DISTRIBUTED DATA COLLECTION (DDC) FOR REINSURANCE (RI) AND RISK ADJUSTMENT (RA): PHARMACY CLAIM FILES

October 8, 2015

Health Insurance Marketplace Program Training Series

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Session Guidelines

- This is a 90-minute webinar session.
- For questions regarding content and the DDC program, please contact your Financial Management (FM) Service Representative directly and copy the Centers for Medicare & Medicaid Services (CMS) Help Desk (CMS_FEPS@cms.hhs.gov).
- For questions regarding logistics and registration, contact the Registrar at: (800) 257-9520.

Intended Audience

- Marketplace and Non-Marketplace issuers new to 2015 Data Submission.
- Issuers interested in a refresher in Pharmacy External Data Gathering Environment (EDGE) server data submission.
- Third Party Administrators (TPAs) and Support Vendors.

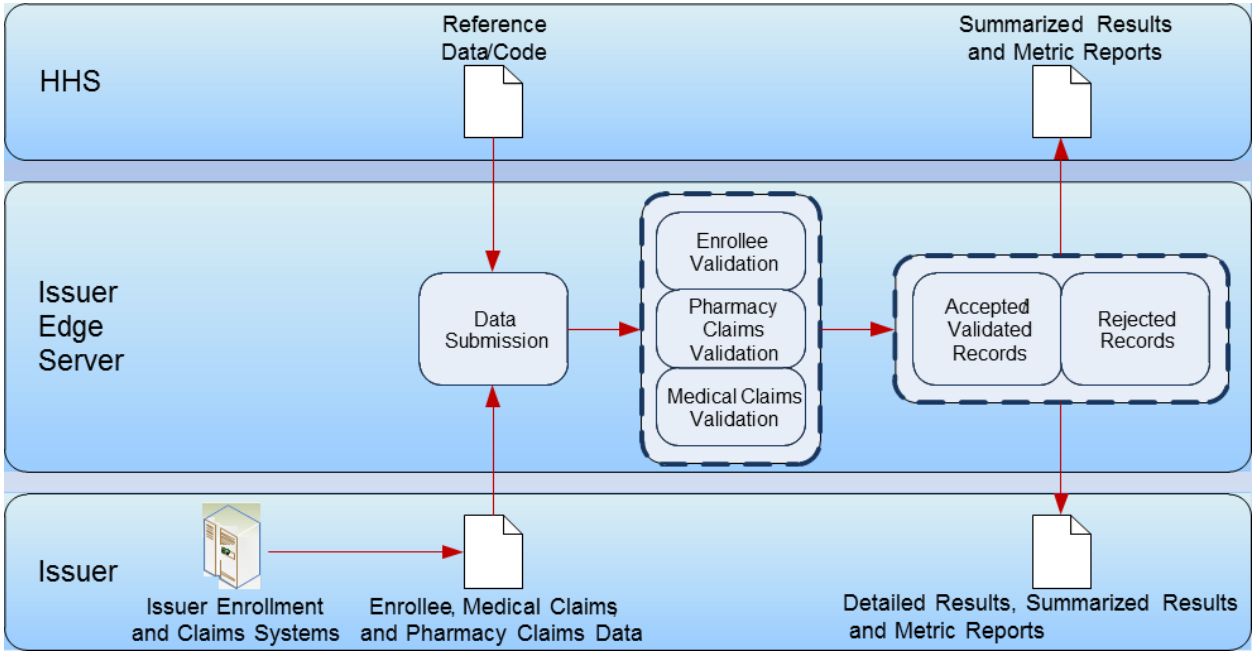
Introduction

- This session will provide issuers and other entities with a brief overview of EDGE server resources and operational guidance for the submission of Pharmacy data to the EDGE server in support of the RI and RA premium stabilization programs.

Review of General File Submission and Resources

Overview of EDGE Server File Processing

- Data is extracted from issuers' proprietary systems, transformed into the necessary data formats, and loaded to the EDGE server. This process is known as the Extract Transform Load (ETL).



Overview of EDGE Server File Processing (continued)

- eXtensible Markup Language (XML) is the required format for inbound data files.
- All files undergo a variety of verification edits that are dependent upon the type of file submitted.
- Upon completion of file processing, outbound files are produced with specific results of all records submitted.
- This session will cover the verification edits for pharmacy files.

EDGE Server File Submission Resources

- The following resources are provided and include information for all file type submissions to the EDGE server. The resources can be found in the Registration for Technical Assistance Portal (REGTAP) Library.
  - Interface Control Document (ICD)
  - XML Schema Definitions (XSDs) and XML Files
  - EDGE Server Business Rules (ESBR)

Interface Control Document (ICD)

- The ICD describes the interface requirements for the transmission of information between CMS and an issuer's EDGE server, including the detailed data exchange format and protocols.
- There are two (2) sets of tables in the ICD for each inbound file:
  - Data Element and Description
  - Technical Field/Element Characteristic

ICD Table

This is an example of the two (2) tables used for the Pharmacy File Header segment of the inbound XML file.

6.1.8.2 Business Data Elements and Descriptions

File Header Category Data

The data elements and corresponding XML element names for the ESPCS File Header Category Data are shown in Table 12. These elements are defined in the *EDGEServerPharmacyClaimSubmission.xsd*.

Table 12: ESPCS File Header Category Data

Note: Table 16: ESPCS File Header Category Field Element Characteristics– provides the specific data types and restrictions, as well as the verification edits performed, on these data elements.

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names
File ID	Unique identifier for pharmacy claim file.	File Header	1	fileIdentifier
Execution Zone	Indicator to denote for which environment the file is intended.	File Header	1	executionZoneCode
Interface Control Release Number	Denotes the version number of the ICD that the file corresponds to as identified on page one (1) of this document. A file must have the latest version number to be accepted. The last two (2) digits of the version , however, reflect a cosmetic change to the ICD and are not validated.	File Header	1	interfaceControlReleaseNumber

6.1.8.3 Field/Element Characteristics

This section defines the data type, restrictions and verification rules for each data element included on the ESPCS file. The root element of the ESPCS in the XSD is *EDGEServerPharmacyClaimSubmission*. This element is required and all the other elements defined in this section for the ESPCS are embedded within this element start and end tags.

Table 16: ESPCS File Header Category Field Element Characteristics

Note: Table 12: ESPCS File Header Category Data – provides the description of the data element and the frequency of occurrence on the inbound file.

XML Element Names	Business Data Element	Data Type	Required/ Situational/ Not Required	Face Validity	Referential Check	Logical Checks	Restrictions
fileIdentifier	File ID	string	Required	N	N	Y (If a file is accepted, the File ID must be unique within an execution zone.)	Length = 12
executionZoneCode	Execution Zone	string	Required	Y	Y	N	Length = 1 Enumeration Values: 'T' 'P' Enumeration Values Description: 'T' = Test Envrionment 'P'= Production Environment
interfaceControlReleaseNumber	Interface Control Release Number	string	Required	N	Y	N	Length = 8 Format – XX.XX.XX Restriction: The last two (2) digits submitted are not required to match the number on page 1 of this document. For example, the scenario below would pass validation: Latest ICD Version: 01.00.10 File ICD Version Passed: 01.00.00

Notice that Table 12 is the Business Data Element and Description, and Table 16 is the Technical Field/Element Characteristics.

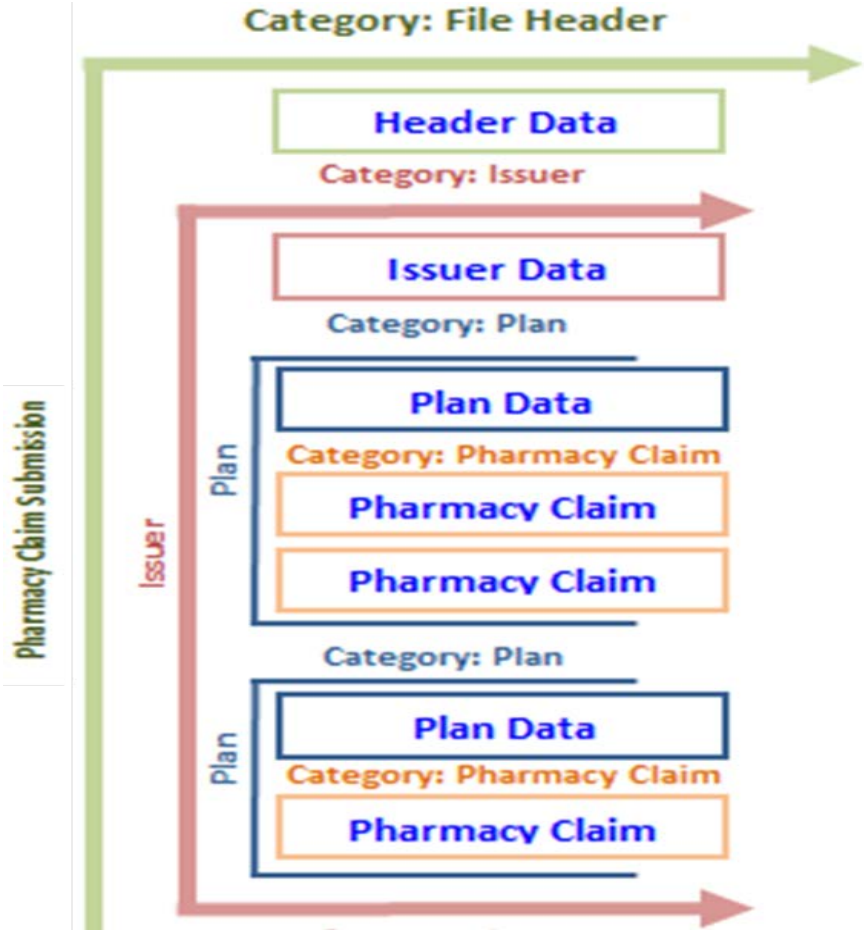
Pharmacy XML Basic Structure

Pharmacy XML Basic Structure

- A pharmacy XML file is segmented by levels of data, as shown in this table.

File Level	Pharmacy Claims File
Header	X
Issuer	X
Plan	X
Pharmacy Claim	X

Pharmacy XML Basic Structure
(continued)



This graphic illustrates the levels in an XML pharmacy claim file.

- Header
- Issuer
- Plan
- Pharmacy Claim

Pharmacy XML Example

General Pharmacy File Submission

General Pharmacy File Processing

- Pharmacy Files must be submitted at least quarterly.
  - CMS recommends that issuers submit files monthly.
- When submitting pharmacy files, issuers should refer to the CMS published submission timelines in the REGTAP Library.

Rule	Only pharmacy claims for enrollees in the Individual and Small Group Market, both inside and outside the Marketplace, will be accepted. All other claims will be rejected. Issuers who only have small group market plans should submit pharmacy claims even though they are not used in RA calculations.
Rule	The Unique Enrollee ID and Plan ID reported on the pharmacy claims file must correspond to a Unique Enrollee ID and Plan ID on the enrollment file.

General Pharmacy File Processing (continued)

- During the initial file load process, pharmacy claim files are not compared to the enrollment files or stored enrollment records.
  - Enrollment and Claim files are processed independent of each other.
  - The process of cross referencing the enrollee and claim data tables for identifying claims eligible for reinsurance and risk adjustment is performed during program specific processing.
- Pharmacy claims for enrollees who are not matched on an enrollment file will be considered orphaned and will not be considered during the RI calculation process.

General Pharmacy File Processing (continued)

- 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.

Rule	The initial pharmacy file submission will contain pharmacy claims with a fill date equal to or greater than the benefit year. Unlike the enrollment file, pharmacy files are NOT complete replacements. **Full file submissions will result in claims being rejected as duplicates.**

- Issuers should plan accordingly to ensure that all claims are corrected and submitted for consideration by April 30th of the following applicable benefit year.

General Pharmacy File Processing (continued)

- In an effort to provide the most complete and accurate reporting of accepted and rejected records in a claim file and provide the reasons for rejection, the file processing software will apply the verification rules to all data elements on the claim.
- Issuers who process a claim multiple times in a single day may choose to submit all versions of the claim on a single claim file or only submit the final version of the claim.
  - If only a final claim is submitted, the Total Allowed Costs and Plan Paid Amount should reflect the entirety of the costs and amount paid.

Header, Issuer and Plan Level Verifications

Header, Issuer and Plan Level Verifications

- There are two (2) data elements at the header, issuer and plan levels that are specific to pharmacy claims files.
- The following data elements must pass a required and logical check verification process:
  - Total Claim Count
  - Total Plan Paid Amount

Total Claim Counts

Rule	The Total Count of Claims at the header level must equal the count of all claim records on the file. Similarly, the Total Count of Claims reported at the issuer level and plan level must equal the count of the total claim records for that specific level. If a reported value at the header, issuer or plan level does not match the total count for the indicated level, then that level and all associated sub-levels will be rejected.

Plan Paid Amounts

Rule	The Total Plan Paid Amount at the header level will be compared to the sum of all Total Plan Paid Amounts in the file. Similarly, the Total Plan Paid Amount at the plan level will be compared to the sum of all Total Plan Paid Amounts for the claims associated with that plan.

Plan Paid Amounts (continued)

Rule	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 “Total Plan Paid Amount” is $524,500, the “Total Plan Paid Amount for Issuer” would not be rejected. An informational edit would be sent to the submitter identifying the discrepancy**.**

Data Element Requirements

Prescription Service Reference Number

Prescription/Service Reference Number

- A unique number assigned by the pharmacy to identify a single dispensing event.
- Does not need to be unique across all pharmacies utilized by an issuer.

Rule	Issuers must submit the Prescription/Service Reference Number assigned by the pharmacy.
Rule	If submitting non-retail pharmacy claims, such as staff model plans, issuers will need to create a unique number, up to 12 digits, for the Prescription/Service Reference Number.

Product/Service ID

- Product/Service ID is a unique ID of the product or service dispensed. The ID submitted is typically a National Drug Code (NDC).
  - For items dispensed at a pharmacy but that do not have an NDC number, such as diabetic supplies, issuers may submit a National Health Related Item Code (HRI) or the Universal Product Code (UPC).
    - The HRI or UPC cannot exceed 11-digits.

Rule	If multiple NDCs were supplied under a single prescription event, only the highest cost NDC should to be submitted on the pharmacy claim file.

Pharmacy Amounts

- **Total Allowed Costs** are the sum of ingredient cost, dispensing fees and sales tax, where applicable.
- **Plan Paid Amount** represents the total cost of the product/service paid by the plan (including amounts paid for ingredient cost, dispensing fee and sales tax).
  - The reported Plan Paid Amount does not need to be adjusted to reflect manufacturer rebates.

Fill Number

Fill Number is the code that identifies whether the prescription is an original (00) or refill (01-999).

Rule	Issuers who do not capture a Fill Number may choose to default the Fill Number to one (1) or sequence the Fill Number manually. However, if there are multiple fills with the same Fill Date, the claims may be rejected as duplicate if the other seven (7) key elements are the same.

Pharmacy Claim Key and Duplicates

Pharmacy File Common Terms

Active Claim	A claim that was submitted by an issuer, passed all verification edits and was accepted and stored on the pharmacy claims data table.
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.
Pharmacy Claim Key	The following data elements are used to determine a unique claim record: **Issuer ID** **Plan ID** **Dispensing Provider ID Qualifier** **Dispensing Provider ID** **Fill Date** **Prescription/Service Reference Number** **Fill Number** **Dispensing Status** The claim key includes the same elements used by the National Council for Prescription Drug Programs (NCPDP) to define a unique claim.

Duplicate Pharmacy Claim Rules

To ensure that there is only one (1) active version of a claim stored in the pharmacy claim table on the EDGE server, duplicate checks are performed.

Rule	Claims identified as a void or replacement will bypass the duplicate check.
Rule	The eight (8) key elements are used to determine if a duplicate claim exists in the pharmacy claim table. • If the eight (8) key elements match a stored active claim, then the new claim will be rejected as a duplicate.
Rule	The Claim ID must be unique for each claim even when a void or replace is submitted.

Claim Processed Date Time

Claim Processing Date Time

The Claim Processed Date Time element is reported at the claim level and is used to determine order of processing.

- All claims must include a date and time in the Claim Processed Date Time field.
  - Issuers may create a unique Claim Processed Date Time to indicate order of processing.

Claim Processing Date and Time
(continued)

Rule	If the time component is not provided, all claims with the same claim key will be rejected, as the system is not able to determine the processing order of the claims.
Rule	The Claim Processed Date and Time of a void or replace must be later than the Claim Processed Date Time of the original claim or the void/replace will be rejected.

Submission of Void and Replace Claims

Void Logic

- Pharmacy claim files include a data element, which allows issuers to void claims that were previously submitted and accepted and stored as active.
  - By 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 program.

Void Logic (Continued)

Rule	To void a pharmacy claim: • A value of “V” must be present in the Void/Replace Indicator data field. • The eight (8) key elements must be present and match a stored active claim. • If the original claim is not found, the void will be rejected.
Rule	The Claim Processed Date Time must be later than original claim. • If the Claim Processed Date time is equal to or earlier than the original claim, the void will be rejected.

Void Logic (Continued)

Rule	Once a void claim is submitted and the original claim is changed from active to inactive status, the claim is no longer eligible for consideration in the RI calculation. • If the claim was voided in error, the issuer may either resubmit the original claim or submit a replacement claim with a new Claim ID.
Rule	It is very important to note that if a pharmacy claim was submitted and accepted and there is an adjustment that results in a change to one (1) of the **eight (8) key elements**, the original claim submitted must be voided and the adjusted claim submitted as a new original claim with a new Claim ID.

Required Elements to Void a Prior Claim

- All data elements are not required on a void submission.
- The following elements are required and must be populated with a valid value:
  - Record ID
  - Claim ID
  - Claim Processed Date Time
  - Fill Date
  - Prescription Service Reference Number
  - Dispensing Provider Qualifier
  - Dispensing Provider ID
  - Fill Number
  - Dispensing Code
  - Void/Replace Indicator
- The remaining data elements may include null values.
  - If the Total Allowed Cost and Total Paid Amounts are populated, a negative value will be accepted.

Replace Logic

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

Rule	A pharmacy claim submitted with an “R” Void/Replace Indicator will bypass the duplicate logic when searching for the claim to be replaced.
Rule	To replace a pharmacy claim: • A value of “R” must be present in the Void/Replace indicator data field. • The eight (8) key elements must match a stored claim. The original claim that matches the eight (8) key elements may be **active or inactive**. • If the original claim is not found, the replacement will be rejected.

Replace Logic (continued)

Rule	The Claim Processed Date Time must be later than the original claim. • If the Claim Processed Date time is equal to or earlier than the original claim, the replacement claim will be rejected.
Rule	When submitting a replacement claim to account for changes in a Plan Paid Amount, the original claim and the Plan Paid Amount associated with the original claim will be inactivated. The replacement claim should include all final paid charges for the services.

Capitated Services and Submitting Derived Amounts

Derived Pharmacy Amounts

- Issuers will need to derive (or estimate) a Plan Paid Amount for enrollees who received pharmaceutical services under a capitation arrangement.
- The inbound claim file layout contains a Derived Amount Indicator field to identify when the Plan Paid Amount has been calculated for dispensed pharmaceuticals provided under a capitation arrangement.
- The issuer will need to calculate the estimated Plan Paid Amount of the pharmaceuticals dispensed, based on the encounter data submitted by the pharmacy.
- Issuers should refer to 45 CFR § 153.710 for information on calculating derived amounts.

Derived Pharmacy Amounts (continued)

Acceptable values for the Derived Amount Indicator:

- Y = pharmaceuticals were dispensed under a capitation arrangement, and the Plan Paid Amount is a derived value.
- N = pharmaceuticals dispensed are covered under fee for service, and the Plan Paid Amount is the actual amount paid for the service.

Rule	When the value "Y" is reported in the Derived Amount Indicator field: • The Paid Date field may be empty or populated with the date of claim adjudication . • The Plan Paid Amount must be ≥$0 .

Derived Pharmacy Amounts (continued)

Rule	When the value “N” or a null value is reported in the Derived Amount Indicator field: • The Paid Date field must be populated. • The Plan Paid Amount must be ≥ $0.
Rule	Issuers do not need to derive the Total Allowed Cost. • Issuers may use a default value of $1.00 for the Total Allowed Cost.

Upcoming Webinars

Upcoming Webinars

- Upcoming webinar presentations will:
  - Highlight important Business Rules as they relate to a specific inbound file type.
  - Provide information on outbound files.
  - Explain data management and data retention requirements.
- CMS staff will be available at the end of each webinar presentation to answer questions on the material covered in each session.

Upcoming Webinars

Webinar	Scheduled Event Date
Medical Claim Submission	October 15, 2015
Supplemental Diagnosis Submission	October 22, 2015

Questions?

To submit questions by phone:

- ❑ Dial ‘14’ on your phone’s keypad
- ❑ Dial ‘13’ to exit the phone queue

Resources

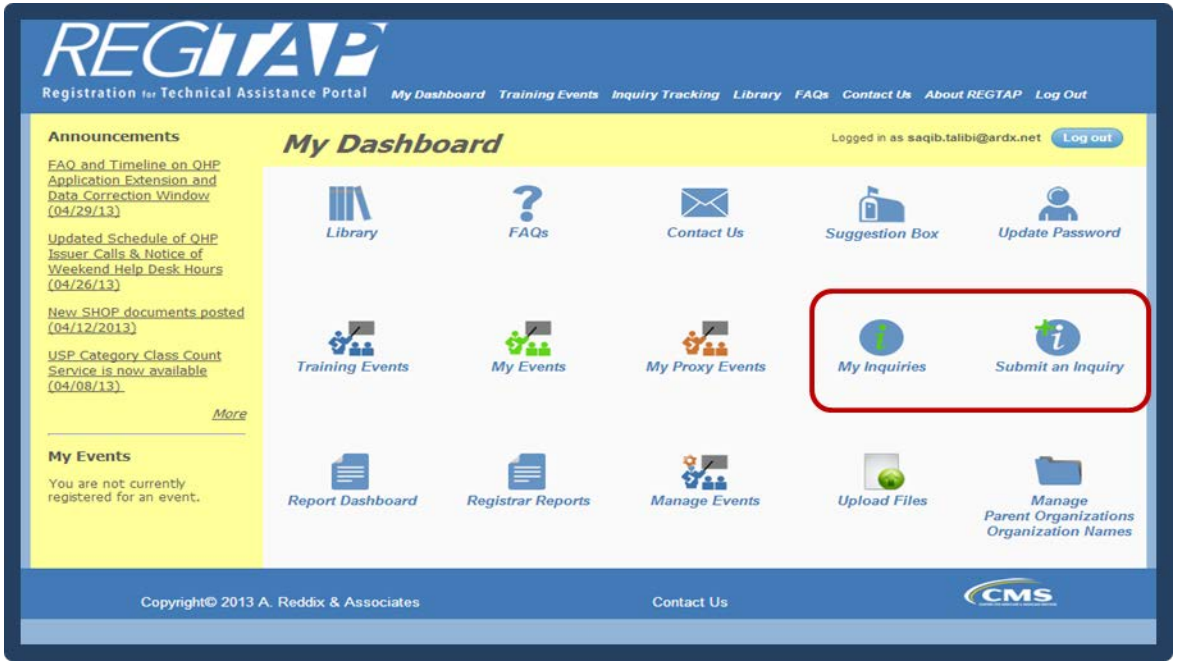
Resources

Resource	Link/Contact Information
Center for Consumer Information and Insurance Oversight (CCIIO)	http://cms.gov/cciio/
Registration for Technical Assistance Portal (REGTAP) • Registration • Inquiry Tracking and Management System (ITMS) • Resource Library • Frequently Asked Questions (FAQs)	https://www.REGTAP.info/

Inquiry Tracking and Management System (ITMS)

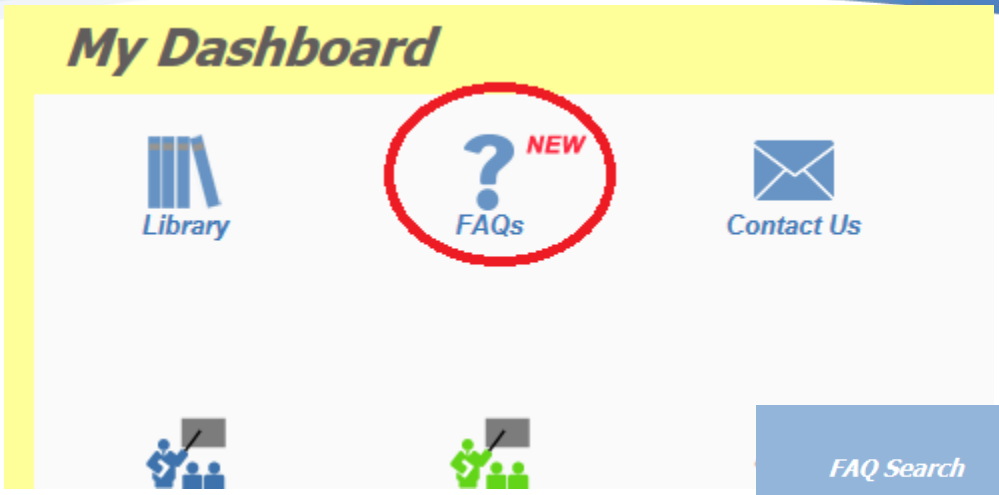
ITMS is available at http://www.REGTAP.info.

Users can submit questions after the User Group by selecting "Submit an Inquiry" from My Dashboard.



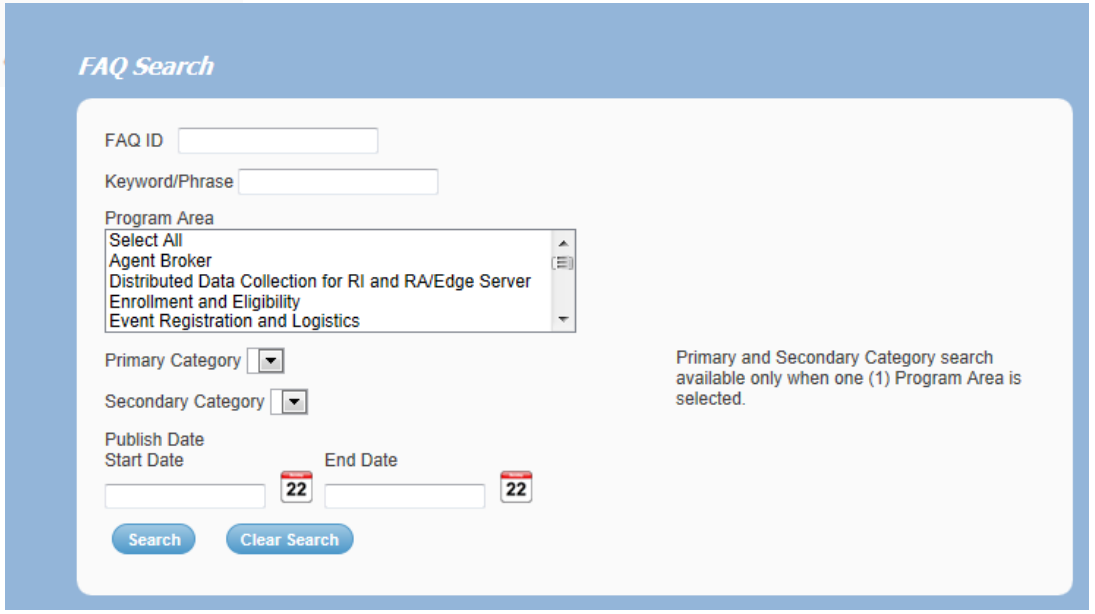
Note: Enter only one (1) question per submission.

FAQ Database on REGTAP



The FAQ Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary categories, and Publish Date.

FAQ Database is available at http://www.REGTAP.info.



Closing Remarks