when using the replacement function.	Submitting a negative **Plan Paid Amount** will reduce the aggregated costs for an enrollee.
5	Once an issuer submits a replacement claim, and the original claim changes from active to inactive status, the inactive version of the claim is no longer eligible for consideration in the RI and RA calculation process.	N/A

Table 45 identifies the six (6) steps involved in replacing a previously submitted pharmacy claim.

Table 45: Steps for Replacing a Previously Submitted Pharmacy Claim

#	Step
1	The issuer submits an original claim that is accepted and stored as active.
2	The issuer submits a replacement and populates the "R" in the **Void/Replace Indicator** field and the pharmacy claim key elements.
3	The EDGE server identifies the replace by the "R" populated in the **Void/Replace Indicator** field.

#	Step
4	The EDGE server uses the eight (8) key elements to find the original claim. • If a match is not found, the void claim is rejected. • If a match is found, the process continues.
5	The EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. • If the date time passes, the original claim is inactivated. • If the date time fails, the original claim will *not* be inactivated and the void claim will be rejected. *When a replace is processed, the EDGE server only inactivates original claims if the date time verification passes.* See Table 41 for **Claim Processed Date Time** information.
6	The EDGE server checks the remaining submitted data elements to determine if the replacement claim should be accepted. • If all data elements pass, the new claim is stored as active. • If one (1) or more data elements fail, then the new claim *is not* stored and the replacement claim is rejected. *Even if the replacement is rejected, the original claim remains inactive.*

Examples

The following examples illustrate the pharmacy claims data table before and after replacement submission. *For these examples, the eight (8) key elements submitted on all claims are identical for the process of matching the replacement to the original claim.*

In Figure 23, the pharmacy claim data table includes the original claim submitted on April 4, 2014 and a replacement of the original claim on April 27, 2014. After submission of the replacement, the EDGE server set the original claim to inactive and accepted the new claim and stored it as active.

Figure 23: Pharmacy Claims Data Table Before and After Replacement Submission – Replace Submission Example

Issuer ID	*Key Elements*	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	*Key Elements*	R	2014-04-27T16:02:20	1735.00	Active
999887	*Key Elements*		2014-04-04T07:41:20	1200.00	Inactive

In Figure 24, the issuer submits another replacement for claim RXC555 on May 2, 2014. The EDGE server compares the **Claim Processed Date Time** to determine if the new claim is later than the most current active version of the claim.

Figure 24: Pharmacy Claims Data Table Before and After Replacement Submission – Additional Replace Submission Example

Issuer ID	*Key Elements*	V/R Indicator	Claim Processed Date Time	Plan Paid Amount
999887	*Key Elements*	R	2014-05-02T06:12:00	2735.00

In Figure 25, the EDGE server found the original claim and compared the **Claim Processed Date Time** to the submitted replacement. Since the submitted replacement is later than the most current active claim, the active claim changes to inactive. Upon verifying all data elements on the replacement claim, the EDGE server accepts and stores it as the new active claim.

Figure 25: Pharmacy Claims Data Table Before and After Replacement Submission Example

Issuer ID	*Key Elements*	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	*Key Elements*	R	2014-05-02T06:12:00	2735.00	Active
999887	*Key Elements*	R	2014-04-27T16:02:20	1735.00	Inactive
999887	*Key Elements*		2014-04-04T07:41:20	1200.00	Inactive

6.9 Fee-for-Service and Capitated Claim Submission

The following section outline the values that must be submitted when submitting fee-for-service (FFS) and capitated pharmacy claims.

All FFS and capitated pharmacy services submitted to the EDGE server must include a **Total Allowed Cost** that is greater than $0. When the allowed cost is equal to $0, and the service was not part of a more inclusive service that was paid, it indicates the service was not covered and/or denied. Therefore, the service is not eligible for consideration in the RA and RI programs and the claim must not be submitted.

The **Plan Paid Amount** may be submitted with a value that is equal to or greater than $0.

6.9.1 FFS Claim Submission

This section explains the use of the **Derived Amount Indicator** and **Paid Date**, and how **Total Allowed Costs** and **Plan Paid Amounts** are defined for submission to the EDGE server when pharmacy claims are processed under a FFS arrangement.

Table 46 identifies the rules for submitting FFS claims.

The rules for paid and allowed amounts indicated in the following table are not applicable to claims with a Void indicator. Void claims do not require population of allowed or paid amounts. See Appendix C.

Table 46: FFS Claims Submission Rules

#	Rule	Notes
1	Issuers must submit a **Derived Amount Indicator** of "N" when submitting FFS claims.	N/A
2	The **Paid Date** field must be populated.	If the **Paid Date** field is not populated, the claim will be rejected.
3	The **Total Allowed Cost** must be greater than $0. • The **Total Allowed Cost** must be submitted as the sum of the **Plan Paid Amount** plus the enrollee liability.	Claims submitted with an allowed cost equal to or less than $0 will be rejected. Prior to January 1, 2016, issuers were permitted to submit any value for the allowed cost.
4	A **Total Allowed Cost** of $1.00 is permitted only when the pharmacy service is included in the **Total Allowed Cost** of a more comprehensive pharmacy service or the **Total Amount Allowed** of a more comprehensive medical service whether the service is either an actual (FFS) paid amount or a derived (capitated) paid amount.	For example, a drug provided in association with an inpatient surgical stay and the drug was covered under the case rate for the inpatient surgical stay.
5	The **Plan Paid Amount** may be submitted with a value equal to or greater than $0.	N/A

Example: FFS Pharmacy Claim

As shown in Figure 26, an FFS claim was processed and resulted in a **Plan Paid Amount** of $200 with an enrollee liability of $20 for a **Total Allowed Cost** of $220.

Figure 26: FFS Pharmacy Claim Example

Record ID	Unique Enrollee ID	Claim ID	Fill Date	Paid Date	Total Allowed Cost	Plan Paid Amount	Derived Amount Indicator
409	J8991t	2017051Rx	2016-02-11	2016-02-20	220.00	200.00	N

Example 2: FFS Pharmacy Claim Covered Under a Comprehensive Service

A pharmacy claim was processed and resulted in a **Total Allowed Cost** and **Plan Paid Amount** of $0. The pharmacy service was included in the **Plan Paid Amount** that was reported on the associated inpatient stay.

Figure 27: FFS Pharmacy Claim Included in Inpatient Stay

Record ID	Unique Enrollee ID	Claim ID	Fill Date	Paid Date	Total Allowed Cost	Plan Paid Amount	Derived Amount Indicator
800	PkM0614	1208RX202	2018-07-15	2018-08-03	$1.00	$0.00	N

6.9.2 Capitated Services Submission

Issuers must derive (or estimate) the paid amounts for pharmacy services provided under a capitation arrangement. Allowed costs on capitated claims must adhere to the requirement that an allowed cost at the header must be greater than $0.

The inbound claim file's **Derived Amount Indicator** field identifies when the paid and allowed cost has been estimated for pharmacy services provided under a capitation arrangement. The issuer must determine the estimated paid amount of the pharmacy services based on the encounter data submitted by the rendering provider for actual services provided. For more information about capitated claims, please refer to 45 CFR §153.710.

This section explains the use of the **Derived Amount Indicator**, **Paid Date** and how **Total Allowed Costs** and **Plan Paid Amounts** are defined for submission to the EDGE server when pharmacy claims are processed under a capitation arrangement.

Table 47 identifies the rules for submitting capitated claims.

The rules for paid and allowed amounts indicated in the following table are not applicable to claims with a Void indicator. Void claims do not require population of allowed or paid amounts. See Appendix C.

Table 47: Capitated Services Submission Rules

#	Rule	Notes
1	Issuers must submit a derived **Plan Paid Amount** that is reasonable and based on a methodology of their choosing for capitated services.	Refer to 45 CFR §153.710. Issuers must make every effort to develop an internal methodology for providing accurate **Plan Paid Amounts** whenever possible.
2	Issuers must submit a **Derived Amount Indicator** of "Y" when submitting capitated services.	N/A
3	The **Paid Date** field may be null or populated with the date of claim adjudication.	Issuers are not required to populate this field for capitated services.

#	Rule	Notes
4	The **Total Allowed Cost** must be greater than $0. • Issuers must submit the derived **Plan Paid Amount** for the **Total Allowed Cost** unless the claim is part of a more inclusive service. See Rule 5.	Claims submitted with an allowed cost equal to or less than $0 will be rejected (unless the claim is a void). Prior to January 1, 2016, issuers were permitted to submit any value for the allowed cost.
5	A **Total Allowed Cost** of $1.00 is permitted only when the pharmacy service is included in the **Total Allowed Cost** of a more comprehensive pharmacy service or the **Total Amount Allowed** of a more comprehensive medical service whether the service is either an actual (FFS) paid amount or a derived (capitated) paid amount.	For example, a drug provided in association with an inpatient surgical stay and the drug was covered under a FFS case rate or capitated payment arrangement for the inpatient surgical stay claim.
6	The **Plan Paid Amount** may be submitted with a value equal to or greater than $0.	N/A

Example 1: Capitated Pharmacy Claim

A capitated encounter was processed and resulted in a **Total Allowed Cost** and **Plan Paid Amount** of $0. As shown in Figure 28, a reasonable method was used to determine the amount that would have been paid for the service under an FFS arrangement, and a derived **Plan Paid Amount** of $125 was estimated.

*The **Total Allowed Cost** is submitted with a value equal to the **Plan Paid Amount**.*

Figure 28: Capitated Pharmacy Claim Example

Record ID	Unique Enrollee ID	Claim ID	Fill Date	Paid Date	Total Allowed Cost	Plan Paid Amount	Derived Amount Indicator
655	Lx0o117	041116Rx	2016-11-02	2016-12-15	125.00	125.00	Y

Example 2: Capitated Pharmacy Claim Covered Under a Comprehensive Service

A capitated encounter was processed and resulted in a **Total Allowed Cost** and **Plan Paid Amount** of $0. The pharmacy service was included in the **Plan Paid Amount** that was derived for the associated inpatient stay.

Figure 29: Capitated Pharmacy Claim Included in Inpatient Stay

Record ID	Unique Enrollee ID	Claim ID	Fill Date	Paid Date	Total Allowed Cost	Plan Paid Amount	Derived Amount Indicator
1000	PFC0401a	0218RX900	2018-04-12	2018-04-30	$1.00	$0.00	Y

7 Medical File Processing

Issuers should submit all paid claims for Small Group and Individual plans, both on and off the Exchange. Software for the RA and RI programs will select program-specific claims based on program-specific business rules.

Medical claims include all paid inpatient and outpatient facility claims (for example, hospital, nursing home, and surgical centers) and all professional claims. Issuers must not submit denied claims to the EDGE server.

According to 45 CFR § 153.700, issuers must provide data and server access in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment and reinsurance program. Each benefit year, a new reporting requirement timeline is posted on REGTAP (https://www.regtap.info/). CMS recommends submitting medical files on a monthly basis.

Note: Unlike the enrollment file, issuers should *not* submit medical claim files as complete replacements, but rather as incremental files. Full replacement claims file submissions will result in claims being rejected as duplicates. For each subsequent claim file, issuers should include new processed claims and any replacements or voids of previously submitted and accepted claims.

CMS recognizes that issuers are not permitted to modify claims submitted by their rendering providers in order to adjudicate those claims. Prior to submission to the EDGE server, issuers must modify some post-adjudication claim data to conform to requirements for data submission to the EDGE server. Issuers are permitted to make modifications to claims extracted from their payment systems to meet EDGE submission requirements, but should retain traceability of such changes in the event of audit. For example, issuers will need to modify **Bill Types**, under certain circumstances, and/or may need to remove or add **Service Code Modifiers**. The following sections explain the specific rules necessary for successful acceptance of medical claims submitted to the EDGE server.

Note: Issuers should correct and resubmit all claims by April 30th of the year following the benefit year. The EDGE server will not accept any new claims, or corrections to rejected claims, after April 30th. If the April 30th deadline falls on a weekend, the deadline will be extended to the next business day.

Table 48 provides a legend to the symbols and formatting used in this document.

Table 48: Legend of Symbols and Formatting

Symbol or Formatting	Significance
Italics	Indicates important information.
Bolded Blue	Indicates a data element present on the inbound submission file. Please see the ICD for data element descriptions along with technical field/element characteristics.
	Indicates an important rule. If this guidance is not followed, it may impact file ingest or calculations.
	Indicates information an issuer should note. Although the information may not impact file ingest or calculations, it requires attention.

7.1 Medical Claims File Definitions

Please see Appendix B: Terms and Definitions for enrollee file definitions.

7.2 Medical Claims Code Set Sources and Reference Table Verifications

The EDGE server reference tables include current medical code sets as required in 45 CFR §160 and 162 – Health Insurance Reform: Standards for Electronic Transactions. Issuers must submit current medical code sets and should enforce correct coding guidelines with their providers.

CMS will update reference tables with new and deleted code information within 90 days after the effective date of such changes. For example, codes effective on January 1st will be loaded to the EDGE servers no later than March 30th. CMS will notify issuers of updates through the standard Distributed Data Collection webinars and the Maintenance Release schedule notifications posted in the REGTAP Library, available at https://www.regtap.info/.

Table 49 lists standard code sets and sources the EDGE server uses to verify submitted codes during data submission.

Table 49: Standard Code Sets and Sources

Code Sets	Code Sources
ICD-10 Diagnosis Codes	https://www.cms.gov/Medicare/Coding/ICD10/index.html
HCPC and HCPC modifiers, as published by CMS	https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html
CPT and CPT modifiers, as published by the American Medical Association (AMA)	https://www.ama-assn.org/practice-management/cpt
Bill Types, Revenue Codes, Discharge Status Codes, as published by the National Uniform Billing Committee (NUBC)	http://www.nubc.org/licensing/index.dhtml
Place of Service (POS) Codes, as published by CMS	http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Table 50 identifies standard code sets rules and how the EDGE server verifies code sets against the reference tables.

Table 50: Code Set and Reference Table Verification Rules

#	Rule	Notes
1	Issuers must not submit local or state codes, home-grown codes, or foreign codes.	The EDGE server will reject these codes with an **Error Message** indicating a reference check failure.
2	Issuers may remove or crosswalk outdated, local or home-grown codes, using reasonable methods, to current codes, in order for claims to be accepted and considered for RA and RI.	Issuers who believe a Service Code is valid and should be added to a reference table should email EDGE_Server_Data@cms.hhs.gov and provide details and supporting documentation of the code and effective dates to add. Issuers will receive a response to all research into missing codes or invalid dates.
3	Both upper and lowercase letters will be accepted during file ingest for diagnosis codes.	Values submitted with a lowercase will be converted and stored to upper case values and will be included in RA calculations, as applicable.
4	Issuers should only submit ICD-10 Diagnosis Codes and include Diagnosis Code Qualifier 02.	Diagnosis Code Qualifier 02 must be included with ICD-10 Diagnosis Codes or claims will be rejected.

#	Rule	Notes
5 	Only Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPC) codes are accepted as valid Service Codes.	Any codes other than CPT or HCPC codes may be rejected. If accepted, claims including such codes will not be included in RA calculations.
6	All claim lines that include a CPT or HCPC Service Code should be submitted with a Service Code Qualifier of 03. All other Service Codes (such as HIPPS codes and dental codes) should be submitted with a Service Code Qualifier of 01.	Service Codes that do not include a Service Code Qualifier of 03 will be accepted during ingest but will be *excluded* during RA claim selection. The Service Code and Service Code Modifier reference checks are bypassed when Service Code Qualifier 01 is used.
7	Submitted service indicator codes (e.g., CPTs, modifiers, Revenue Codes, etc.) must be effective on the date the service was *rendered*.	As long as a code is effective on any day in the statement coverage period, the record will be accepted. This applies to Service Codes, Service Code Modifiers, Place of Service, Diagnosis Codes, Revenue Codes, Bill Types, and Discharge Status Codes.
8	Service Codes are required on professional claims but are optional on institutional claims.	In order for a claim to be selected for RA calculations, at least one (1) RA-eligible service code (CPT or HCPC) and a Service Code Qualifier 03 *must* be included with an outpatient institutional medical claim. Issuers should carefully review the RA claim selection process, outlined in the RA presentations published in REGTAP Library (https://www.regtap.info/).

7.3 General Medical Claims File Processing Rules

This section explains general file processing rules for medical claim (ESMCS) files.

The initial medical claims file submission should contain medical claims with a **Statement Covers From Date** after January 1st of the EDGE benefit year. Subsequent medical claim files should only contain new medical claims processed, replacements, or voids of prior accepted claims and any resubmissions of previously rejected claims.



Note: Full file submissions will result in claims being rejected as duplicates. Please see Section 7.8 for information on identifying duplicate claims.

The EDGE server file processing software applies verification rules to all claim lines submitted with a valid claim header. The software also generates summary and detail reports to account for accepted and rejected records as well as rejection reasons.

Medical claims that pass all verification edits are accepted and stored in a medical claim data table in the EDGE server as active records. The EDGE server application will only select active claims for RA and RI programs.

Table 51 identifies the rules for medical claims file processing.

Table 51: Medical Claims File Processing General Rules

#	Rule	Notes
1	The EDGE server will only accept paid medical claims for enrollees in the Individual and Small Group Market, both inside and outside the Exchange.	All other claims will be rejected.
2	The **Unique Enrollee ID** and **Plan ID** reported on the medical claims file should correspond to a **Unique Enrollee ID** and **Plan ID** on the enrollment file.	Medical claims for enrollees that are not matched to a **Unique Enrollee ID** and **Plan ID** will be considered orphaned and will not be considered during RA and RI processing. Issuers will receive an ECD Report listing active claims that do not have an active enrollee record, as well as enrollees without active claims.
3 	Issuers must only submit institutional claims with **Bill Types** ending in xx1, xx7 or xx8. As appropriate, issuers should assess, and modify institutional claims with **Bill Types** that end in a value other than xx1, xx7, or xx8 for submission to the EDGE server. • **Bill Type** xx1 may be used for original, replacement or void claim submissions. • **Bill Type** xx7 must only be used for replacement claims. The claim record must include the 'R' indicator. • **Bill Type** xx8 must only be used for void claims. The claim record must include the 'V' indicator.	Interim bills and late charges must be combined and submitted with Bill Type xx1 or xx7, as appropriate. Services adjudicated under most **Bill Types** are eligible for consideration in RA and RI, but must be changed to one (1) of the EDGE server acceptable **Bill Types** (xx1, xx7, or xx8). Please see Section 7.17 for information on modifying **Bill Types** for submission Please see Section 7.11 for information on **Bill Type** xx7. Please see Section 7.12 for information on **Bill Type** xx8.

#	Rule	Notes
4	Claims That Cross Benefit Years: Issuers may split claims that cross a benefit year, except for inpatient institutional hospital claims, as outlined in Section 7.17. Issuers may use the rules outlined in section 7.17.3 (outpatient institutional claims) for professional claims that need to be split.	A cross year claim is defined as having a Statement Covers From Date in the year prior to the Statement Covers Through Date (e.g., 12/15/17 – 1/15/18) Refer to section 7.17 for instructions on inpatient and outpatient institutional claims.
5	Issuers may submit all versions of a claim (an original and then an adjusted claim as a replacement claim) or submit the final version of the claim (the final adjusted claim).	Issuers who submit only the final adjusted claim must ensure the claim adheres to the requirements in the ICD and the ESBR. For example, if only the final adjusted institutional claim is submitted, issuers should submit it with a **Bill Type** of xx1, since xx7 is only applicable for replacement claims (Please see Rule 3).
6 	If an enrollee has dual coverage in the *same plan*, issuers must combine the claims and submit them as a single claim with *all* **Diagnosis Codes**, **Service Codes**, **Allowed,** and **Paid Amounts**.	Submitting two (2) claims for the same services will result in duplicate claim rejections.
7	Institutional inpatient claims with overlapping stays, at the same or different facility, will only be accepted for enrollees who have dual coverage in *different plans*.	The EDGE server will not accept institutional inpatient claims with overlapping stays at the same or a different facility, for enrollees in the same plan. Please see Section 7.16 for information on overlapping stays.
8	Provider NPIs submitted to the EDGE Server must meet NPI check digit logic.	The EDGE server will perform a check digit validation algorithm on the NPI submitted. Please see the following site for information related to the check digit algorithm: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

7.4 Default and Substitute Values

Issuers may substitute a data value or use a default value in limited circumstances. Issuers who wish to substitute values or default values for data elements other than those listed in Table 52 should email CMS at EDGE_Server_Data@cms.hhs.gov.

When using default values, issuers should consider the rules for duplicate logic to ensure claims are not incorrectly rejected.

Table 52: Default and Substitute Values

Data Element	Default and Substitute Values
Provider IDs	Issuers may use the Billing and Rendering **Provider ID** interchangeably.
Place of Service Codes	Issuers may use a default value of 11, if no **Place of Service** value is available.
Discharge Status Codes	Issuers may default the **Discharge Status Code** for outpatient institutional claims *only* to a value of 01.
Diagnosis Codes	Issuers may use a default **Diagnosis Code** for dental and vision services only, as outlined in Section 7.7.
Statement Covers From and Through Dates and Dates of Service	Issuers may adjust the dates at the claim line or claim header to align only if the change does not result in a claim being accepted, that would otherwise be rejected for another reason. For example: Modifying the **Statement Covers From or To** date to bypass the overlapping stay logic for an institutional claim, or modifying the Dates of Service to bypass duplicate logic *would not be appropriate*. Modifying the **Statement Covers From** date because the submitting provider included a line charge for an earlier date and that service was covered and paid under the claim *would be acceptable*.

7.5 Claim Header and Claim Line Dependencies

The claim line level follows the claim header level in the XML data file. In order for a claim header to be accepted, *all claim lines* must pass all data elements verifications.

Table 53 identifies the rules for claim header and claim line dependencies.

Table 53: Claim Header and Claim Line Dependencies

#	Rule	Notes
1	If any claim header data element fails verification, the EDGE server will reject the entire claim record, including all associated claim lines.	If a claim is rejected, the issuer should resubmit the entire claim and all associated claim lines to be considered for RA or RI program-specific file processing.
2	If *any* claim line data element fails, the EDGE server will reject the *entire claim record*, including the claim header.	If a claim is rejected, the issuer should resubmit the entire claim and all associated claim lines to be considered for RA or RI program-specific file processing.

#	Rule	Notes
3	Dates of Service reported at the claim line level must be within the Statement Coverage dates at the header.	Please see Table 51 if dates must be modified.

7.6 Header, Issuer, and Plan Level Rules Specific to Medical Claims Files

The general header, **Record ID,** and issuer level rules in Section 4.6, Section 4.7, and Section 4.8 apply to all medical claim files.

Table 54 identifies the rules for an additional three (3) summary total data elements at the header, issuer and plan levels specific to medical claims files that must pass a required and logical check verification process.

Table 54: Header, Issuer and Plan Level Total Verifications

#	Rule	Notes
1	The **Total Claims** reported at the *header level* must equal the count of all claim records for *all issuers and plans* on the file. The **Total Claims** reported at the *issuer level* must equal the count of all records for the specific *issuer* submitted. The **Total Claims** reported at the *plan level* must equal the count of all claim records for the specific *plan* submitted. If the **Total Claims** at the header, issuer or plan level does not match the **Total Claims** for the indicated level, the EDGE server will reject that level and all associated sublevels.	For example, if the header level fails and is rejected, the issuer and plan levels will also be rejected.
2	The **Total Claim Lines** reported at the *header level* must equal the count of all claim line records for *all issuers and plans* on the file. The **Total Claim Lines** reported at the *issuer level* must equal the count of all the claim line records for the specific *issuer* submitted. The **Total Claim Lines** reported at the *plan level* must equal the count of all the claim line records for the specific *plan* submitted. If the **Total Claim Lines** at the header, issuer or plan level does not match the **Total Claim Lines** for the indicated level, the EDGE server will reject that level and all associated sublevels.	For example, if the header level fails and is rejected, the issuer and plan levels will also be rejected.

#	Rule	Notes
3	The EDGE server will compare the **Total Plan Paid Amount on File** at the *header level* to the sum of all plan paid amounts for *all issuers and plans* in the file. The EDGE server will compare the **Total Plan Paid Amount for Issuer** at the *issuer level* to the sum of all plan paid amounts for the specific *issuer* on the file. The EDGE server will compare the **Total Plan Paid Amount** at the *plan level* to the sum of all plan paid amounts for the specific *plan* on the file.	If a reported total does not match the associated sum of the level, *then the level will not be rejected*; however, an informational **Error Message** will be produced, notifying the submitter of the discrepancy. For example, if the **Total Plan Paid Amount for Issuer** is $525,000, but the sum of all the issuer's **Plan Paid Amounts** is $524,500, the file will not be rejected. An informational edit will be sent to the submitter identifying the discrepancy.

7.7 Dental and Vision Claims

Table 55 identities the rules for dental and vision claims on the ESMCS files and the required data elements necessary for their inclusion.

Table 55: Dental and Vision Claims

#	Rule	Notes
1	Issuers may submit dental and vision claims included under major medical health plans on the medical claim file.	Issuers should not submit standalone dental and vision plans, which are excluded from RA and RI.
2	All dental and vision claims covered under major medical and submitted on the medical claim file require a valid **Diagnosis Code**. If routine dental and vision services covered under major medical do not include **Diagnosis Codes**, issuers may submit an ICD-10 default value of Z0120 for dental services and Z0100 for vision services.	N/A
3	All professional claims require a **POS Code** value. If a **POS Code** is not available, issuers may use **POS Code** 11 (office) as a default value.	N/A
4 	Issuers *must use* Service Code Type 01 to identify dental services that are submitted with codes that begin with a D.	The EDGE server will reject dental codes for reference check failure if the issuer does not use Service Type Code 01.
5	Issuers may remove Service Code Modifiers from dental and vision claims.	Issuers should ensure the removal of modifiers does not result in rejection due to duplicate claims. Please see Section 7.8 for duplicate claim rules.

7.8 In and Out of Network Medical Claims

Table 56 identifies the rules for populating the In- and Out-of-Network indicator for medical claims. The In and Out-of-Network indicator was added to claims files for use in the AV Calculator and data analysis. As discussed in the 2018 Payment Notice, CMS intends to use the EDGE Server claims data in the AV Calculator in future years. AV helps consumers meaningfully compare plan designs. The AV Calculator calculates AV based on in-network cost sharing, including multi-tiered networks and is not a pricing tool.

Table 56: In-Network and Out-of-Network Indicator

#	Rule	Notes
1	An In-Network and Out-of-Network Indicator is required for claims with a Statement Covers Through Date of January 1, 2018 and later. The In-Network and Out-of-Network Indicator must be either "I" for In-Network or "O" for Out-of-Network.	The indicator should be populated based on the provider's status (not the service/product being provided).
2	Issuers must populate the header line of a claim with "O" if any of the service lines in the claim is populated with a value of "O". • If all of the services lines are populated with "I", then the header level must be "I". • If all of the service lines are populated with "O", then the header level must be "O". • If the service line includes any "O", then the header level must be "O".	The EDGE server will reject a claim if the header line is populated with "I" and any of the service lines are populated with "O".

7.9 Duplicate Medical Claims

Duplicate medical claims submission is the most common cause of claims rejection. To ensure that only one (1) version of an active claim is stored, the EDGE server will perform two (2) types of duplicate claim checks: claim header level duplicates and claim line level duplicates.

Note: Issuers should not submit EDGE server claims or claim lines that are denied for no coverage or lacking previous authorization. For claim lines denied as part of a more inclusive service (included in another covered service), issuers may submit the denied claim lines along with the covered service claim or remove denied claim lines completely from data submission.

Table 57 identifies rules for claim header level duplicate checks. Table 56 identifies rules for claim line level duplicates.

Table 57: Duplicate Checks Performed at the Claim Header

#	Rule	Notes
1	Issuers should not reuse **Claim IDs** on *original claim* submissions (no V or R in the Void/Replace Indicator field). Issuers may reuse **Claim IDs** when submitting a void or replacement claim.	This rule only applies to Medical Claims. Please see the Pharmacy File Processing Section 6.5 for information about Duplicate Claim IDs. The medical claim processing logic checks for duplicate **Claim IDs** on all *active and inactive* claims to prevent the storage of duplicate **Claim IDs** across multiple claim families. If after submission of an original claim, the **Claim ID** matches a stored claim, the new claim and all associated claim lines will be rejected. Issuers can run a Structured Query Language (SQL) query to identify the active stored claim that caused the rejection of a new claim. Please see the EDGE Server Operations and Maintenance Manual (O&MM) available in the REGTAP Library.

7.9.1 Claim Line Duplicate Checks

Duplicate claim line checks are performed across *different claims* only. They are not performed across claims lines in a single claim. In addition, duplicate claim line checks are performed between professional claims and outpatient institutional claims. That is, the system will compare claim lines of newly submitted professional and outpatient institutional claims against both active stored professional and outpatient institutional claims. Professional and outpatient institutional claim lines are never compared to inpatient institutional claims and inpatient institutional claims do not undergo claim line duplicate checks.

Table 58 identifies duplicate checks performed at the claim line.

Table 58: Duplicate Checks Performed at the Claim Line

#	Rule	Notes
1	Inpatient institutional claims do not undergo duplicate checks at the claim line level due to overlapping stay logic. Statement coverage dates that overlap by more than one (1) day at the same or different facility are rejected as duplicates.	Please see Section 7.16, Table 71 for information on overlapping stays.
2	The EDGE server will accept duplicate services reported on multiple service lines *within a single claim*, with or without an exception modifier. The EDGE server will reject duplicate services reported on *different claims, either within the same file or previously submitted and stored on the claim data table*, unless they are submitted with an appropriate exception modifier.	Please see Section 7.9 for information on exception modifiers. Issuers can run a SQL query to identify the active stored claim that caused the rejection of a new claim. Please see the EDGE Server Operations and Maintenance Manual (O&MM) available in the REGTAP Library.

#	Rule	Notes
3	Issuers should not submit duplicate professional or outpatient institutional claim services. The EDGE server uses the following data elements to determine if a duplicate claim line exists: Professional Claims • **Plan ID** • **Unique Enrollee ID** • **Rendering Provider Qualifier** • **Rendering Provider ID** • **Date of Service – From** and **Date of Service – To** • **Service Code** • **Service Code Modifier(s)** • **Place of Service Code** Institutional Outpatient Claims • **Plan ID** • **Unique Enrollee ID** • **Rendering Provider ID Qualifier** • **Rendering Provider ID** • **Bill Type** • **Revenue Code** • **Service Code** • **Service Code Modifier** • **Date of Service – From** and **Date of Service – To**	Duplicate edits may be bypassed in accordance with the information in Section 7.9.

Duplicate checks *at the line level* of professional and outpatient institutional claims are performed on a single or a combination of data values. In addition to the data elements listed in Table 56 the dates of service at the line level are also compared. If any single Date of Service (DOS) (for example, DOS from 2/4/17) on the inbound claim matches any date within the DOS range (for example, DOS from 2/4/17 to 2/6/17) of the active stored claim, it is considered a match.

Table 59 identifies what types of claims will be accepted or rejected.

Table 59: Accepted and Rejected Claims

When the following elements are submitted on a new claim ….	…and an active claim exists in the medical claim table with …	…the new claim is…
Revenue Code (only) (E.G REV 0480)	Matching **Revenue Code** *and* **DOS** (E.G REV 0480)	Rejected
Revenue Code *and* **Service Code** REV 0480 and 93530	Matching **Revenue Code** *and* **Service Code** combination *and* **DOS** REV 0270 and 93530	Rejected
Revenue Code, **Service Code** *and* Modifier REV 0480 and 93530-RT	Matching **Revenue Code**, **Service Code** *and* Modifier combination *and* **DOS** (including inclusive services; please see Section 7.9) REV 0480 and 93530-RT REV 0480 and 93530 (no modifier)	Rejected
Revenue Code, **Service Code** *and* Exception Modifier (please see Section 7.9) REV 0480 and 93530-51	Matching **Revenue Code** *and* **Service Code** *and* any Modifier *and* **DOS** REV 0480 and 93530 REV 0480 and 93530-51	Accepted
Revenue Code, **Service Code** *and* any Modifier REV 0480 and 93530-RT	Matching **Revenue Code**, **Service Code** *and* Exception Modifier (please see Section 7.9) *and* **DOS** REV 0480 and 93530-RT-51	Accepted

Note: Submission of Revenue Codes is *not* required. If a Revenue Code is not present, a comparison of the other data elements will be performed, as indicated, with the same result.

7.10 Exceptions to the Line Level Duplicate Check

Some **Revenue Codes**, **Service Codes** and **Service Code Modifiers** may be billed multiple times in a single day. Therefore, they are exempt from the duplicate checks at the claim line level, even when the duplicate service is billed on a separate claim. Table 60 identifies the rules for these exceptions.



Note: If duplicate services on different claims are valid and eligible for reimbursement, as determined by the issuer through internal operational policies or other guidelines, the issuer may use one (1) of the methods in Rules 2 and 3 to submit the claims. Issuers should document their reasonable determination to support such claims that may be selected for audit.

Table 60: Exceptions to Duplicate Checks at the Claim Line Level

#	Rule	Notes
1	The *duplicate check at the line level* will be bypassed when the following are included on a professional or outpatient institutional claim. **Service Code Modifiers**: If any of the following modifiers are included as one (1) of the four (4) allowable modifier values in a claim line, the EDGE server will accept the claim line: • 25 = Separately Identifiable E&M Service • 27 = Multiple Outpatient Hospital E/M Encounters • 51 = Multiple Procedures • 59 = Distinct Procedural Service • 76 = Repeat Procedure or Service • 91 = Repeat Clinical Diagnostic Laboratory Test • GG = Repeated Mammogram • CA = CMS Approved **Revenue Codes**: • 0250-0259 (Pharmacy) • 0270-0279 (Supplies) • 0631-0637 (Drugs) • 0761 (Observation) **Service Codes**: • 90460 through 90474 (Immunization Administration) • 99199 (Unlisted Procedure Code) **Miscellaneous:** • The EDGE server will bypass claims identified as duplicates if the duplicate line has a zero (0) dollar paid amount.	Please see Table 50 for full descriptions from the official sources. Modifiers may be submitted in any position on the claim; they do not need to be submitted as the first modifier. Service Code Modifier CA is a CMS-created code. It is not an industry standard modifier. See Rule 3 for applicable use. Issuers can run a SQL query to identify the active stored claim that caused the rejection of a new claim. Please see the EDGE Server Operations and Maintenance Manual (O&MM) available in the REGTAP Library.

#	Rule	Notes
2	Issuers may combine claims so that duplicated services are included under a single **Claim ID**. Issuers should include all diagnoses and **Service Codes** (where applicable), and aggregate the allowed and paid amounts for the claims being combined.	Duplicate services in a single claim are not rejected. Please see Option 1 in the examples.
3	Issuers should append Service Code Modifier CA noted above to an adjudicated claim where they have confirmed that the duplicate service is allowable, in order for the EDGE server to accept that claim. Issuers must begin using the Service Code Modifier CA to bypass the duplicate logic for dates of service on or after January 1, 2018. However, Issuers may begin using this code immediately.	Prior to January 2018, issuers could use any exception modifier to bypass the logic.

The following sections illustrate how issuers may submit services performed multiple times for a single Date of Service.

7.10.1 Example of Same Service Rendered Multiple Times on the Same Day without a Service Code Modifier

In Figure 30, the same service is rendered multiple times on the same day without one (1) of the exception **Service Code Modifiers** and both services are submitted in a single claim. The EDGE server will accept this claim.

Figure 30: Same Service Rendered Multiple Times for a Single Date of Service Example

Unique Enrollee ID	Claim ID	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Status
B99715	994A		2014-06-04	2014-06-04	60.00	2014-06-30T12:12:00	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Status
1	80061		2014-06-04	2014-06-04	30.00		Accepted
2	80061		2014-06-04	2014-06-04	30.00		Accepted

7.10.2 Example of Same Service Rendered Multiple Times on the Same Day under Two Different Claims without a Modifier

In Figure 31 and Figure 32, the same service is rendered multiple times on the same day, but the two (2) services were reported under two (2) different claims without a

modifier. The EDGE server will accept the first claim (Figure 31) and reject the second claim (Figure 32) as a duplicate.

Figure 31: Same Service Rendered Multiple Times for a Single Date of Service Claim 1 Example

Unique Enrollee ID	Claim ID	Void /Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	1401CL9		2014-11-12	2014-11-12	30.00	2014-12-01T08:01:42	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061		2014-11-12	2014-11-12	30.00		Accepted

Figure 32: Services Performed Multiple Times for a Single Date of Service Claim 2 Example

Unique Enrollee ID	Claim ID	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	9927RX1		2014-11-12	2014-11-12	30.00	2014-12-15T14:22:04	Rejected due to line failure

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061		2014-11-12	2014-11-12	30.00		Rejected due to duplicate of claim 1401CL9

7.10.3 Example of Same Service Rendered Multiple Times on the Same Day with a Modifier

If an issuer determines that the duplicate service is valid, the issuer may modify the claim data submission in one (1) of two (2) ways.

Option 1: Replace the prior claim, adding the second claim line and aggregating the two (2) claim lines to get a new **Total Amount Paid** at the header. Please see Figure 33.

Figure 29: Services Performed Multiple Times for a Single Date of Service Option 1 Example

Unique Enrollee ID	Claim ID	Void /Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	1401CL9	R	2014-11-12	2014-11-12	60.00	2014-12-15T14:22:04	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061		2014-11-12	2014-11-12	30.00		Accepted
2	80061		2014-11-12	2014-11-12	30.00		Accepted

Note: The date of the replacement claim must be later than the original submission of the claim. In Figure 31, the **Claim Processed Date Time** of the replacement claim is the same as the second claim, but it can be any date time after the original.

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Option 2: Add an exception modifier to the second claim. Please see Figure 34.

Figure 34: Services Performed Multiple Times for a Single Date of Service Option 2 Example

Unique Enrollee ID	Claim ID	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	9927RX1		2014-11-12	2014-11-12	30.00	2014-12-15T14:22:04	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061	25	2014-11-12	2014-11-12	30.00		Accepted

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7.11 Inclusive Services Not Allowed on the Same Day

The EDGE server may identify some professional and outpatient institutional claims as duplicate because the submitted service is part of a more inclusive service submitted on the same day. Table 61 lists inclusive services that the EDGE server will identify as

duplicate. Table 62 provides an explanation and example of each **Service Code Modifier**.



Note: These services are also subject to exception modifiers. For example, if a service line has a **Service Code Modifier** 26 and 25, it will be accepted because **Service Code Modifier** 25 is an exception to the duplicate logic.

Table 62: Inclusive Services Not Allowed on the Same Date

#	Modifier	Rule	Notes
1	26 or TC	Issuers should not submit global services (no modifier) and professional (26 mod) or technical (TC mod) components on *different claims*.	The absence of a **Service Code Modifier** implies that both service components, 26 and TC, were performed. Therefore, the same service was performed on the same day Please see Table 60 for explanations and examples.
2	50	Issuers should not submit a claim for the same service with a modifier 50 and a claim with a modifier RT or LT.	**Service Code Modifier** 50 indicates a bilateral procedure. Submitting the same claim with a service line including modifier LT or RT would be duplicative. Please see Table 60 for explanations and examples.
3	RT/LT	Issuers should not submit a claim for the same service with a modifier RT or LT and a claim with a modifier 50 or no modifier.	**Service Code Modifier** LT/RT indicates a procedure on a particular side. Submitting the same claim with a service line including modifier 50 (bilateral) or no modifier would be duplicative. Please see Table 60 for explanations and examples.
4	RR, NU, UE	Issuers should not submit claims with **Service Code Modifiers** RR, NU, and UE for the same time period.	**Service Code Modifier** RR (rental), NU (new purchase), and UE (used purchase) cannot occur for the same dates of service. The EDGE server identifies a blank modifier, when billed with a DME **Service Code**, to be a new purchase and therefore would be duplicative of any other modifier. Please see Table 60 for explanations and examples.

Table 63: Examples for Inclusive Service Code Modifiers

When the following elements are present on a stored active claim	…and the following elements are submitted on a new claim …	…the new claim is rejected
Service Code **Service Code Modifier** 26 or TC The reverse is also true: **Service Code** and **Service Code Modifier**	Matching **Service Code** No **Service Code Modifier** Matching **DOS** Matching **Service Code** *and* **Service Code Modifier** 26 or TC and Matching DOS	Original Claim: DOS: 1/15/2014 Service: 71020-26 EDGE Accepted New Claim: DOS: 1/15/2014 Service: 71020 *Rejected: Duplicate service*
Service Code **Service Code Modifier** 50 The reverse is also true. **Service Code** **Service Code Modifier** RT	Matching **Service Code** **Service Code Modifier** RT Matching DOS **Service Code** **Service Code Modifier** 50 Matching DOS	Original Claim: DOS: 3/1/14 Service: 20610-50 EDGE Accepted New Claim: DOS: 3/1/14 Service: 20610-RT *EDGE Rejected*
Service Code **Service Code Modifier** LT The reverse is also true. **Service Code** No **Service Code Modifier**	Matching **Service Code** No **Service Code Modifier** Matching DOS **Service Code** **Service Code Modifier** LT Matching DOS	Original Claim: DOS: 1/28/14 Service: 20610-LT EDGE Accepted New Claim: DOS: 1/28/14 Service: 20610 *EDGE Rejected*
Service Code **Service Code Modifier** NU, RR, UE or blank	Matching **Service Code** **Service Code Modifier** NU, RR, UE or blank Matching DOS	Original Claim: E0240-RR 1/1/14 – 1/30/14 Accepted New Claim: E0240 1/16/14 Rejected – Rental claim on file New Claim: E0240-NU 1/20/14 Rejected – Rental claim on file New Claim:

When the following elements are present on a stored active claim	…and the following elements are submitted on a new claim …	…the new claim is rejected
		E0240-UE 2/2/14 Accepted – New DOS

7.12 Claim Processed Date Time

The EDGE server uses the **Claim Processed Date Time** data element, reported at the claim header level, to determine processing order. Issuers should differentiate claims adjusted multiple times and submitted on the same or subsequent medical claim file for appropriate processing.



Note: Issuers who do not capture or populate the time component of the **Claim Processed Date Time** should carefully review these rules.

Table 63 identifies rules for claim processing date time.

Table 63: Claim Processing Date Time Rules

#	Rule	Notes
1 	All claims must include a date and time in the **Claim Processed Date Time** field.	Issuers may create the time component to clearly identify the order of processing when submitting multiple claims on a single file, or when submitting a void/replace claim.
2	If an issuer submits multiple versions of the same claim, due to void or replacement, each claim must include a unique time component of the **Claim Processed Date Time**, even if the **Void/Replace Indicator** is included.	If the time component of the **Claim Processed Date Time** is not provided, or is not unique, the EDGE server will reject all claims with the same **Issuer ID** and **Claim ID**, as the system is unable to identify the processing order of the claims.
3	The **Claim Processed Date Time** of a submitted void or replacement claim *must be later* than the most current stored active claim or the void or replacement claim will be rejected.	Please see Section 7.12 for information on submission of voids. Please see Section 7.13 for information on submission of replacements.

The following examples illustrate the **Claim Processed Date Time** rules.

In Figure 35, the EDGE server will reject both claims because the **Claim Processed Date Time** is identical on the original claim and the replacement claim.

Figure 35: Claim Processing Data Time Rules Example

Issuer ID	Claim ID	Void / Replace Indicator	Original Claim ID	Total Plan Paid Amount	Claim Processed Date Time
9988776	2014041299256			5000.00	**2014-06-03T00:00:00**
9988776	2014041299277	R	2014041299256	5500.00	**2014-06-03T00:00:00**

In Figure 36, the EDGE server will accept both claims because each claim has a unique **Claim Processed Date Time**.

Figure 36: Claim Processing Data Time Rules – Unique Processed Date Time Example

Issuer ID	Claim ID	Void / Replace Indicator	Original Claim ID	Total Plan Paid Amount	Claim Processed Date Time
9988776	2014041299256			5500.00	**2014-06-03T00:00:00**

The EDGE server also uses **Claim Processed Date Time** to identify the order of processing when void and replacement claims are submitted on different files. Please see Section 7.12, Table 63 and Section 7.13, Table 14 for more information.

7.13 Voiding Medical Claims

Issuers can void previously submitted and accepted claims stored as active. Using the value "V" as the **Void/Replace Indicator**, an issuer can change an active stored claim to an inactive status, thereby removing it from consideration for RI or RA calculations. The EDGE server will accept submission of multiple void and replace claims within a single medical claim file.

Table 64 identifies the rules for void processing for medical claims.

Table 64: Void Processing Logic for Medical Claims

#	Rule	Notes
1	Issuers can reuse Claim IDs when voiding medical claims.	N/A
2	For the EDGE server to void a medical claim, the following must be true: • A "V" must be in the **Void/Replace Indicator** field. • Issuers may only use **Bill Type** xx1 or xx8 for institutional claims. • The **Issuer ID** and **Original Claim ID** must match a stored active claim. • The **Claim Processed Date Time** must be later than original claim.	Please see Table 59 for **Claim Processed Date Time Rules**.

#	Rule	Notes
3	Once an issuer submits a void claim and the original claim changes from active to inactive status, the claim is no longer eligible for consideration in the RI or RA programs.	N/A
4	An issuer may reactivate a voided claim by submitting a replacement claim (R indicator) with a **Claim Processed Date Time** later than the submitted void claim. An issuer may also reactivate a previously voided claim by submitting a new original claim (no R indicator) but it *must* include a new **Claim ID**.	The same **Claim ID** may be used if replacing a voided claim. **Claim IDs** must be unique. Please see Table 56.
5 	The following data elements must be present on a void claim. All other fields may be null. Claim Header • **Record ID** • **Void/Replace Indicator ("V")** • **Claim ID** • **Original Claim ID** • **Claim Processed Date Time** (must be later than the claim being voided) Claim Line • **Record ID** • **Claim Line Sequence Number** (may be defaulted to 0 for all lines) **Total Amount Allowed** and **Total Amount Paid** are *not* required. If populated, the value can be a negative amount. The EDGE server will verify any other submitted data values in accordance with the restrictions in the ICD. The EDGE server will reject any data element that fails verifications.	Please see Appendix D for required data elements when submitting a void claim.

Table 65 identifies the six (6) steps involved in voiding a previously submitted medical claim.

Table 65: Steps to Void a Previously Submitted Medical Claim

#	Step
1	The issuer submits an original claim that is accepted and stored as active.
2	The issuer submits a void and populates the "V" in the **Void/Replace Indicator** field and the **Original Claim ID**.

#	Step
3	The EDGE server identifies the void by the "V" populated in the **Void/Replace Indicator** field.
4	The EDGE server uses the **Original Claim ID** to find the original claim. • If a match is not found, the void is rejected. • If a match is found, the process continues.
5	The EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. • If the date time passes, the original claim will be inactivated. • If the date time fails, the original claim will *not* be inactivated and the void claim will be rejected. *When a void is processed, the EDGE server only inactivates original claims if the date time verification passes.* Please see Table 62 for **Claim Processed Date Time** information.
6	The EDGE server checks the remaining required data elements to determine if the void claim should be accepted. • If all data elements pass, the void claim is stored as inactive. • If one (1) or more data elements fail, then the void claim will not be stored and the void claim will be rejected. *Even if the void is rejected, the original claim remains inactive.*

The following examples illustrate the medical claims data table before and after void submission.

In Figure 37, the medical claims data table shows claim 123, processed on February 27, 2014. The EDGE server accepted the claim and stored it with a status of active.

Figure 37: Medical Claims Data Table Before Void Submission Example

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
999887	123			2014-02-27T16:02:20	720	735.00	Active

In Figure 38, the issuer submits a void on March 2, 2014 with a **Claim Processed Date Time** later than the original claim. The EDGE server uses the **Original Claim ID** to locate the active claim in the data table.

Figure 38: Medical Claims Data Table Void Submission Example

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount
999887	123	123	V	2014-03-02T10:01:50	720	735.00

In Figure 39, the EDGE server has found the original claim and changed the status from active to inactive. The submitted void is included in the claim data table as inactive.

Figure 39: Medical Claims Data Table After Void Submission Example

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
999887	123	123	V	2014-03-02T10:01:50	720	735.00	Inactive
999887	123			2014-02-27T16:02:20	720	735.00	Inactive

7.14 Replacing Medical Claims

Issuers can replace previously submitted, accepted, and stored claims. By using the value “R” as the **Void/Replace Indicator**, an issuer can change an active stored claim to an inactive status and replace the inactive claim with a new version.

Table 66 identifies the rules for replacement processing for medical claims.

Table 66: Replacement Processing Logic for Medical Claims

#	Rule	Notes
1	Issuers can reuse **Claim IDs** when replacing medical claims.	N/A

#	Rule	Notes
2	For the EDGE server to replace a medical claim, the following must be true: • An "R" must in the **Void/Replace Indicator** field. • Issuers must include all required data elements on a replacement claim in order for the replacement claim to be processed. • Issuers may only use **Bill Type** xx1 or xx7 on institutional claims. • The **Issuer ID** and **Original Claim ID** must match a stored claim (either active or inactive). • The **Claim Processed Date Time** must be later than the most current active or inactive claim.	N/A
3	The issuer may use any previously submitted **Claim ID** as the **Original Claim ID** for the service being replaced. If multiple claims exist in a claim family, any Claim ID within the family may be used. The **Claim Processed Date Time** will be compared to the **Claim Processed Date Time** of the most recent active or inactive claim in the claim family.	N/A
4	The issuer should include the final, aggregated **Total Amount Paid**, as well as all **Diagnosis Codes** and **Service Codes**, in the replacement claim. Issuers should not submit a negative value for the **Total Amount Paid** when replacing a claim.	The original claim will be inactivated and the replacement claim will be used to calculate RI payments and RA risk scores. Submitting a negative **Total Amount Paid** will reduce the aggregated costs for an enrollee.
5	If the EDGE server rejects a replacement claim, issuers should resubmit a corrected version of the replacement claim, in accordance with the replacement rules here.	In most cases, if a replacement claim is rejected, the original claim is inactivated and is therefore no longer eligible for consideration in RA or RI. Please see Steps 5 and 6 in Table 66 for information related to claim inactivation.

Table 67 identifies the six (6) steps involved in replacing a previously submitted medical claim.

Table 67: Steps to Replace a Previously Submitted Medical Claim

#	Step
1	The issuer submits an original claim that is accepted and stored as active.
2	The issuer submits a replacement and populates the "R" in the **Void/Replace Indicator** field and the **Original Claim ID**.

#	Step
3	The EDGE server identifies the replacement by the "R" populated in the **Void/Replace Indicator** field.
4	The EDGE server uses the **Original Claim ID** to find the original claim. • If a match is not found, the replacement is rejected. • If a match is found, the process continues.
5	The EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. • If the date time passes, the original claim will be inactivated. • If the date time fails, the original claim will not be inactivated and the replacement claim is rejected. *The EDGE server may inactivate original claims without accepting a replacement.*
6	The EDGE server checks the remaining required data elements to determine if the replacement claim should be accepted. • If all data elements pass, the replacement claim is stored as active. • If one (1) or more data elements fail, the replacement claim will not be stored and the replacement claim will be rejected. *If rejected, there will be no active claim on file for the enrollee because the original claim was already inactivated in Step 6.*

The following examples illustrate the medical claims data table before and after replacement submission.

In Figure 40, the medical claim data table includes the original claim submitted on January 15, 2014 and a replacement of the original claim on February 27, 2014. After submission of the replacement, the EDGE server set the original claim to inactive and accepted and stored the new claim as active.

Note: A new **Claim ID** (999A1) was used for the replacement claim, which referenced the **Original Claim ID** (999). If a new replacement is needed, either **Claim ID** 999 or 999A1 may be used for the **Original Claim ID** because they belong to the same claim family.

Figure 40: Medical Claims Data Table Before and After Replacement Submission Example 1

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
12345	999A1	999	R	2014-02-27T16:02:20	720	735.00	Active
12345	999			2014-01-15T11:14:55	720	135.00	Inactive

In Figure 41, the issuer submits replacement claim 999A2 on March 2, 2014. Either 999 or 999A1 may be used as the **Original Claim ID**. The system will compare the **Claim Processed Date Time** to determine if the new claim is later than the most current active version of the claim.

Figure 41: Medical Claims Data Table Before and After Replacement Submission Example 2

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount
12345	999A2	999	R	2014-03-02T10:01:50	720	1735.00

In Figure 42, the EDGE server found the original claim and compared the **Claim Processed Date Time** to the submitted replacement. Since the submitted replacement is later than the most current active claim, the active claim is changed to inactive. Upon verifying all data elements on the replacement claim, the EDGE server accepts and stores the claim as the new active claim.

Figure 42: Medical Claims Data Table Before and After Replacement Submission Example 3

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
12345	999A2	999A1	R	2014-03-02T10:01:50	720	1735.00	Active
12345	999A1	999	R	2014-02-27T16:02:20	720	735.00	Inactive
12345	999			2014-01-15T11:14:55	720	135.00	Inactive

7.15 FFS and Capitated Claim Submission

The following section outlines the values that must be submitted at the claim header and claim line levels when submitting FFS and capitated medical claims.

All FFS and capitated medical services submitted to the EDGE Server must include a **Total Amount Allowed** that is greater than $0 at *the claim header* level. When the claim header allowed amount is equal to $0, and the service was not inclusive or part of a more comprehensive service that was paid, this indicates the service was not covered and/or denied. Therefore, the service is not eligible for consideration in the RA and RI programs and the claim must not be submitted. The **Amount Allowed** at *the claim line* level may be equal to or greater than $0.

Both the **Total Amount Paid**, *on the claim header* level, and the **Amount Paid**, at *the claim line* level may be submitted with a value that is equal to or greater than $0.

7.15.1 FFS Claim Submission

This section explains the use of the **Derived Amount Indicator** and **Date Paid,** and how **Total Amount Allowed** and **Total Amount Paid** are defined for submission to the EDGE server when medical claims are processed under a FFS arrangement.

Table 68 identifies the rules for submitting FFS claims.



The rules for paid and allowed amounts indicated in the following table are not applicable to claims with a Void indicator. Void claims do not require population of allowed or paid amounts. See Appendix C.

Table 68: FFS Claims Submission Rules

#	Rule	Notes
1	Issuers must submit a **Derived Amount Indicator** of "N" *at the claim header and claim line* when submitting FFS claims.	Issuers who have FFS and capitated services on the same claim should refer to Section 7.14.3.
2	The **Date Paid** field must be populated.	If the **Date Paid** field is not populated, the claim will be rejected.
3 	The **Total Amount Allowed** *at the claim header* must be greater than $0. • The **Total Amount Allowed** must be submitted as the sum of the **Total Amount Paid** plus the enrollee liability unless the claim is part of a more inclusive service as stated in Rule 4.	Claims submitted with a Total Amount Allowed equal to or less than $0 will be rejected. Prior to January 1, 2016, issuers were permitted to submit any value for the **Total Amount Allowed**.

#	Rule	Notes
4	A **Total Amount Allowed** of $1.00 is permitted only when the medical service is included in the **Total Amount Allowed** of a more comprehensive service, either an actual (FFS) paid amount or a derived (capitated) paid amount.	For example, a lab service provided in association with an inpatient surgical stay and the lab service was covered under the case rate for the inpatient surgical stay.
5	The **Amount Allowed** *at the claim line* level may be equal to or greater than $0.	N/A
6	The **Total Amount Paid**, *at the claim header* level, and **Amount Paid**, *at the claim line* level, may be submitted with a value equal to or greater than $0.	N/A

Example 1: Claim with FFS Claim Lines and an Inclusive Service

A FFS claim was processed and resulted in a **Total Amount Paid** of $1200 with an enrollee liability of $300 for a **Total Amount Allowed** of $1500. Claim Line 2 was an inclusive service covered under Claim Line 1. The claim would be submitted to the EDGE server as shown in Figure 43.

Figure 43: FFS Claim Example with Inclusive Service

Record ID	Claim ID	Statement Covers From	Statement Covers Through	Date Paid	Total Amount Allowed	Total Amount Paid	Derived Amount Indicator
194	6454T1	2016-03-12	2016-03-12	2016-05-01	1500.00	1200.00	N

Record ID	Claim Line	Date of Service From	Date of Service To	……	Amount Allowed	Amount Paid	Derived Amount Indicator
195	1	2016-03-12	2016-03-12	……	1500.00	1200.00	N
196	2	2016-03-12	2016-03-12	……	0.00	0.00	N

Example 2: FFS Claim Covered Under a More Comprehensive Service

A FFS claim was processed and resulted in a **Total Amount Paid** of $0 with an enrollee liability of $0 because the claim was part of the **Total Amount Paid** for the associated inpatient stay. Claim Line 1 was an inclusive service covered under an associated claim. The claim would be submitted to the EDGE server as shown in Figure 44.

Figure 44: FFS Claim Covered Under a More Comprehensive Service

Record ID	Claim ID	Statement Covers From	Statement Covers Through	Date Paid	Total Amount Allowed	Total Amount Paid	Derived Amount Indicator
2550	M90LB	2018-05-01	2018-05-01	2018-05-28	$1.00	$0.00	N

Record ID	Claim Line	Date of Service From	Date of Service To	.....	Amount Allowed	Amount Paid	Derived Amount Indicator
2551	1	2018-05-01	2018-05-01	.....	$0.00	$0.00	N

7.15.2 Capitated Services Submission

Issuers must derive (or estimate) paid amounts for medical services provided under a capitation arrangement. Allowed amounts on capitated claims must adhere to the requirement that an allowed amount at the claim header must be greater than $0.

The inbound claim file's **Derived Amount Indicator** field identifies when the paid and allowed amount has been estimated for medical services provided under a capitation arrangement. The issuer must determine the estimated paid amount of the medical services based on the encounter data submitted by the rendering provider for actual services provided. For information about capitated claims, please refer to 45 CFR §153.710.

This section explains the use of the **Derived Amount Indicator**, **Date Paid** and how **Total Amount Allowed** and **Total Amount Paid** are defined for submission to the EDGE server when medical claims are processed under a capitation arrangement.

Table 69 identifies the rules for submitting capitated claims.

The rules for paid and allowed amounts indicated in the following table are not applicable to claims with a Void indicator. Void claims do not require population of allowed or paid amounts. See Appendix C.

Table 69: Capitated Services Submission Rules

#	Rule	Notes
1	Issuers must submit a derived **Total Amount Paid**, at the claim header, that is reasonable and based on a methodology of their choosing.	Refer to 45 CFR §153.710. Issuers must make every effort to develop an internal methodology for providing accurate derived allowed amounts whenever possible.

#	Rule	Notes
2	Issuers must submit a **Derived Amount Indicator** of "Y" at the claim header and all claim lines when submitting capitated services.	Issuers who have FFS and capitated services on the same claim should refer to Section 7.14.3.
3	The **Date Paid** field may be null or populated with the date of claim adjudication.	Issuers are not required to populate this field for *capitated services*.
4	The **Total Amount Allowed** *at the claim header* must be greater than $0. • Issuers must submit the derived **Total Amount Paid** in the **Total Amount Allowed** data field unless the claim is part of a more inclusive service as stated in Rule 5.	Claims submitted with a **Total Amount Allowed** equal to $0 will be rejected. Prior to January 1, 2016, issuers were permitted to submit any value for the allowed cost.
5	A **Total Amount Allowed** of $1.00 is permitted only when the medical service is included in the **Total Amount Allowed** of a more comprehensive service, either an actual (FFS) paid amount or a derived (capitated) paid amount.	For example, a lab service provided in association with an inpatient stay and the lab service was covered under a FFS case rate or capitated payment arrangement for the inpatient stay claim.
6	The **Amount Allowed** *at the claim line* level may be equal to or greater than $0.	N/A
7	The **Total Amount Paid**, *at the claim header level*, and **Amount Paid**, *at the claim line level*, may be submitted with a value equal to or greater than $0.	N/A

Example: Capitated Medical Claim

In Figure 45, a capitated encounter was processed and resulted in a **Total Amount Allowed** and **Total Amount Paid** of $0. A reasonable method was used to determine the amount that would have been paid for the service under a FFS arrangement, and a derived **Total Amount Paid** of $125 was estimated.

*The **Total Amount Allowed** is submitted with a value equal to the **Total Amount Paid**.*

*The **Amount Allowed** and **Amount Paid** on the claim line could also be submitted as 0.00.*

Figure 45: Claim with Only Capitated Service Lines Claim Header Example

Record ID	Claim ID	Statement Covers From	Statement Covers Through	Date Paid	Total Amount Allowed	Total Amount Paid	Derived Amount Indicator
886	DC02557	2016-08-22	2016-08-22		125.00	125.00	Y

Record ID	Claim Line	Date of Service From	Date of Service To	……	Amount Allowed	Amount Paid	Derived Amount Indicator
887	1	2016-08-22	2016-08-22	……	125.00	125.00	Y

Example 2: Capitated Claim Covered Under a More Comprehensive Service

A capitated claim was processed and resulted in a **Total Amount Allowed** and **Total Amount Paid** of $0 and was part of a more comprehensive service that was submitted separately with a derived **Total Amount Allowed**. The claim would be submitted to the EDGE server as shown in Figure 46.

Figure 46: Capitated Claim Covered Under a More Comprehensive Service

Record ID	Claim ID	Statement Covers From	Statement Covers Through	Date Paid	Total Amount Allowed	Total Amount Paid	Derived Amount Indicator
2550	M90LB	2018-05-01	2018-05-01	2018-05-28	$1.00	$0.00	N

Record ID	Claim Line	Date of Service From	Date of Service To	……	Amount Allowed	Amount Paid	Derived Amount Indicator
2551	1	2018-05-01	2018-05-01	……	$0.00	$0.00	N

7.15.3 Mixed Claims – FFS and Capitated Services

Issuers with claims that include both FFS and capitated services should derive the paid amounts associated with the capitated services and submit both the FFS and capitated services to the EDGE server.

This section explains the use of the **Derived Amount Indicator, Date Paid** and how **Total Amount Allowed** and **Total Amount Paid** are defined for submission to the EDGE server when medical claims include some service lines are paid as FFS and other service lines are covered under capitation.

Table 70 identifies the rules for submitting claims that include both FFS and capitated services.

The rules for paid and allowed amounts indicated in the following table are not applicable to claims with a Void indicator. Void claims do not require population of allowed or paid amounts. See Appendix C.

Table 70: Mixed Claims - FFS and Capitated Services Rules

#	Rule	Notes
1	Issuers must submit a **Derived Amount Indicator** of "Y" *at the claim header* when submitting claims that include both FFS and capitated services.	Issuers must make every effort to develop an internal methodology for providing accurate derived allowed amounts whenever possible.
2	Issuers should submit the applicable **Derived Amount Indicator**, *at the claim line*, that indicates if the claim services were capitated ("Y") or FFS ("N").	N/A
3	The **Date Paid** field may be null or populated with the date of claim adjudication.	Issuers are not required to populate this field for capitated services.
4	The **Total Amount Allowed** *at the claim header* must be greater than $0. • Issuers must submit the **Total Amount Paid** in the **Total Amount Allowed** data field unless *all services* on the claim are part of a more inclusive service as outlined in Rule 5.	Claims submitted with a Total Amount Allowed equal to $0 will be rejected.
5	A **Total Amount Allowed** of $1.00 is permitted only when the medical service is included in the **Total Amount Allowed** of a more comprehensive service, either an actual (FFS) paid amount or a derived (capitated) paid amount.	CMS expects there to be an allowed amount greater than $0 in the case of mixed claims, under most circumstances, since a service will either have an actual payment (FFS) or will have a derived payment (capitated).
6	The **Amount Allowed** *at the claim line* level may be equal to or greater than $0 for any service.	N/A
7	The **Total Amount Paid**, *at the claim header level*, and **Amount Paid**, *at the claim line level*, may be submitted with a value equal to or greater than $0 for any service.	N/A

Example: Claim with FFS and Capitated Service Lines

In Figure 47, one (1) claim line was covered under capitation, resulting in an **Amount Paid** of $0, and one (1) claim line was paid as FFS, resulting in an **Amount Paid** of $60. A reasonable method was used to determine the amount that would have been paid for the service submitted on Claim Line 1. A derived **Amount Paid** of $140 was estimated for the capitated service.

Figure 47: Claim with FFS and Capitated Service Lines Claim Header Example

Record ID	Claim ID	Statement Covers From	Statement Covers Through	Date Paid	Total Amount Allowed	Total Amount Paid	Derived Amount Indicator
4422	C021MX	2016-11-10	2016-11-10		200.00	200.00	Y

Record ID	Claim Line	Date of Service From	Date of Service To	.....	Amount Allowed	Amount Paid	Derived Amount Indicator
4423	1	2016-11-10	2016-11-10	.....	0.00	60.00	N
4424	2	2016-11-10	2016-11-10	.....	0.00	140.00	Y

*The **Total Amount Allowed** is submitted with a value equal to the **Total Amount Paid**.*

Example 2: Mixed Claim Covered Under a More Comprehensive Service

CMS expects this to be an uncommon scenario since at least one claim would likely have an actual paid amount or a derived amount.

A claim with both FFS and capitated services was processed and resulted in a **Total Amount Paid** of $0 and was part of a more comprehensive service that was submitted separately with a derived **Total Amount Allowed** greater than $0. The claim would be submitted to the EDGE server as shown in Figure 48.

Figure 48: Mixed Claim Covered Under a More Comprehensive Service

Record ID	Claim ID	Statement Covers From	Statement Covers Through	Date Paid	Total Amount Allowed	Total Amount Paid	Derived Amount Indicator
6227	UnKSrvc1	2018-09-01	2018-09-01	2018-10-28	$1.00	$0.00	Y

Record ID	Claim Line	Date of Service From	Date of Service To	.....	Amount Allowed	Amount Paid	Derived Amount Indicator
6228	1	2018-09-01	2018-09-01	.....	$0.00	$0.00	Y
6229	2	2018-09-01	2018-09-01	.....	$0.00	$0.00	N

7.16 Tobacco Cessation Services Covered Under Capitation

Issuers who cover tobacco cessation services under capitated arrangements may submit such services to the EDGE server for consideration. Table 71 identifies the rules for submitting tobacco cessation services.

Table 71: Tobacco Cessation Services

#	Rule	Notes
1	The **Amount Paid** submitted for tobacco cessation services must be a derived amount and not the issuer's paid per member per month amount.	Please see Table 69, Rule 4 and Rule 5.
2	Issuers must submit all required data elements, as identified in the ICD, including the most current CPT or HCPC **Service Codes** and **Diagnosis Codes** published. For claims with **Statement Covers From** 10/1/2015 or later, issuers may use a default ICD-10 **Diagnosis Code** value of F17200 or Z87891. Issuers may use a default **Service Code** value of G0436, G0437, 99406 or 99407 until such codes are replaced or no longer valid.	The current default values for the **Diagnosis Codes** are applicable to the ICD-10 coding system only.



Note: Issuers may submit tobacco cessation services that are covered under a fee-for-service arrangement to the EDGE server in accordance with the requirements in the ICD and this document.

7.17 Overlapping Stay Logic for Inpatient Claims

Issuers should not submit a medical claim that indicates an enrollee was an inpatient at the same or different facility for the same time period, except on the date of a transfer or if the **Plan ID** is different.

Table 72 identifies the rules for determining whether inpatient stay has an overlapping stay.

Table 72: Inpatient Stays on Medical Claims Files

#	Rule	Notes
1	When an issuer submits an inpatient claim, the EDGE server uses the following data elements to determine if a similar claim is on the medical claim data table in an active status: • **Unique Enrollee ID** • **Statement Covers From** • **Statement Covers Through** • **Plan ID**	N/A

#	Rule	Notes
2	The EDGE server identifies any active inpatient claim with a date equal to or between the **Statement Covers From Date** and **Statement Covers Through Date**. If the **Statement Covers From** date or the **Statement Covers Through** date is the only date that overlaps, the EDGE server accepts the new claim. If any date between the **Statement Covers From Date** and **Statement Covers Through** date overlaps, then the EDGE server compares the **Plan ID**: • If the **Plan ID** on the new claim is different from the **Plan ID** of the active claim, the EDGE server will accept the new claim. • If the **Plan ID** on the new claim is the same as the **Plan ID** of the active claim, EDGE server will reject the new claim.	Issuers can run a SQL query to identify the active stored claim that caused the rejection of a new claim. Please see the EDGE Server Operations and Maintenance Manual (O&MM) available in the REGTAP Library.

Examples: Inpatient Overlapping Stays Rules

In Figure 49, only the **Statement Covers Through** on Claim 123 overlaps the **Statement Covers From** on Claim 456. Therefore, Claim 456 passes the overlapping stay logic, and the EDGE server will accept it.

Figure 49: Inpatient Overlapping Stays Example

	Unique Enrollee ID	Claim ID	Plan ID	Statement Covers From	Statement Covers Through	Status	Accept/ Reject
Previously Accepted Claim	M4jk903	123	12345VA001999901	2014-01-17	**2014-01-22**	Active	
New Claim	M4jk903	456	12345VA001999901	**2014-01-22**	2014-01-25		Accept

In Figure 50, the **Statement Covers From** on Claim 456 is between the statement coverage dates on Claim 123, and the **Plan ID** is the same. Therefore, Claim 456 fails the overlapping stay logic, and the EDGE server will reject it.

Figure 50: Inpatient Overlapping Stays Multiple Days Overlap with Same Plan ID Example

Unique Enrollee ID	Claim ID	Plan ID	Statement Covers From	Statement Covers Through	Status	Accept /Reject
B99!n5	456	98765VA001999901	**2014-03-20**	**2014-03-25**		Reject
B99!n5	123	98765VA001999901	**2014-03-15**	**2014-03-28**	Active	

In Figure 51, the statement coverage dates on Claim 456 are the same as the statement coverage dates on Claim 123, but the **Plan ID** is different. Therefore, Claim 456 passes the overlapping stay logic, and the EDGE server will accept it.

Figure 51: Inpatient Overlapping Stays Multiple Days Overlap with Different Plan ID Example

Unique Enrollee ID	Claim ID	Plan ID	Statement Covers From	Statement Covers Through	Status	Accept /Reject
B99!n5	456	**12345VA001999901**	**2014-03-15**	**2014-03-28**		Accept
B99!n5	123	**98765VA001999901**	**2014-03-15**	**2014-03-28**	Active	

7.18 Institutional Bill Types

Issuers must include a **Bill Type** for all institutional claims submitted on a medical claim file. However, to streamline file processing, the EDGE server will only accept a subset of **Bill Types**. Issuers must assess and convert, where appropriate, any **Bill Type** with a frequency code other than xx1, xx7, or xx8 for consideration in RA and RI programs. Table 73 identifies the rules for permitted **Bill Types**.

Please see Section 7.18 and Section 7.19 for information on converting interim bills and late charges for submission.

Table 73: Institutional Bill Types

#	Rule	Notes
1	The first digit of the **Bill Type** indicates the type of facility in which a service was performed. The EDGE server will accept all facility types. The second digit of the **Bill Type** indicates the bill classification. The EDGE server will accept all classifications. The third digit of the Bill Type indicates frequency. All **Bill Types** submitted must have a frequency code of 1, 7 or 8: • **Bill Type** xx1 may be used for original, replacement, or void claim submissions. • **Bill Type** xx7 may only be used for replacement claims, and the claim record must include the "R" indicator. • **Bill Type** xx8 may only be used for void claims, and the claim record must include the "V" indicator.	Issuers may convert eligible claims with Bill Types that have a frequency code other than xx1, xx7, or xx8 in order for those claims to be considered for RA and RI. Please see Table 73 for more information.
2	Only **Bill Types** included in the RA program will be selected at the time of RA calculation. Acceptable RA **Bill Types** are: 111, 117, 131, 137, 711, 717, 761, 767, 771 and 777.	The RI program has no **Bill Type** exclusions.
3	An institutional inpatient claim must have a **Discharge Status Code** other than 30 (still a patient) to be accepted.	N/A
4	Issuers may default the **Discharge Status Code** to 01 for any outpatient institutional claim. Issuers may modify the **Discharge Status Code** to 01 for *inpatient* institutional claims when the issuer has confirmed that no additional services will be covered or payments made and in accordance with issuer's company policies and where: • The **Discharge Status Code** was either not submitted or incorrectly submitted with a 30 by the Rendering Provider.	If new information becomes available that changes the **Discharge Status**, issuers must submit a replacement. Issuers should apply reasonable judgment and good business practices when making the decision to use the default discharge status 01 to submit claims to the EDGE server.

Table 74 identifies the rules for converting **Bill Types** other than xx1, xx7, or xx8.

Note: CMS uses NUBC as the official source of Bill Type frequency descriptions.

Table 74: Converting Eligible Claims with Bill Type Frequencies Other than xx1, xx7 or xx8

#	Frequency	Rule	Notes
1	0 – Non-Payment/Zero	CMS considers nonpayment or zero (0) claims denied services and therefore not eligible for consideration for RA or RI.	If an issuer determines a claim represents a valid paid service that should be included in RA or RI, an issuer may convert the **Bill Type** into an acceptable frequency code (xx1, xx7, or xx8) for submission. Issuers will need to provide supporting documentation that these claims were paid and therefore eligible for consideration should they be selected during audit.
2	2, 3, and 4 – Interim First, Continuing, and Last	Institutional interim billing rules apply.	Please see Section 7.17.1 for information on institutional interim billing.
3	5 – Late Charges (Only)	Late charges rules apply.	Please see Section 7.18 for information on late charges.
4	6 – Reserved for National Assignment	CMS considers any **Bill Type** codes with this description as undefined and therefore not eligible for consideration for RA or RI.	If an issuer determines a claim represents a valid paid service that should be included in RA or RI, an issuer may convert the **Bill Type** into an acceptable frequency code (xx1, xx7 or xx8) for submission. Issuers will need to provide supporting documentation that these claims were paid and therefore eligible for consideration should they be selected during audit.
5	9 – and any Alpha **Bill Type** Frequency	Services covered and paid under these **Bill Type** frequencies may be eligible for consideration.	If an issuer determines a claim represents a valid paid service that should be included in RA or RI, an issuer may convert the **Bill Type** into an acceptable frequency code (xx1, xx7 or xx8) for submission. Issuers will need to provide supporting documentation that these claims were paid and therefore eligible for consideration should they be selected during audit.

7.18.1 Institutional Interim Billing

For EDGE server medical claim file processing, CMS established rules to streamline EDGE server file processing of inpatient and outpatient interim bills received and processed by issuers, which are complex and span long periods of time.

CMS used the following assumptions to determine the rules for institutional interim bills:

- An interim bill is used to report ongoing inpatient care.
- An interim bill is used to report inpatient stays that exceed 30 days.
- Inpatient stays that exceed 30 days are typically submitted to issuers, with **Bill Type** frequency codes of xx2, xx3 or xx4.
- Outpatient services provided over long periods of time (such as ongoing therapy) are less complex and are usually submitted and adjudicated more frequently (30 days or less).

7.18.2 Inpatient Interim Billing and Cross Year Claims

Table 75 identifies the rules for inpatient interim bills and cross year claims.

Table 75: Inpatient Interim Bill Rules

#	Rule	Notes
1	Issuers must not submit inpatient interim bills with frequency codes xx2, xx3, and xx4 on the medical claim file to the EDGE server.	Please see the subsequent rules for methods of submitting inpatient interim bills.
2	Inpatient Hospital • Issuers must aggregate all interim bills into a final claim and submit it with frequency code xx1. • Aggregated claims must include all *paid* charges and discharge **Diagnosis Codes** for the entire length of stay. • Issuers must submit adjustments to aggregated interim claims using the replacement claim process and frequency code xx1 or xx7. Claims That Cross Benefit Years Issuers must submit inpatient hospital claims that cross a benefit year, in aggregate, in the year when the discharge occurred. Issuers may *not* split inpatient hospital claims across benefit years.	Please see examples in Section 7.17.1.1.

#	Rule	Notes
3	**Inpatient interim bills** – All locations other than an Inpatient Hospital setting: Option 1 • Issuers may aggregate interim bills and include all paid charges and discharge **Diagnosis Codes** for the duration of the stay. • Issuers must submit aggregated claims with a **Bill Type** frequency code of xx1. • Issuers must submit adjustments using the replacement claim process and frequency code xx1 or xx7. Option 2 • Issuers may submit interim claims, after each claim is adjudicated, but must only include the paid amounts and discharge diagnoses associated with the interim period. • Interim claims must have **Statement Coverage From** and **Statement Coverage Through** dates that reflect the interim period only. Otherwise, subsequent claims may be rejected as duplicates. • Issuers must submit interim claims with a **Bill Type** frequency code of xx1. • Issuers must submit adjustments using the replacement claim process and frequency code xx1 or xx7. Claims That Cross Benefit Years Issuers may submit inpatient claims that occur in a setting other than a hospital and cross a benefit year, in aggregate, either at the time of discharge (Option 1) or split (Option 2) across benefit years. Issuers may also combine Options 1 and 2 and submit an aggregated amount for one (1) benefit year and another aggregated amount for the following benefit year. Statement coverage periods and/or dates of service, submitted as an aggregated claim, may be strict (ending on December 31) or may span benefit years.	Please see examples in Section 7.17.1.2.

CMS expects issuers to have and apply internal operational policies that define the point in time at which no further action will be taken on claims. CMS also expects issuers will apply such policies, or other reasonable guidelines, to determine when all claims have been adjudicated and are finalized prior to submission to the EDGE server. Issuers should adequately document reasonable determinations for claims that may be selected for audit.

Note: If new information becomes available that changes the status of the interim bill or the aggregated claim detail, an issuer must submit a replacement claim. Issuers must apply reasonable judgment and good business practices when determining the final action of any services submitted to the EDGE server.

The following sections provide examples of interim bill submission.

7.18.2.1 Hospital Inpatient Interim Bill Submission

This section provides examples of hospital inpatient interim bill submission.

Example 1: Hospital Inpatient Stay within a Benefit Year

In Figure 52, an enrollee was an inpatient at a hospital from April 4, 2014 – June 28, 2014. The hospital submitted three (3) interim bills. The issuer processed each claim with a final total paid amount of $482,339. The final claim was processed on July 17, 2014.

Figure 52: Hospital Inpatient Stay Within a Benefit Year Example 1

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99Pn5	123a	112	2014-04-04	2014-04-30	4254	127850.00	2014-05-14T14:50:11
B99Pn5	123b	113	2014-04-04	2014-05-30	4254 6954	221950.00	2014-06-12T22:12:00
B99Pn5	123c	114	2014-04-04	2014-06-28	4254 6954	482339.00	2014-07-17T08:05:52

As shown in Figure 53, the issuer must submit the full inpatient stay as one (1) occurrence, for the entire statement coverage period, and include all **Diagnosis Codes** and the aggregated **Total Amount Paid** for the stay with **Bill Type** 111.

Figure 53: Hospital Inpatient Stay Within a Benefit Year Example 2

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99Pn5	123c	**111**	**2014-04-04**	**2014-06-28**	**4254 6954**	**482339.00**	2014-07-17T08:05:52

Example 2: Hospital Inpatient Stay Across a Benefit Year

Issuers must submit claims that include dates of service that cross a benefit year (such as 12/15/2014 – 1/31/2015) as a single claim, at the time of discharge with a **Bill Type** of 111.

In Figure 54, an enrollee was an inpatient at a hospital from December 15, 2014 – January 31, 2015. The hospital submitted two (2) interim bills. The issuer processed each claim with a final total **Paid Amount** of $235,000.

Figure 54: Hospital Inpatient Stay Across a Benefit Year Example 1

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
J22n54	1412	112	2014-12-15	2015-01-15	82003	165000.00	2015-01-28T08:26:01
J22n54	1601	114	2015-01-16	2015-01-31	82003	70000.00	2015-02-13T17:01:40

As shown in Figure 55, the issuer must submit the full inpatient as one (1) occurrence, for the entire statement coverage period, and include all **Diagnosis Codes** and the aggregated **Total Amount Paid** for the stay.

Figure 55: Hospital Inpatient Stay Across a Benefit Year Example 2

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
J22n54	A1601	**111**	**2014-12-15**	**2015-01-31**	**82003**	**235000.00**	2015-02-13T17:01:40

7.18.2.2 Non-Hospital Inpatient Interim Bill Submission

The following sections provide examples of non-hospital inpatient interim bill submission.

Example 1: Non-Hospital Inpatient Stay within a Benefit Year

In Figure 56, an enrollee was an inpatient at a skilled nursing facility from February 1, 2014 – May 15, 2014. The skilled nursing facility submitted four (4) interim bills. The issuer processed each claim with a final total **Paid Amount** of $577,783. The final claim was processed on May 28, 2014.

Figure 56: Non-Hospital Inpatient Interim Bill Submission Example 1

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
G1j8TR7	994A	212	2014-02-01	2014-02-28	25000 5559	165081.00	2014-03-05T11:26:00
G1j8TR7	994B	213	2014-03-01	2014-03-30	25000 5559	165081.00	2014-04-02T12:12:00
G1j8TR7	994C	213	2014-04-01	2014-04/30	25000 5559	165081.00	2014-05-08T09:15:52
G1j8TR7	994D	214	2014-05-01	2014-05-15	25000 5559	82540.00	2014-05-28T16:44:02

Option 1: As shown in Figure 57, issuers may either submit one (1) final claim, for the entire statement coverage period, including all **Diagnoses Codes** and the final total **Paid Amount** with a **Bill Type** frequency of xx1.

Figure 57: Non-Hospital Inpatient Interim Bill Submission Example 2

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
G1j8TR7	994D	**211**	**2014-02-01**	**2014-05-15**	**25000 5559**	**577783.00**	2014-05-28T16:44:02

Option 2: As shown in Figure 58, issuers may choose to submit each claim, for each interim period, which only includes the statement coverage period, **Diagnoses Codes**, and **Paid Amounts** for that interim period. Issuers must submit each individual claim with a **Bill Type** frequency of xx1.

Figure 58: Non-Hospital Inpatient Interim Bill Submission Example 3

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
G1j8TR7	994A	**211**	**2014-02-01**	**2014-02-28**	**25000 5559**	**165081.00**	2014-03-05T11:26:00
G1j8TR7	994B	**211**	**2014-03-01**	**2014-03-30**	**25000 5559**	**165081.00**	2014-04-02T12:12:00
G1j8TR7	994C	**211**	**2014-04-01**	**2014-04-01**	**25000 5559**	**165081.00**	2014-05-08T09:15:52
G1j8TR7	994D	**211**	**2014-02-01**	**2014-05-15**	**25000 5559**	**82540.00**	2014-05-28T16:44:02

Example 2: Non-Hospital Inpatient Stay Across a Benefit Year

Issuers may either submit one (1) final claim (Figure 52) or submit each claim for each interim period (Figure 53).

Issuers may combine these approaches and submit an aggregated claim for each benefit year. The claims may be aggregated with a strict benefit year or across a benefit year.

In Figure 54, an enrollee was an inpatient at a Home Health facility from November 15, 2014 – March 10, 2015. The Home Health agency submitted four (4) interim bills. The issuer processed each claim with a final total Paid Amount of $608,000. The final claim was processed on March 30, 2015.

Figure 59: Non-Hospital Inpatient Stay Across a Benefit Year Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	994A	322	2014-11-15	2014-12-14	33520	158700.00	2014-12-28T09:16:04
Ds22Mb	994B	323	2014-12-15	2015-01-14	33520	158700.00	2015-01-20T11:32:00
Ds22Mb	994C	323	2015-01-15	2015-02-14	33520	158700.00	2015-02-18T19:05:52
Ds22Mb	994D	324	201-02-15	2015-03-10	33520 7282	131900.00	2015-03-30T06:24:02

Aggregating Using a Strict Benefit Year

In Figure 60, the issuer aggregated using a strict benefit year.

Figure 60: Aggregating Using a Strict Benefit Year Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	141231	**321**	**2014-11-15**	**2014-12-31**	**33520**	**236700.00**	2014-12-31T08:00:00

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	150310	**321**	**2015-01-01**	**2015-03-10**	**33520 7282**	**381300.00**	2015-03-30T06:00:00

Aggregating Across a Benefit Year

In Figure 61, the issuer aggregated across a benefit year.

Figure 61: Aggregating Across a Benefit Year Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	141231	321	2014-11-15	2014-12-14	33520	158700.00	2014-12-28T09:16:04

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	150310	321	2014-12-15	2015-03-10	33520 7282	449300.00	2015-03-30T06:24:02

7.18.3 Outpatient Interim Billing and Cross Year Claims

Table 76 identifies the rules for outpatient interim billing and cross year claims.

Table 76: Outpatient Interim Bill Rules

#	Rule	Notes
1	Issuers must not submit outpatient interim bills with frequency codes xx2, xx3 and xx4 on the medical claim file to the EDGE server.	Please see the subsequent rules for methods of submitting outpatient interim bills.

#	Rule	Notes
2	Outpatient interim bills – all locations: Option 1 • Issuers may aggregate interim bills and include all paid charges and **Diagnosis Codes** for the duration of services. • Issuers must submit aggregated claims with a **Bill Type** frequency code of xx1. • Issuers must submit adjustments using the replacement claim process and frequency code xx1 or xx7. Option 2 • Issuers may submit interim claims, after each claim is adjudicated, but must include only the **Paid Amounts** and **Diagnosis Codes** associated with the interim period. • Interim claims must have **Statement Coverage From dates** and **Statement Coverage Through dates** that reflect the interim period only, otherwise, subsequent claims may be rejected as duplicates. • Issuers must submit interim claims with a **Bill Type** frequency code of xx1. • Issuers must submit adjustments using the replacement claim process and frequency code xx1 or xx7. Claims That Cross Benefit Years: Issuers may submit outpatient claims that cross a benefit year, in aggregate, either at the time of discharge (Option 1) or split (Option 2) across benefit years. Issuers may also combine Options 1 and 2 and submit an aggregated amount for one (1) benefit year and another aggregated amount for the following benefit year. Statement coverage periods and/or dates of service, submitted as an aggregated claim, may be strict (ending on December 31) or may span across a benefit year.	CMS expects submission of outpatient services that cross a benefit year to be similar in nature, with a common set of **Diagnosis Codes** that is applicable to both benefit years. Please see the examples that follow this table. For information on splitting professional claims please see section 7.3, Table 50. Cross year outpatient claims will not be selected for RA. Cross year outpatient claims will be not be selected for HCRP if the plan or rating area is inactive in the current payment year.

The following sections provide examples of outpatient interim bill submission.

7.18.3.1 Outpatient Interim Bill Submission Example

In Figure 62, an enrollee had ongoing outpatient physical therapy at a rehabilitation hospital from March 15, 2014 – June 15, 2014. The rehabilitation hospital submitted four (4) interim bills. The issuer

processed each claim with a final total **Paid Amount** of $60,225. The final claim was processed on June 30, 2014.

Figure 62: Outpatient Interim Bill Submission Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
W2ll3r	825-01	132	2014-03-15	2014-03-30	8154	10100.00	2014-04-02T09:06:44
W2ll3r	825-02	133	2014-04-01	2014-04-30	8154	20025.00	2014-05-03T14:09:02
W2ll3r	825-03	133	2014-05-01	2014-05-30	8154	20025.00	2014-06-04T07:05:52
W2ll3r	825-04	134	2014-06-01	2014-06-15	8154	10075.00	2014-06-30T15:24:00

Option 1: As shown in Figure 63, issuers may either submit one (1) final claim, for the entire statement coverage period, including all **Diagnoses Codes** and the final **Total Amount Paid**.

Figure 63: Outpatient Interim Bill Submission Option 1 Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
W2ll3r	825-03	**131**	**2014-03-15**	**2014-06-15**	**8154**	**60225.00**	2014-06-30T15:24:00

Option 2: As shown in Figure 64, issuers may choose to submit each claim, for each interim period, which only includes the statement coverage period, **Diagnoses Codes**, and **Total Amount Paid** for that interim period.

Figure 64: Outpatient Interim Bill Submission Option 2 Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
W2ll3r	825-01	**131**	2014-03-15	2014-03-30	8154	10100.00	2014-04-02T09:06:44
W2ll3r	825-02	**131**	2014-04-01	2014-04-30	8154	20025.00	2014-05-03T14:09:02
W2ll3r	825-03	**131**	2014-05-01	2014-05-30	8154	20025.00	2014-06-04T07:05:52
W2ll3r	825-04	**131**	2014-06-01	2014-06-15	8154	10075.00	2014-06-30T15:24:00

7.18.3.2 Outpatient Services Across a Benefit Year

Issuers may either submit one (1) final claim (Figure 63) or submit each claim, for each interim period (Figure 64).

Issuers may choose to combine these approaches and submit an aggregated claim for each benefit year. The claims may be aggregated with a strict benefit year or across a benefit year.

In Figure 65, an enrollee was receiving ongoing psychiatric counseling at a community mental health center from November 10, 2014 – February 20, 2015. The mental health center submitted four (4) interim bills. The issuer processed each claim with a final **Total Amount Paid** of $2800. The final claim was processed on February 26, 2015.

Figure 65: Outpatient Services Across a Benefit Year Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2014111	762	2014-11-10	2014-12-13	30928	800.00	2014-12-28T11:20:04
CT6o8n	2014121	763	2014-12-14	2015-01-10	30928	800.00	2015-01-20T06:32:10
CT6o8n	2015011	763	2015-01-11	2015-02-07	30928	800.00	2015-02-18T19:00:00
CT6o8n	2015021	764	2015-02-08	2015-02-20	30928	400.00	2015-02-26T08:14:00

Aggregating using a Strict Benefit Year

In Figure 66, the issuer aggregated using a strict benefit year.

Figure 66: Aggregating Using a Strict Benefit Year Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2014999	**761**	**2014-11-10**	**2014-12-31**	**30928**	**1000.00**	2014-12-31T07:00:00

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2015999	**761**	**2015-01-01**	**2015-02-20**	**30928**	**1800.00**	2015-02-28T07:00:00

Aggregating Across a Benefit Year

In Figure 67, the issuer aggregated across a benefit year.

Figure 67: Aggregating Across a Benefit Year Example

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2014111	761	2014-11-10	2014-12-13	30928	800.00	2014-12-28T11:20:04

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2015021	761	2014-12-14	2015-02-20	30928	2000.00	2015-02-26T08:14:00

7.19 Late Charges

For EDGE server medical claim file processing, CMS established business rules for late charge claims received and processed by issuers. These business rules streamline EDGE server file processing related to late charges.

For EDGE server submissions, late charges are additional medical service charges incurred and submitted under a separate bill by the rendering provider, for example, a hospital that submits a bill for additional drugs or services after the issuer has already adjudicated the first claim.

Table 77 identifies rules for late charges.

Table 77: Late Charge Rules

#	Rule	Notes
1	Issuers must not submit **Bill Types** with a frequency code of xx5 on the medical claim file to the EDGE server. Claims with **Bill Types** ending in five (5) will be *rejected* unless converted to **Bill Type** with a frequency code of xx1 or xx7.	Please see the subsequent rules for methods of submitting late charges.
2	Issuers must aggregate late charges associated with an inpatient stay with the original claim to which they are associated. If the initial claim was previously submitted and accepted, issuers should submit a new claim using the replacement claim process and a **Bill Type** frequency of xx7.	N/A

#	Rule	Notes
3	Issuers may aggregate late charges associated with an outpatient institutional service with the original claim to which they are associated with a **Bill Type** of xx1 or xx7, if the claim was previously submitted and accepted, or submit the late charge as a separate claim with **Bill Type** xx1.	If the issuer submits the late charge as a unique claim, the issuer must follow the Duplicate Medical Claims rules in Section 7.8 to prevent rejection due to duplicate checks.

The following figures provide examples of late charges submission.

In Figure 68, a claim was processed on June 24, 2014, with a final total **Paid Amount** of $26,432. A new claim, with late charges, was submitted on June 28, 2014 and an additional **Paid Amount** of $806.00 was issued.

Figure 68: Submission of Late Charges Example 1

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	06011	111	2014-06-15	2014-06-18	54000	26432.00	2014-06-24T11:05:14
Ds22Mb	06011	115	2014-06-15	2014-06-18	54000	806.00	2014-06-28T15:19:02

As shown in Figure 69, issuers may choose to submit one (1) final claim that includes the original claim and the late charge claim. The final claim includes the **Total Amount Paid** for both claims. The **Bill Type** is 111.

Figure 69: Submission of Late Charges Example 2

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	06011	**111**	**2014-06-15**	**2014-06-18**	**54000**	**27238.00**	2014-06-28T15:19:02

As shown in Figure 70, issuers may also choose to submit the original claim and then submit an adjustment when the late charges are processed. The replacement claim has a **Total Amount Paid,** which is the aggregate of the original claim and the late charges. The **Bill Type** is 117.

Figure 70: Submission of Late Charges Example 3

Unique Enrollee ID	Claim ID	Bill Type	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Diagnosis Code	Total Amount Paid	Claim Processed Date Time
Ds22Mb	06011	111		2014-06-15	2014-06-18	54000	26432.00	2014-06-28T15:19:02
Ds22Mb	06011	**117**	**R**	2014-06-15	2014-06-18	54000	**27238.00**	2014-06-24T11:05:14

7.20 Mother and Baby Claims

Some hospital claims for childbirth include both the mother's record and the newborn infant's record on the same claim (**Diagnoses Codes** and **Service Codes**). The RA and RI programs use unique enrollee-based claims; therefore, mother/baby claims that are bundled do not allow the appropriate attribution of claims-based data to the mother and infant.



Note: CMS recognizes that some states require bundling mother/baby claims for a specific timeframe. In these circumstances, issuers will need to consider CMS submission deadlines and determine the best time to unbundle and submit enrollment and claims.

Depending on the enrollment status of the baby, issuers should bundle or unbundle mother and baby claims according to the scenarios in Table 78.

Table 78: Mother and Baby Claims Submission Scenarios

If….	Then…
Baby is enrolled.	Issuer must unbundle claims and follow the rules in Table 74. Mom and baby will receive their own unique risk scores, and claims will be aggregated separately for reinsurance.
Baby is not enrolled. *Issuer wants both the mom and the baby to be considered for RA and RI.*	Issuer must unbundle claims and follow the rules in Table 74. Mom and baby will receive their own unique risk scores, and claims will be aggregated separately for reinsurance.
Baby is not enrolled. *Issuer only wants the mom to be considered for RA and RI.*	Issuer is not required to unbundle claims. All claim costs and diagnosis codes will be assigned to the mother during calculations. There will be no risk score or reinsurance calculation for the baby.

Table 79 identifies rules for mother and baby claims.

Table 79: Submission of Unbundled Mother and Baby Claims

#	Rule	Notes
1	Issuers should submit mother and baby claims separately as unique claims. Issuers should implement and adhere to a consistent policy for unbundling claims.	Please see Table 77 for mother and baby claims submissions scenarios CMS will not unbundle mother and baby services.

#	Rule	Notes
2	A **Unique Enrollee ID** and enrollment period must be created for any baby who is not enrolled in accordance with Section 5.10.	If a **Unique Enrollee ID** and enrollment period is not created, the baby will not be included in RA or RI calculations.
3	Issuers should submit the appropriate **Diagnosis Code(s)** and **Total Amount Paid** on claims that are associated with the appropriate **Unique Enrollee ID** that appears on the enrollment file.	Unique adult, child and infant models exist for RA calculations, so it is important to assign the appropriate **Diagnosis Codes** to the mom and the baby. If issuers do not unbundle claims, the RA software will only produce a risk score for the mother. Similarly, the total amount paid for claims is aggregated by enrollee ID. If issuers do not unbundle claims, the RI software will aggregate all claim costs to the mother only.

7.21 Transportation Claims

Transportation claims are eligible for consideration if they are covered services and issuers incur costs for such services. Table 80 identifies the rules for transportation claims.

Table 80: Transportation Claims

#	Rule	Notes
1	Issuers should submit transportation services using valid **Service Codes** and **Service Code Modifiers**.	N/A
2	If no **Diagnosis Code** is available, issuers may include a **Diagnosis Code** from an associated medical claim that was adjudicated within 30 days of the date of transport.	N/A

7.22 Transplant Claims

Transplant services covered under an eligible enrollee should be submitted to the EDGE Server. In some cases, the services for the transplant *donor* are covered under the transplant *recipient's* coverage. As a result, services for the transplant donor are often billed under the transplant recipient's enrollee ID.

When donor services are covered by the recipient's health plan, issuers are not required to separate donor and recipient transplant services that are billed under a single claim. On the other hand, claims that are submitted separately for donor services covered under the recipient's health plan will need to be combined for successful submission to the EDGE server, as outlined in Table 81.

Table 81: Transplant Claims – Donor Services Covered Under Recipient

#	Rule	Notes
1	Issuers should submit one (1) *institutional inpatient claim* using the transplant recipient enrollee ID and include all the incurred costs for the transplant donor on the transplant recipient's *inpatient* claim. • All incurred costs includes inpatient, outpatient and professional claim services incurred for the *donor.*	N/A
2	Issuers should submit all other *recipient* services related to the transplant (outpatient institutional and professional) as unique claims.	Do not include outpatient and professional services *for the recipient* on the recipient inpatient claim unless those services were already bundled in the inpatient claim.
3	Issuers should only submit the **Diagnosis Codes** associated with the transplant *recipient*.	Issuers should not include diagnoses for the transplant donor.
4	Issuers should aggregate and submit all donor costs, *as a single claim line*, on the recipient inpatient institutional claim. An **Amount Allowed** *at the claim line level* may be submitted with a value equal to or greater than $0.00.	Issuers do not need to submit each individual service for the donor on the claim.
5	Issuers should adjust the **Total Amount Allowed** at the *claim header* to include the **Amount Allowed** related to the donor *at the claim line level*. If no **Amount Allowed** is reported at the claim line level for the donor services, issuers should add the **Amount Paid** for the donor services, *reported at the claim line level*, to the **Total Amount Allowed** reported *at the claim header*.	N/A
6	Issuers do not need to change **Statement Covers From** and **Statement Covers Through** dates on the transplant recipient inpatient institutional claim header to accommodate line level transplant donor services that are outside the inpatient stay. *However*, dates of service reported at the line level must be within the statement coverage dates at the header. Please see Rule 7.	N/A
7	**Date of Service – From** and **Date of Service – To** at the *claim line level* do not necessarily have to reflect the actual dates of service. Issuers may submit a single Date of Service or multiple dates of service at the claim line level. The Date(s) of Service reported must fall within the statement coverage period reported at the claim header for the claim to be accepted.	N/A

If an issuer is responsible for the transplant donor services, separate and apart from the recipient coverage, then the donor claims should be submitted under the donor enrollee ID as outlined in Table 82.

Table 82: Transplant Claims – Donor Services and Recipient Services Covered Separately

#	Rule	Notes
1	Issuers should submit unique institutional inpatient claims for the donor and recipient using **Unique Enrollee IDs**.	Donor and recipient risk scores and costs will be calculated based on the **Unique Enrollee ID**.
2	Issuers should submit all other donor and recipient services related to the transplant (outpatient institutional and professional) as unique claims.	Do not include outpatient and professional services on the inpatient claim unless those services were already bundled in the inpatient claim.
3	Issuers should only submit the **Diagnosis Codes** associated with each **Unique Enrollee ID**.	Issuers should not include Diagnosis Codes for both the donor and recipient on a unique enrollee claim.

7.23 Incurred Claims Otherwise Not Adjudicated

CMS recognizes that an issuer may incur medical service costs without the adjudication of a provider claim. For example, an issuer may reimburse members directly for services that would have otherwise been paid to a rendering provider. Claims incurred for medical costs that are not otherwise adjudicated are eligible for consideration under the RA and RI programs as long as those costs were incurred by the issuer. CMS assumes that issuers have performed the necessary due diligence to validate such services were rendered and reimbursement is valid.

Table 83 identifies the rules for submitting non-adjudicated claims.

Table 83: Submitting Claims Otherwise Not Adjudicated

#	Rule	Notes
1	Issuers must include all required data elements and provide data that conforms to all verifications.	Please see the ICD for additional information on data elements.
2	Issuers may use default values provided within this document where necessary. All other data must be obtained from issuer sources (member bill and provider documentation).	N/A
3	Issuers must retain and make available documentation that supports that such services were validated, authorized and/or rendered, should such claims be selected under audit.	N/A
4	For such services to be selected for RI or RA, an enrollment record must exist and claims must meet each program's claim selection criteria.	N/A

8 Supplemental Diagnosis Code File Processing

The PPACA RA model predicts annualized plan liability expenditures using age, sex and health status derived from **Diagnosis Codes**. Therefore, capturing all relevant diagnoses is important to the accuracy of risk adjustment. The Supplemental Diagnosis file allows issuers to submit Supplemental Diagnosis information to the EDGE server for consideration in the RA Program. CMS recognizes the limited circumstances in which relevant diagnoses may be missed or omitted during claim or encounter submission. In the following sections, CMS provides specific business rules for the submission of supplemental **Diagnosis Codes**, if they were missed or omitted in the original claim.

Table 84 provides a legend to the symbols and formatting used in this document.

Table 84: Legend of Symbols and Formatting

Symbol or Formatting	Significance
Italics	Indicates important information.
Bolded Blue	Indicates a data element present on the inbound submission file. Please see the ICD for data element descriptions along with technical field/element characteristics.
	Indicates an important rule. If this guidance is not followed, it may impact file ingest or calculations.
	Indicates information an issuer should note. Although the information may not impact file ingest or calculations, it requires attention.

8.1 Guidance on Diagnosis Code(s) Derived from Health Assessments

An issuer may use a **Diagnosis Code** derived from a health assessment *if all* of the following apply:

- The **Diagnosis Code** is supported by medical record documentation and complies with standard coding principles and guidelines.
- The **Diagnosis Code** is related to medical services performed during the patient visit and is the result of a medical service(s) that resulted in a *paid* medical claim or reported encounter.
- The **Diagnosis Code** is the result of medical services performed by a State licensed medical provider.
- The **Diagnosis Code** complies with general medical claim file or supplemental diagnosis file submission business rules (please see Section 8.4).

Unacceptable health assessment sources of **Diagnosis Codes** for distributed data collection include the following:

- A patient-reported list of diseases or conditions not related to medical services provided and paid for at a patient visit
- **Diagnosis Codes** from medical services that occurred outside the plan enrollment period for the enrollee

If a claim for a paid service or accepted encounter *was not previously submitted and accepted*, an issuer may submit **Diagnosis Codes** from a distributed data collection-acceptable health assessment following the medical claim submission process (Please see requirements above. If a claim *was previously submitted and accepted* on the EDGE server, the issuer may submit **Diagnosis Codes** following the **Supplemental Diagnosis Code** submission process.

8.2 Acceptable Sources of Supplemental Diagnoses

There are two (2) acceptable sources for supplemental diagnoses: *medical record* and *electronic data interchange (EDI).* The following sections discuss these sources.

8.2.1 Medical Records

Supplemental Diagnosis Code discovery results from medical record review by the issuer after medical billing or through routine medical record review. The issuer *must* evaluate all diagnoses on the original claim submitted to the EDGE server and *must* delete any diagnoses not supported by the medical record.

Issuers should follow their normal business practices to address any identified discrepancies resulting from a medical record review. During the course of a medical record review, if an issuer discovers **Diagnosis Codes** are inappropriately included on or excluded from a claim, the issuer should take corrective action.

Issuers have two (2) options, described in Table 85, for submitting **Supplemental Diagnosis Codes** for EDGE server data collection as a result of medical record review.

Table 85: Options for Supplemental Diagnosis Code File Submission

Option #	Option
Option 1	**Void/Replace Process**: If a **Supplemental Diagnosis Code** is linked to a claim that was previously submitted and accepted by the EDGE server, issuers can follow the EDGE server process for voiding a claim or replacing a claim and eliminate the need to a supplemental diagnosis file.
Option 2	**Add/Delete Process**: If a **Supplemental Diagnosis Code** is linked to a claim that was previously submitted and accepted by the EDGE server, then issuers can use the add/delete process for **Supplemental Diagnosis Code** file submission. Please see Table 89.

CMS recommends issuers adhere to sound business practices. For either option, issuers *must* document any **Diagnosis Code** changes, since EDGE server data are subject to audit. All Amazon EDGE and On-Premise EDGE issuers are required to retain all original data stored in their MySQL data tables for a period of 10 years.

8.2.2 Electronic Data Interchange (EDI)

Issuers may submit **Supplemental Diagnosis Codes** for **Diagnosis Codes** received via EDI that exceed the number of **Diagnosis Codes** accepted by the issuer's claims system (truncated in the translator/EDI front-end).

8.3 Supplemental Diagnosis File Definitions

Please see Appendix B: Terms and Definitions for supplemental diagnosis file definitions.

8.4 General Supplemental Diagnosis Code File Processing Rules

This section illustrates general file processing rules for the ESSFS files in Table 86.

Supplemental files are *incremental* file submissions. Each subsequent supplemental diagnosis file should include the following:

- New diagnoses being added to an original claim
- Any diagnosis being deleted from an original claim
- Any voids of previously submitted supplemental diagnosis records.



Note: Full replacement supplemental diagnosis file submissions will result in records being rejected as duplicates.

An issuer may submit more than one (1) Supplemental Diagnosis Code for an original claim on a supplemental record.

Table 86: Supplemental Diagnosis Code File Processing General Rules

#	Rule	Notes
1	A **Supplemental Diagnosis Code** *must* be associated with a *paid* claim or encounter for services that occurred during an enrollee's period of enrollment in an RA-covered plan. A supplemental diagnosis code *must* be linked to a previously submitted and accepted EDGE server medical claim.	**Diagnosis Codes** associated with a denied claim are not eligible for submission.
2	Submission of a **Supplemental Diagnosis Code** must be supported by medical record documentation and comply with standard coding principles and guidelines.	N/A
3	The medical service(s) that result in a **Supplemental Diagnosis Code** must have occurred during the data collection period (January 1 through December 31, 20XX) for a given benefit year.	N/A
4	The submission of a **Supplemental Diagnosis Code** must include the **Original Medical Claim ID** and the same **Plan ID** that was adjudicated and resulted in a **Paid Amount** or reported encounter.	**Diagnosis Codes** from denied claims are not acceptable.
5	The submission of a **Supplemental Diagnosis Code** must include **Service From and To** dates that fall within the **Statement Covers From** and **Statement Covers Through Date** on the referenced claim and must be associated with the service that resulted in the **Diagnosis Code**.	N/A
6	If a claim has been inactivated and replaced by a new claim, then the **Supplemental Diagnosis Codes** will be linked to the replacement claim.	If a claim and its supplemental record are submitted and accepted, and the **Claim ID** on the supplemental is part of an active claim family, the **Supplemental Diagnosis Codes** will be included in RA calculations and reporting.
7	The **Unique Enrollee ID** reported on the **Supplemental Diagnosis Code** file must correspond to a **Unique Enrollee ID** on the enrollment file.	**Supplemental Diagnosis Code** records for enrollees who are not matched to a **Unique Enrollee ID** are considered orphaned and are not considered during RA processing.
8	Issuers should correct and must submit all **Supplemental Diagnosis Code** files by April 30th of the year following the benefit year for consideration.	Any new **Supplemental Diagnosis Code** files, or corrections to rejected files, *will not* be accepted after April 30th for the benefit year

8.5 Header, Issuer and Plan Level Rules Specific to Supplemental Diagnosis Code Files

The general header, **Record ID** and issuer level rules outlined in Section 4.6, Section 4.7, and Section 4.8 apply to all **Supplemental Diagnosis Code** files.

In addition, three (3) summary total data elements at the header, issuer and plan levels specific to **Supplemental Diagnosis Code** files must pass the required and logical check verification process.

Table 87 describes the rules for header, issuer and plan level total verifications.

Table 87: Header, Issuer and Plan Level Total Verifications

#	Rule	Notes
1	The **Total Detail Records** reported at the header level must equal the count of all detail records for all issuers and plans on the file. The **Total Detail Record**s reported at the issuer level must equal the count of all detail records for the specific issuer submitted. The **Total Detail Record**s reported at the plan level must equal the count of all detail records for the specific plan submitted. If the **Total Detail Records** at the header, issuer or plan level do not match the **Total Detail Records** for the indicated level, that level and all associated sub-levels will be rejected.	For example: If the header level fails and is rejected, the issuer and plan levels will also be rejected.

8.6 Duplicate Supplemental Diagnosis Code Detail Records

To ensure that only one (1) version of an active **Supplemental Diagnosis Detail Record** is stored, the EDGE server performs duplicate checks.

Table 88 identifies the rules for duplicate checks.

Table 88: Duplicate Checks Performed at the Supplemental File Header

#	Rule	Notes
1	Issuers should not reuse **Supplemental Diagnosis Detail Record IDs**. For all **Supplemental Diagnosis Detail Records**, a duplicate check is performed using the **Issuer ID** and the **Supplemental Diagnosis Detail Record ID** reported at the detail record level.	If the **Issuer ID** and **Supplemental Diagnosis Detail Record ID** match a *stored active* Supplemental Diagnosis Detail Record, then the new Supplemental Diagnosis Detail Record will be rejected.

#	Rule	Notes
2	Issuers should not remove, on the **Original Medical Claim ID**, the **Supplemental Diagnosis Code** on a Supplemental Diagnosis Detail Record indicated as a **Delete**. Issuers should not remove, on the **Original Medical Claim ID**, the **Supplemental Diagnosis Code** from a previously accepted **Supplemental Diagnosis File**.	If the **Original Medical Claim ID** does not include any **Supplemental Diagnosis Code** on a Supplemental Diagnosis Detail Record indicated as a **Delete**, or the issuer removes the **Supplemental Diagnosis Code** from a previously accepted **Supplemental Diagnosis File**, the Supplemental Detail Record will be rejected.
3	Issuers should not include, on the **Original Medical Claim ID** or a previously accepted **Supplemental Diagnosis File**, any **Supplemental Diagnosis Code** on a Supplemental Diagnosis Detail Record indicated as an **Add**.	If any **Supplemental Diagnosis Code** on a Supplemental Diagnosis Detail Record indicated as an **Add is** already included on the **Original Medical Claim ID** or a previously accepted **Supplemental Diagnosis File**, the Supplemental Detail Record will be rejected.

8.7 Detail Record Processed Date Time

The **Detail Record Processed Date Time** data element is reported at the detail record level and determines the order of processing. An issuer that adjusts detail records multiple times and submits them on the same or subsequent **Supplemental Diagnosis Code** file *must* differentiate them for appropriate processing.

Table 89 identifies the rules for capturing or populating the time component of the **Detail Record Processed Date Time**.

Table 89: Detail Record Processed Date Time Rules

#	Rule	Notes
1	All **Supplemental Diagnosis Code Adds**, **Deletes**, and **Voids** must include a *unique* detail record creation date and time in the **Detail Record Processed Date Time** field.	Issuers may create the time component to clearly identify the order of processing when submitting multiple detail records in a single supplemental diagnosis file or when submitting a **Void**.
2	Issuers who process a detail record multiple times the same day may submit one (1) of the following: • All versions of the detail record in a single supplemental diagnosis file • The final version of the detail record	N/A

#	Rule	Notes
3	If an issuer submits multiple versions of the same detail record, each detail record must include a *unique time component* for the **Detail Record Processed Date Time**, even if the **Void** indicator is included.	If the time component of the **Detail Record Processed Date Time** is not provided, or is not unique, then all detail records with the same **Issuer ID** and **Supplemental Diagnosis Detail Record ID** will be *rejected*, because the system is unable to identify the processing order of the records.

8.8 Adding and Deleting Supplemental Diagnosis Codes

When a valid Supplemental **Diagnosis Code** is discovered after medical record review or through EDI truncation, and is linked to an active medical claim in the EDGE server medical claim data table, it can be submitted as an **Add** on the detail record of the ESSFS file.

When a **Diagnosis Code** submitted in error as a result of medical record review is linked to an active medical claim in the EDGE server medical claim data tables, it can be submitted as a **Delete** on the detail record of the ESSFS file.

Table 90 identifies the rules for **Add** and **Delete**.

Table 90: Supplemental Diagnosis Code Add and Delete Rules

#	Rule	Notes
1	Issuers may add a supplemental diagnosis to a previously accepted medical claim by submitting: • A value of "A" in the **Add/Delete/Void Indicator** • A unique **Supplemental Diagnosis Detail Record ID** • Dates of Service that are within the Statement Coverage Dates at the claim header on the linked **Original Claim ID**.	If the diagnosis *is not present* on the medical claim, the **Supplemental Diagnosis Code** *will be accepted.* If the diagnosis is *already present* on the original claim, the **Supplemental Diagnosis Code** *will be rejected.*
2	Issuers may delete a supplemental diagnosis on a previously submitted medical claim by submitting: • A value a "D" in the **Add/Delete/Void Indicator** data field • A unique **Supplemental Diagnosis Detail Record ID** • Dates of Service that are within the Statement Coverage Dates at the claim header on the linked **Original Claim ID**.	If the diagnosis *is not present* on the original claim, the deleted **Supplemental Diagnosis Code** will be rejected. If the diagnosis *is present* on the original claim, the deleted **Supplemental Diagnosis Code** *will be accepted.*

#	Rule	Notes
3	The enrollee ID on all active supplemental records MUST match the enrollee ID on the most recent active medical claim.	If an enrollee ID was changed on a medical claim through the use of a replacement claim the diagnosis codes will not be associated to the correct enrollee ID.
4	To update the enrollee ID on a supplemental record issuers must: • Submit a "V" (void) supplemental record for all diagnosis associated with the incorrect enrollee ID and • Submit an "A" (add) supplemental record with the correct enrollee ID.	Supplemental records that are not updated to reflect the correct enrollee ID will be excluded from the risk score of the actual enrollee or will be applied to the risk score of the incorrect enrollee if that enrollee is eligible for RA.

8.9 Voiding Supplemental Diagnosis Code Detail Records

Medical claim files include a data element that allows issuers to void claims previously submitted and accepted and stored as active. By using the value “V” as the **Void/Replace Indicator** on a claim file, an issuer can change an active stored claim to an inactive status, thereby removing it from consideration for RI or RA.

Similarly, supplemental files include a data element that allows issuers to void a **Supplemental Diagnosis Detail Record** previously accepted and stored as active.

Table 91 identifies the rules for void processing logic for **Supplemental Diagnosis Detail Record**.

Table 91: Void Processing Logic for Supplemental Diagnosis Code Detail Records

#	Rule	Notes
1	Issuers may Void a previously accepted **Supplemental Diagnosis Detail Record** in supplemental diagnosis file by submitting: • A value of “V” in the **Add/Delete/Void Indicator** data field. • The **Original Supplemental Diagnosis Detail ID** must match a stored **Supplemental Diagnosis Detail Record ID.** • The date time stamp on the void must be later than the date time stamp on the **Original Supplemental Detail Record ID**.	If these conditions are met, then the matched **Supplemental Diagnosis Detail Record** is inactivated and will not be included in RA calculations.

#	Rule	Notes
2	Only the **Void Indicator**, **Original Supplemental Diagnosis Detail ID**, **Supplemental Diagnosis Detail Record ID**, and **Detail Record Processed Date and Time** undergo validation edits. All other data elements on a Void bypass edits. Issuers may include or exclude the additional data elements when submitting a **Void**.	N/A
3	Issuers may reactivate a voided **Supplemental Diagnosis Detail Record** by submitting a new **Supplemental Diagnosis Detail Record** with a new **Supplemental Diagnosis Detail Record ID**.	N/A

Table 92 identifies the steps for voiding a previously submitted supplemental diagnosis record.

Table 92: Steps for Voiding a Previously Submitted Supplemental Diagnosis Record

#	Step
1	The issuer submits an original supplemental record that is accepted and stored as active.
2	The issuer submits a void and populates the "V" in the **Add/Delete/Void Indicator** field and the **Original Supplemental Diagnosis Detail ID**.
3	The EDGE server identifies the void or replace by the "V" populated in the **Add/Delete/Void Indicator** field.
4	The EDGE server uses the **Original Supplemental Diagnosis Detail ID** to find the original supplemental record. • If a match is not found, the void is rejected. • If a match is found, the process continues.
5	The EDGE server uses the **Detail Record Processed Date Time** to determine if the original supplemental record should be *inactivated*. • If the date time passes, then the original record is inactivated. • If the date time fails, then the original record will *not* be inactivated and the void is rejected.
6	The EDGE server checks the remaining submitted data elements to determine if the void record should be accepted. • If all data elements pass, the new record is stored as inactive. • If one (1) or more data elements fail, then the new record *is not* stored and the void claim is rejected. *Even if the void is rejected, the original record remains inactive.*

9 Plan Data

CMS deploys reference tables to issuers' EDGE servers, one (1) of which is the plan data reference table. The plan data reference table contains all RA- and/or RI-eligible on-Exchange and off-Exchange plan data elements used in EDGE file processing

validations and program calculations. This section defines plan data sources and CMS data integration rules, and describes how issuers can troubleshoot plan data problems. This section *does not* replace the verifications in the ICD or in other sections of this document.

Table 93 provides a legend to the symbols and formatting used in this document.

Table 93: Legend of Symbols and Formatting

Symbol or Formatting	Significance
Italics	Indicates important information.
Bolded Blue	Indicates a data element present on the inbound submission file. Please see the ICD for data element descriptions along with technical field/element characteristics.
	Indicates an important rule. If this guidance is not followed, it may impact file ingest or calculations.
	Indicates information an issuer should note. Although the information may not impact file ingest or calculations, it requires attention.

9.1 Plan Data Reference Table Definitions

The element names stored in the plan reference data table are identified in the EDGE Server Common Schema Data Dictionary which is available in the REGTAP Library. Additional information on how to run queries and updating plan data can be found in Section 6 of the Operations Manual.

9.2 Plan Data Reference Sources

Plan data is collected and integrated for deployment to issuers' EDGE servers from the sources listed below.

CMS develops the plan data reference table by using a hierarchy where on-Exchange data can only be updated by the exchange sources, and the off-Exchange data can only be updated by the Rate and Benefit Information System (RBIS). In extenuating circumstances, issuers can use the EDGE server Issuer Template for updating off-Exchange and on-Exchange data. CMS will verify any changes to on-Exchange plan data and notify issuers of approval/disapproval of such updates.

Table 94 identifies the Plan Reference Data source ranking

Table 94: Plan Reference Data Source Ranking

Data Source Ranking	Description
1 – FFE Data	Federally Facilitated Exchange Data for on-Exchange
2 – SBE Data	State Based Exchange (SBE) Data for on-Exchange
3 – Issuer Template	Issuer Template for off-Exchange If an issuer submits on-Exchange data, CMS will have the applicable Exchange verify the update requested to determine approval/disapproval.
4 – RBIS	HIOS' RBIS for off-Exchange

Table 95 identifies plan reference data sources.

Table 95: Plan Reference Data Sources

Data Source	Description
FFE	Federally Facilitated Exchange (FFE) data is received by CMS directly from issuers submitting their Qualified Health Plan (QHP) application data to HIOS' plan data module for FFE or System for Electronic Rate and Form Filing (SERFF) for State Partnership Exchange (SPE). For FFE and SPE QHP data, the plan reference data will reflect only *certified QHP data*.
SBE	State-based Exchange (SBE) data is received by CMS directly from issuers submitting their Qualified Health Plan (QHP) application data to System for Electronic Rate and Form Filing (SERFF) or the SBE's proprietary system. For SBE QHP data, the plan reference data will reflect only *certified QHP data* received by CMS.
RBIS	Off-Exchange data comes to CMS directly form issuers submitting their non-QHP data to HIOS' Rate and Benefit Information System (RBIS). Although this is an annual collection, a quarterly window is open to allow for submitting plan updates. For off-Exchange data, the plan reference data will reflect only data that is submitted through RBIS.
Issuer Template	An Issuer Template is submitted directly by issuers to CMS. This template is submitted as needed, during a very limited timeframe, when the plan data table is missing plans or has incorrect plan data from one (1) of the above data sources. Generally, this template is only used to correct off-Exchange plans submitted to RBIS and is only allowed during particular windows (published in advance for the applicable benefit year via REGTAP) and under particular conditions. *Issuers should not rely on this template to correct their plan data as it is only to be used when other means of plan data updates are unavailable.*
Previous Years Plan Reference Data	Currently, CMS is seeking an automated solution to make available previous benefit year's plan data for the current payment year.

Note: For detailed information on how to update plan reference data, please refer to the 2016 Plan Data Upload Presentation Slides, posted in the REGTAP Library.

9.3 Plan Data Integration

CMS integrates various data sources based on order of precedence. Plan data received from an on-Exchange data source will take precedence over an off-Exchange data source when the same plan data appears in both. Table 96 and Table 97 identify the rules for how data is loaded for both on-Exchange and off-Exchange plans.

Table 96: Rules for On-Exchange Data Integration

#	Rule	Notes
1	All certified QHPs for the applicable benefit year are included in the plan data reference table deployment. • The on-Exchange certified QHP offerings include the standard Variant ('01') and cost sharing reductions or Cost Sharing Reduction (CSR) Variants ('02' through '06'). • For Medicaid expansion plans, CMS *manually adds* applicable Variants ('31' through '36')	N/A
2 	Plan data received through the FFE, SPE and SBE is given the *highest priority* when loading information into the plan reference table.	N/A
3	FFM, SPM and SBM plan data are mutually exclusive submissions, meaning there is no overlap between data sources.	N/A

Table 97: Rules for Off-Exchange Data Integration

#	Rule	Notes
1	All off-Exchange plans that have been submitted, validated and attested to for the applicable benefit year are included in the plan reference deployment. Off-Exchange plans include a '00' Variant *only*.	Since all on-Exchange certified QHPs are also required to be offered off-Exchange, the off-Exchange version of the QHP must be submitted to RBIS as a '00' Variant.
2	To be included in an extract from RBIS, issuers *must* complete, submit, validate and attest to their non-QHP templates. RBIS submissions require issuers to attest to their data on a *quarterly basis*.	N/A
3	If submitted, an EDGE server Issuer Template will take precedence over any submitted RBIS data.	RBIS data is the *only* data source that can be overridden by the EDGE server Issuer Template.

9.4 Identifying Missing Plan Data

CMS understands that sometimes enrollment records are not successfully accepted by the EDGE server due to missing or inaccurate plan data. Table 98 lists the recommended steps to follow to identify if record rejection is due to missing plan data. In the event of missing plan information, follow these steps to verify the plan is missing from the plan reference table and contact the appropriate source owner for corrective actions.

Table 98: Steps for Identifying Missing Plan Data

#	Step
1	Issuers should verify with their organizations internal team responsible for plan data submission that the **INSRNC_PLAN_ID** for the given enrollee is correct. *Note: Often the **INSRNC_PLAN_ID** itself is inaccurate or the enrollee was assigned to an incorrect plan.*
2	Issuers should verify the Plan ID is in the "INSRNC_PLAN" table of the "EDGE_SRVR_COMMON" schema on the EDGE server for each **INSRNC_PLAN_ID** for the applicable market year with active enrollees. If the plan is missing from the table, submit an Issuer Template with the corrected information. Please see Appendix E for the appropriate query to use to verify the plan is in the "INSRNC_PLAN" table.
3	Issuers should verify all applicable Rating Areas for the associated plan are in the "ISSR_PLCY_RATG_AREA" table of the "EDGE_SRVR_COMMON" schema of the EDGE server for each **INSRNC_PLAN_ID** that has *active enrollees* in the associated plan. If any Rating Areas with enrollment are missing from the table, submit a template with the corrected information. Please see Appendix E for the appropriate query to use to ensure all applicable Rating Areas are in the "ISSR_PLCY_RATG_AREA" table.

10 Risk Adjustment and Reinsurance Calculations

CMS deploys commands from the CMS management console that initiates RA and RI calculations. Issuers may also run local commands to evaluate their progress and to ensure their preliminary calculations are as expected before the data submission window closes on April 30th of the applicable benefit year, or the following business day if April 30th falls on a weekend.

Below is a high-level overview of the method for identifying claims for each program. For detailed information on the selection of claims and calculations by the RA and RI programs, please refer to the below documents, posted in the REGTAP Library:

Risk Adjustment and Reinsurance Claim Selection

Claims and enrollment records are not compared at the time of data submission. All data is processed independently and stored as active records in the respective tables. Upon execution of a CMS or issuer-initiated RA or RI command on the EDGE server,

the RA and RI calculation programs begin. The first step in the process is to select the claims and the associated data elements that are eligible for each program.

Both the RA and RI programs select claims using the logic in Table 99.

Table 99: RA and RI Claim Selection Logic

#	Selection Logic	Notes
1	Select all *active claims* with a **Statement Covers Through Date** that has a year that is equal to the current benefit year being calculated.	Only current benefit year claims are included in the calculations. Claims that have a **Statement Covers Through Date** in a future benefit year are not included until the following benefit year.
2	Select all active enrollment records with *at least one (1) day* of enrollment in the current benefit year.	There must be at least one (1) day of enrollment in the current benefit year for accurate risk score calculations to be performed and to verify coverage of services for claims submitted.
3	Select claims that have a **Statement Covers *From* Date** that falls within an active enrollment period *with the same Plan ID.*	This step confirms the enrollee was covered under the plan that was populated on the submitted claim.

Further selection of claims eligible for each program are outlined in the resources published in the REGTAP Library (https://www.regtap.info/) for the RA and RI program areas as indicated below.

Risk Adjustment

- Risk Adjustment - Comprehensive Overview Presentation Slides
- RA Risk Score Calculation Part 1 & Part 2 Presentation Slides & RA Reports and Proration Presentation Slides

Reinsurance

Reinsurance (RI) Quick Reference Guide Version 2.0

11 Assistance with Business Rules

Assistance with Business Rules

For assistance with any of the file processing rules outlined in this document or any other questions, please visit REGTAP at https://www.regtap.info/. The REGTAP Library contains a history of Distributed Data Collection for RI and RA presentation slides and supporting documents, as well as a Frequently Asked Questions (FAQs) database.

12 Appendix A: Revision History

Table 100 identifies the changes made from the previous version of this document.

Table 100: Revision History

Version	Section	Table	New/Modify Move/Delete	Description
9.0	5.4.2	22	New	Added explanatory language to rule 2
9.0	6	N/A	Modify	Modified introductory paragraph for Pharmacy File Processing
9.0	6.2	32	New	Added explanatory language to rule 6
9.0	6.4	N/A	New	Added introductory paragraph for In and Out of Network Indicator
9.0	6.4	34	New	Added In-Network and Out-of-Network Indicator Rules
9.0	6.4	36	New	Added explanatory language to rule 1
9.0	6.4	36	New	Added explanatory language to rule 2
9.0	6.4	36	New	Added new rule 3 regarding the Product/Service ID Qualifier
9.0	6.4	37	New	Added explanatory language to rule 2
9.0	6.5	39	Modify	Modified explanatory language for the notes section of rule 1
9.0	6.9	N/A	Modify	Modified introductory paragraph for Fee-for-Service and Capitated Claim Submission
9.0	6.9.1	46	Modify	Modified language to rule 3 Total Allowed Cost
9.0	6.9.1	46	New	Added new rule 4 regarding when a Total Allowed Cost of $1.00 can be reported
9.0	6.9.2	N/A	Modify	Modified introductory paragraph for Capitated Services Submission
9.0	6.9.2	47	New	Added explanatory language to notes section to rule 1
9.0	6.9.2	47	New	Added explanatory language to rule 4
9.0	6.9.2	47	New	Added new rule 5 regarding when a Total Allowed Cost of $1.00 can be reported
9.0	6.9.2	N/A	Modify	Modified figure 28 Capitated Pharmacy Claim Included in Inpatient Stay
9.0	7	N/A	Modify	Modified introductory paragraph for Medical File Processing
9.0	7.2	50	New	Added explanatory language to rule 6
9.0	7.3	51	Modify	Added explanatory language to rule 4 Claims that cross Benefit Years

Version	Section	Table	New/Modify Move/Delete	Description
9.0	7.8	N/A	New	Added new section on In and Out-of-Network Medical claims
9.0	7.9	57	New	Added explanatory language to rule 1
9.0	7.9.1	58	New	Added explanatory language to rule 2
9.0	7.10	60	New	Added explanatory language to rule 1
9.0	7.15	N/A	Modify	Modified introductory paragraph for FFS and Capitated Claim Submission
9.0	7.15.1	67	New	Added explanatory language to rule 3
9.0	7.15.1	67	New	Added new rule 4 regarding when a Total Allowed Cost of $1.00 can be reported
9.0	7.15.1	N/A	Modify	Modified figure 43 FFS Capitated Claim Covered Under a More Comprehensive Service
9.0	7.15.2	N/A	Modify	Modified introductory paragraph for Capitated Services Submission
9.0	7.15.2	68	New	Added explanatory language to rule 1
9.0	7.15.2	68	New	Added explanatory language to rule 4
9.0	7.15.2	68	New	Added new rule 5 regarding when a Total Allowed Cost of $1.00 can be reported
9.0	7.15.3	69	New	Added explanatory language to rule 1
9.0	7.15.3	69	New	Added explanatory language to rule 4
9.0	7.15.3	69	New	Added new rule 5 regarding when a Total Allowed Cost of $1.00 can be reported
9.0	7.15.3	N/A	Modify	Modified figure 47 on Mixed Claim Covered Under a More Comprehensive Service
9.0	7.17	71	New	Added explanatory language to rule 2
9.0	7.18	72	New	Added explanatory language to rule 4
9.0	7.18.3	75	New	Added explanatory language to notes on rule 2 for cross year outpatient claims will not be selected for RA.
9.0	8.4	85	New	Added explanatory language to rule 4
9.0	8.8	89	New	Added new rule 3 regarding enrollee ID
9.0	8.8	89	New	Added new rule 4 regarding updating enrollee ID on a supplemental record
8.0	5.2	16	Modify	Modified Rule 2 and Note to clarify that issuers must submit at least two (2) years of enrollment records for each enrollee every benefit year
8.0	5.6	N/A	Modify	Modified the renewal code to 021041 in the Note Box

Version	Section	Table	New/Modify Move/Delete	Description
8.0	5.6	26	Delete	Deleted Rule 5 to remove the requirement that a renewal EPAI (021041) must be preceded by an initial or mod EPAI
8.0	5.6	25	New	Added explanatory language to Code 021041
8.0	6.2	N/A	Delete	Deleted language indicating that the initial pharmacy file submission should contain pharmacy claims with a Fill Date equal to or greater than January 1 of the benefit year being submitted
8.0	6.9.2	46	New	Added regulatory information to Note to Rule 1
8.0	6.9.2	46	Modify	Modified the explanatory language for Rule 4
8.0	7.2	49	Modify	Modified the rule to indicate that both upper and lower case letters will be accepted during file ingest for diagnosis codes
8.0	7.2	49	New	Added examples of service indicator codes to Rule 7
8.0	7.2	49	Modify	Modified the language of the Note to Rule 7 to indicate that as long as a code is effective on any day in the Statement to Coverage period, the record will be accepted. Modified the language of the Note
8.0	7.9	58	New	Added modifier “CA” to Rule 1 to indicate CMS Approved and added explanatory language to the Note to Rule 1 to indicate that CA is a CMS-created code
8.0	7.9	58	New	Added Service Code 99199 (Unlisted Procedure Code) to Rule 1
8.0	7.9	58	New	Added Miscellaneous explanatory language to Rule 1 to indicate that the EDGE server will bypass claims identified as duplicates if the duplicate line has a zero (0) dollar paid amount
8.0	7.9	58	Modify	Modified Rule 3 to indicate that issuers should append Service Code Modifier CA to an adjudicated claim where they have confirmed that the duplicate service is allowable, and modified the Note to Rule 3 to reflect this change
8.0	7.14.2	67	New	Added Rule 1 to indicate that issuers must submit a derived paid amount that is reasonable and based on a methodology of their choosing
8.0	7.14.2	67	Modify	Modified the explanatory language for Rule 4
8.0	7.14.3	68	Modify	Modified the explanatory language for Rule 4
7.0	All	N/A	Modify	Formatting changes throughout the document to clarify, organize, and highlight information

Version	Section	Table	New/Modify Move/Delete	Description
7.0	All	N/A	Modify	Language revisions throughout the document to update, clarify, or further explain information
7.0	3	1	New	Added Legend of Symbols and Formatting
7.0	3	N/A	New	Added new paragraph "Issuers should use this document…"
7.0	3	N/A	New	Added Sections 9 and 10 to summary list of sections
7.0	4	2	New	Added Legend of Symbols and Formatting
7.0	4	All	New	Added Notes column to capture notes relevant to each rule
7.0	4.1	N/A	New	Added language to paragraph 1 regarding use of XMLs
7.0	4.2	N/A	Move	Moved table of terms and definitions to Appendix B
7.0	4.3	N/A	Modify	Section reorganized for easier readability No policy or operational changes Added information about Validation zone Enhanced information about Production and Test Zones
7.0	4.4	N/A	Move	Deleted language and incorporated it into step-by-step tables in Section 4.3.3
7.0	4.6	N/A	Modify	Combined previous Section 4.7 with Section 4.6
7.0	5	15	New	Added Legend of Symbols and Formatting
7.0	5	All	New	Added Notes column to capture notes relevant to each rule
7.0	5.1	N/A	Move	Moved table of terms and definitions to Appendix B
7.0	5.2	16	New	Added Rule 2
7.0	5.2	16	Move	Moved Rule 5 to note in Rule 1
7.0	5.2.2	18	Move	Moved Rule 3 to note in Rule 4 Deleted Rule 4 – Information available in section 5.5
7.0	5.3	20	Modify	Combined header and issuer level total verifications into one (1) table
7.0	5.4.1	21	Modify	Combined Rules 1 and 2 into Rule 1
7.0	5.4.2	22	Move	Moved Rule 4 to note in Rule 1
7.0	5.5	N/A	New	Added explanatory language for enrollees covered under multiple plans
7.0	5.5	24	Modify	Modified and combined previous rules for dual coverage with overlapping enrollment in the same plan into one (1) table

Version	Section	Table	New/Modify Move/Delete	Description
7.0	5.6	25	New	Added new Enrollment Period Activity Indicator Description Table
7.0	5.6	26	New	Added EPAI Rules using information previously included in Table 25
7.0	5.8	N/A	New	Added EDGE server proration calculation formula
7.0	5.8.2	28	Move	Moved Rule 3 from Table 27 (ESBR v.6.0) to introductory text
7.0	5.10	N/A	Move	Moved previous Rule 1 to introductory text
7.0	5.10.1	N/A	Move	Moved previous Rule 5 from Table 29 (ESBR v6.0) to introductory text
7.0	5.10.2	N/A	Move	Moved previous Rule 6 from Table 29 (ESBR v.6.0) to introductory text
7.0	5.10.2	30	New	Added Rule 2 – previously included in Table 29, Rule 4 (ESBR v.6.0)
7.0	6	31	New	Added Legend of Symbols and Formatting
7.0	6	All	New	Added Notes column to capture notes relevant to each rule
7.0	6	N/A	New	New policy language regarding use of RX claims for RA Added Note for additional clarification
7.0	6.1	N/A	Move	Moved table of terms and definitions to Appendix B
7.0	6.2	32	Move	Moved Rules 2 and 3 from table to opening paragraph
7.0	6.6	N/A	Modify	Clarified language and added Note box
7.0	6.6	40	Modify	Combined previous Rule 2 and 3 into Rule 2
7.0	6.6	N/A	Delete	Deleted second example figure
7.0	6.7	41	New	Added Rule 1 and Rule 5
7.0	6.8	43	Modify	Added language to Rule 1 for clarification
7.0	6.8	43	Modify	Divided previous Rule 3 into Rule 3 and Rule 4
7.0	6.9	N/A	Modify	Changed title of subsection to Fee-for-Service and Capitated Claim Submission and added clarifying language
7.0	6.9	N/A	Modify	Restructured section into Section 6.9.1 and 6.9.2 and modified rules to be specific to FFS Claims Submission and Capitated Services Submission
7.0	6.9.1	N/A	New	Added example to illustrate FFS Pharmacy Claims
7.0	7	N/A	New	Added clarifying language
7.0	7	47	New	Added Legend of Symbols and Formatting
7.0	7.1	N/A	Move	Moved table of terms and definitions to Appendix B

Version	Section	Table	New/Modify Move/Delete	Description
7.0	7.2	N/A	Modify	Changed title of section to Medical Claims Code Set Sources and Reference Table Verifications
7.0	7.2	48	New	Restructured list of Standard Code Sets into a table
7.0	7.2	49	New	Restructured list of rules into a table
7.0	7.3	50	Move	Moved Rule 3 from Table 49 (ESBR v.6.0) to Table 49
7.0	7.3	50	Modify	Combined previous Rule 4 and 5 into Rule 3
7.0	7.4	51	Modify	Changed the order of Diagnosis Code and Statement Covers From and Through Dates and Dates of Service in table
7.0	7.5	52	Modify	Combined previous Rule 3 to notes column of Rule 2
7.0	7.8	N/A	New	Added Note and clarifying language
7.0	7.8	55	Modify	Combined previous Rule 1 and 2 into Rule 1 and revised language for clarification
7.0	7.8.1	N/A	New	Added section to restructure information in previous Section 7.8 and add clarifying language
7.0	7.8.1	56	Move	Moved previous Rule 4 to Section 7.9
7.0	7.8.1	57	New	Added table and explanatory language and note to identify scenarios for accepted and rejected claims
7.0	7.9	N/A	Modify	Restructured examples into sections 7.9.1, 7.9.2, and 7.9.3
7.0	7.10	59	Modify	Restructured previous Rules table for clarity
7.0	7.10	60	New	Added table for examples of inclusive Service Code Modifiers
7.0	7.11	61	Move	Moved previous Rule 2 to Table 50 as Rule 4
7.0	7.13	64	Modify	Combined previous Rules 5 and 6 into Rule 5
7.0	7.14	N/A	Modify	Changed title of section to Fee-for-Service and Capitated Claim Submission
7.0	7.14	N/A	Modify	Restructured section into Section 7.14.1, 7.14.2, and 7.14.3 and modified rules to be specific to FFS Claims Submission, Capitated Services Submission, and Mixed Claims
7.0	7.14.1	N/A	New	Added example to illustrate FFS Only Claims
7.0	7.14.2	N/A	New	Added example to illustrate Capitated Medical Claims
7.0	7.14.3	N/A	New	Added example to illustrate Claim with FFS and Capitated Service Lines
7.0	7.17	N/A	Modify	Combined previous Section 7.17 and 7.18 into Section 7.17

Version	Section	Table	New/Modify Move/Delete	Description
7.0	7.17	N/A	Modify	Restructured section into Section 7.17.1, 7.17.1.1, 7.17.1.2, 7.17.2, 7.17.2.1, and 7.17.2.2
7.0	7.17	72	Modify	Restructured previous Rules table for clarity
7.0	7.17.1	73	Delete	Deleted previous Rule 4 from Table 61 (ESBR v.6.0)
7.0	7.19	N/A	New	Added Note for additional clarification
7.0	7.19	76	New	Added table for additional clarification
7.0	7.19	77	Modify	Modified previous Rules 2, 3, and 4 to Rules 2 and 3
7.0	7.20	N/A	New	Added language for additional clarification
7.0	7.21	N/A	New	Added section
7.0	8	82	New	Added Legend of Symbols and Formatting
7.0	8	N/A	Modify	Modified section to add Section 8.1, 8.2, 8.2.1, and 8.2.1
7.0	8.3	N/A	Move	Moved table of terms and definitions to Appendix B
7.0	8.4	84	Modify	Combined previous Rules 7 and 8 into Rule 7
7.0	8.9	89	Move	Moved previous Rules 3, 4, and 5 to Table 90
7.0	8.9	90	New	Added table to provide steps for voiding a previously submitted supplemental diagnosis record
7.0	9	N/A	New	Added Section 9 to provide information on Plan Data
7.0	10	N/A	New	Added a high level overview of the method for identifying claims for RA and RI programs
7.0	10	97	New	Added table to provide further information on RA and RI claim selection logic

13 Appendix B: Terms and Definitions

Table 101 identifies the terms and definitions used in the EDGE Server Business Rules.

Table 101: EDGE Server Business Rules Terms and Definitions

Term	Definition
Active Claim	Claim that was submitted by an issuer, passed all verification edits, and was accepted and stored on the medical and pharmacy claims data table.
Active Detail Record	Detail record that was submitted by an issuer, passed all verification edits, and was accepted and stored on the **Supplemental Diagnosis Code** file data table.
Benefit Year	An EDGE server benefit year aligns with the RA and RI benefit year, which is a calendar year from January 1st through December 31st of the applicable year.
Claim Family	An original claim and all the void or replace claims that are associated with the original claim. For example, if an original claim is replaced and then the replacement claim is voided, the claim family would be comprised of all three (3) claims.
Claim ID	A unique number the issuer adjudication system generated to uniquely identify the transaction. The issuer may modify the issuer-adjudicated **Claim ID**.
Dispensing Status	Indicates if the prescription was a partial fill (P) or completion of a partial fill (C). A null value implies a complete fill.
Enrollee Level Verification	The process of verifying the data elements in the enrollee level of the XML file. The enrollee level is included only in enrollment files.
Enrollment Period Activity Indicator (EPAI)	Indicates the reason the issuer created a specific enrollment period for a specific enrollee. CMS uses effective dates associated with specific indicators to determine the age the issuer used to rate the enrollee.
Enrollment Period Level Verification	The process of verifying the data elements in the enrollment period level of the XML file. The enrollment period level included is only in enrollment files.
File Type Verification	The process of verifying that a file is suitable for processing on an EDGE server. For more information on file type verification, please see Section 4.4.
Header Level Verification	The process of verifying data elements in the header level of the XML file. For more information on header level verification, please see Section 4.6.
Inactive Claim	A previously accepted version of a claim that has been voided or replaced. A claim must have been accepted and stored as active to be changed to inactive.
Inactive Detail Record	A previously accepted version of a detail record that has been voided. A detail record must have been accepted and stored as active to be changed to inactive.
Issuer Level Verification	The process of verifying data elements in the issuer level of the XML file. For more information on issuer level verification, please see Section 4.8.

Term	Definition
Medical Claims Header Verification	The process of verifying data elements in the medical claim header level of the XML file. The medical claim header level is included only in medical claim files. For more information on medical claim header verifications, please see Section 7.
Medical Claims Line Verification	The process of verifying data elements in the medical claim line level of the XML file. The medical claim line level is included only in medical claim files. For more information on medical claim line verifications, please see Section 7.
Non-Subscriber/ Dependent	An enrollee affiliated with another enrollee who is the subscriber. For more information on non-subscriber/dependent, please see Section 5.4.
Original Claim ID	A **Claim ID** previously submitted, accepted, and stored on the EDGE server medical claims data table. This data element is only filled when the **Void/Replace Indicator** is populated.
Original Medical Claim ID	The **Medical Claim ID** to which the supplemental claim is linked, and which was submitted on a previous medical claim file and accepted by the EDGE server.
Original Supplemental Diagnosis Detail Record ID	Identifies the original **Supplemental Diagnosis Detail Record ID** when processing a void.
Orphan/Orphaned	An active claim that has no corresponding active enrollee record.
Pharmacy Claims Level Verification	The process of verifying data elements in the pharmacy claim level of the XML file. The pharmacy claim level is only in pharmacy files. For more information on pharmacy claim level verifications, please see Section 6.
Plan Level Verification	The process of verifying data elements in the plan level of the XML file. The plan level is only present in pharmacy, medical and supplemental diagnosis files.
Premium Amount	The monthly total rated premium charged for a subscriber's policy, including the Advanced Premium Tax Credit (APTC) amount. The **Premium Amount** may include more than the amount billed directly to a subscriber. The monthly **Premium Amount** does not necessarily represent the amount billed to the subscriber. The **Premium Amount** is only reported on the enrollee record when the enrollee is identified as the subscriber with a **Subscriber Indicator** of "S". **Note**: Any change in a specific subscriber enrollee's premium rating requires the issuer to report a new enrollment period for that subscriber.
Prescription/Service Reference Number	A unique number assigned by a pharmacy to identify a single dispensing event. A **Prescription/Service Reference Number** does not need to be unique across all pharmacies an issuer uses. See Section 6.4 for specific business rules.

Term	Definition
Product/Service ID	Unique ID of the product or service dispensed. The ID can be a National Drug Code (NDC), National Health Related Item Code (HRI), or the Universal Product Code (UPC).
Subscriber	A designated enrollee used to report a charged premium for the plan included on the enrollment period. A subscriber does not need to be a parent or guardian if the parent or guardian is not enrolled in the plan. For more information on the subscriber, please see Section 5.4.
Subscriber ID	The **Unique Enrollee ID** of the enrollee identified in the file as the designated subscriber, with an "S" for the **Subscriber Indicator**. This data element represents a masked identifier, not a medical record number or cardholder ID. Please see Section 5.4 for specific business rules.
Supplemental Diagnosis File Detail Record Verification	The process of verifying data elements in the supplemental diagnosis file detail record level of the XML file. The supplemental diagnosis file detail record level is only included in supplemental diagnosis files. For more information on supplemental diagnosis file detail record verifications, please see Section 8.
Unique Enrollee ID	The masked identifier for an enrollee. This is not a medical record number, social security number (SSN), driver's license number, or cardholder ID (45 CFR § 153.720). Issuers must establish their own method of de-identifying an **Enrollee ID**. Issuers may use an existing internal ID, provided the ID was not used for exchange enrollment transaction or on the enrollee membership card. Issuers must use the same **Unique Enrollee ID** if the enrollee switches plans within the issuer. Issuers who wish to change the **Unique Enrollee ID** from one (1) benefit year to another must consider the rules for cross-year claims for RA and RI. The same **Enrollee ID** must be used from one (1) year to another in order for a cross-year claim to be considered. The EDGE server will treat variations in upper and lower case values in the **Unique Enrollee IDs** as unique individuals. Use of special characters may cause system errors and result in file failure. As such, CMS suggests that issuers only use alpha-numeric characters in the masking of **Unique Enrollee IDs**.

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14 Appendix C: Acronyms

Table 102: EDGE Server Business Rules Acronyms

Acronym	Term
CCIIO	Center for Consumer Information and Insurance Oversight
CEFR	EDGE Server Claim and Enrollee Frequency Report
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS – EDGE Server
CPT/HCPCS	Current Procedural Terminology/Healthcare Common Procedure Coding System
DDC	Distributed Data Collection
ECD	Enrollee (Without) Claims Detail
ECS	Enrollee (Without) Claims Summary
EDGE	External Data Gathering Environment
ES	EDGE Server
ESDMCE	EDGE Server Detail Medical Claim Error Report for Medical Submission
ESDPCE	EDGE Server Detail Pharmacy Claim Error Report for Pharmacy Submission
ESDEE	EDGE Server Detail Enrollment Error Report for Enrollment Submission
ESDSFE	EDGE Server Detail Supplemental Diagnosis File Error Report
ESES	EDGE Server Enrollment Submission
ESFAR	EDGE Server File Accept-Reject Report for Enrollee, Medical and Pharmacy Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental Diagnosis File Submission
ESSEFE	EDGE Server Detail Supplemental Diagnosis File Error Report
ESSMFE	EDGE Server Summary Medical Claim File Accept-Reject Error Report
ESSPFE	EDGE Server Summary Pharmacy Claim File Accept-Reject Error Report
ESSSFE	EDGE Server Summary Supplemental Diagnosis File Accept-Reject Error Report
FDA	Federal Drug Administration
FDEEAF	Frequency by Data Element for Enrollment Accepted Files Report
FDEPAF	Frequency by Data Element for Pharmacy Accepted Files Report
FDEMAF	Frequency by Data Element for Medical Accepted Files Report
FDESAF	Frequency by Data Element for Supplemental Accepted Files Report
ETL	Extract, Transform and Load
FFM	Federally Facilitated Marketplace
FTP	File Transfer Protocol
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Term
HTTP(S)	Hypertext Transfer Protocol (Secure)
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
MC	Medical Claim
NDC	National Drug Code
NPI	National Provider Identifier
PMPM	Per Member Per Month
PPACA	Patient Protection and Affordable Care Act
RA	Risk Adjustment
RACSD	Risk Adjustment Claim Selection Detail Report
RACSS	Risk Adjustment Claim Selection Summary Report
RADVPS	Risk Adjustment Data Validation Population Summary Statistics Report
RARSD	RA Risk Score Detail Report
RARSS	Risk Adjustment Risk Score Summary Report
RATEE	Risk Adjustment Transfer Elements Extract
RAUF	Risk Adjustment User Fee
RBIS	Rates and Benefit Information System
REV Code	Revenue Code
RI	Reinsurance
RIDE	Reinsurance Detail Enrollee Report
RISR	Reinsurance Summary Report
RxC	Pharmacy Claim
SBE	State-based Exchange
SE	EDGE Server System Error Report
SFTP	Secure File Transfer Protocol
SSH	Secure Shell
SSL	Secure Socket Layer
UI	User Interface
XML	eXtensible Markup Language
XSD	XML Schema Definition

15 Appendix D: Quick Reference of Data Elements Required and Not Required When Voiding Claims

Table 103: Medical Claims – Data Element Requirements, Claim Header Level

XML Element	Restriction	Comments
recordIdentifier	Required	
insuredMemberIdentifier	Not Required	Will validate if populated.
formTypeCode	Not Required	Will validate if populated.
claimIdentifier	Required	
originalClaimIdentifier	Required	Must match a claim in the database.
claimProcessedDateTime	Required	Must be later than the claim being voided.
billTypeCode	Not Required	Will validate if populated.
voidReplaceCode	Required	Must be “V”.
diagnosisTypeCode	Not Required	Will validate if populated.
diagnosisCode	Not Required	Will validate if populated.
dischargeStatusCode	Not Required	Will validate if populated.
statementCoverFromDate	Not Required	Will validate if populated.
statementCoverToDate	Not Required	Will validate if populated.
billingProviderIDQualifier	Not Required	Will validate if populated.
billingProviderIdentifier	Not Required	Will validate if populated.
issuerClaimPaidDate	Not Required	Will validate if populated.
allowedTotalAmount	Not Required	Will validate if populated; may be a negative value.
policyPaidTotalAmount	Not Required	Will validate if populated; may be a negative value.
derivedServiceClaimIndicator	Not Required	Will validate if populated.

Table 104: Medical Claims – Data Element Requirements, Service Line Level

XML Element	Restriction	Comments
recordIdentifier	Required	
serviceLineNumber	Required	This is defined as a numeric parameter. Issuers must include the original service line number or may default all lines to zero (0). This cannot be null.
serviceFromDate	Not Required	Will validate if populated.
serviceToDate	Not Required	Will validate if populated.
revenueCode	Not Required	Will validate if populated.
serviceTypeCode	Not Required	Will validate if populated.

XML Element	Restriction	Comments
serviceCode	Not Required	Will validate if populated.
serviceModifierCode	Not Required	Will validate if populated.
serviceFacilityTypeCode	Not Required	Will validate if populated.
renderingProviderIDQualifier	Not Required	Will validate if populated.
renderingProviderIdentifier	Not Required	Will validate if populated.
allowedAmount	Not Required	Will validate if populated; may be a negative value.
policyPaidAmount	Not Required	Will validate if populated; may be a negative value.
derivedServiceClaimIndicator	Not Required	Will validate if populated.

Table 105: Pharmacy Claims – Data Element Requirements

XML Element	Restriction	Comments
recordIdentifier	Required	
insuredMemberIdentifier	Not Required	Validates if populated.
claimIdentifier	Required	
claimProcessedDateTime	Required	Must be later than the claim being voided.
prescriptionFillDate	Required	Must match stored active claim to void.
issuerClaimPaidDate	Not Required	Validates if populated.
prescriptionServiceReferenceNumber	Required	Must match stored active claim to void.
nationalDrugCode	Required	Must match stored active claim to void.
daysSupply	Required	Must match stored active claim to void.
pharmacyNetworkIndicator	Required	Must match stored active claim to void.
dispensingProviderIDQualifier	Required	Must match stored active claim to void.
dispensingProviderIdentifier	Required	Must match stored active claim to void.
prescriptionFillNumber	Required	Must match stored active claim to void.
dispensingStatusCode	Required	Must match stored active claim to void.
voidReplaceCode	Required	Must be “V”.
allowedTotalCostAmount	Not Required	Validates if populated; may be a negative value.
policyPaidAmount	Not Required	Validates if populated; may be a negative value.
derivedServiceClaimIndicator	Not Required	Validates if populated.

16 Appendix E: Queries for Identifying Missing Plan Data

Table 106 identifies the queries to use for identifying missing plan data.

Table 106: Queries for Identifying Missing Plan Data

Request	Query
To verify the plan is in the "INSRNC_PLAN" table	select * from EDGE_SRVR_COMMON.INSRNC_PLAN where INSRNC_PLAN_ID = 'Insert 16-Digit Plan ID' and MARKETYEAR = 'Insert Market Year' and ACTIVE_FL = 'Y';
To ensure all applicable Rating Areas are in the "ISSR_PLCY_RATG_ AREA" table	select * from EDGE_SRVR_COMMON.ISSR_PLCY_RATG_AREA where PLAN_ID = 'Insert 16-Digit Plan ID' and MARKETYEAR = 'Insert Market Year' and ACTIVE_FL = 'Y';

Return to Section 9: Plan Data.