DISTRIBUTED DATA COLLECTION (DDC) FOR REINSURANCE (RI) AND RISK ADJUSTMENT (RA): EDGE DATA MANAGEMENT – PART 2

December 22, 2015

Health Insurance Marketplace Program
Training Series

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Agenda

- Session Guidelines
- Intended Audience
- Purpose
- Review of Data Management – Part 1
- Rejections – Non-Specific Error Codes
- Duplicate Claim Errors
- Data Management for Reinsurance Overview
- Upcoming Webinars
- Questions
- Resources
- Closing Remarks

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, please contact the Registrar at: (800) 257-9520.

Intended Audience

- Amazon and On-Premise External Data Gathering Environment (EDGE) server issuers (Marketplace and Non-Marketplace) of plans in states where the U.S. Department of Health & Human Services (HHS) operates the Affordable Care Act (ACA) RA and RI Programs
- Third Party Administrators (TPAs) and Support Vendors

Purpose

- This presentation is a continuation of the December 15, 2015 Data Management webinar.
- This presentation will cover the management of:
  - Non-specific Error Codes
  - Duplicate Error Codes
  - Data management for RI
- A follow up session will be held to address data management for RA.

Review of Data Management – Part 1

Issuer Data Management Responsibility

- It is important that issuers establish a process by which they analyze the detail and summary data in the outbound files provided.
  - This process should be performed frequently and consistently to identify patterns in rejected data and to identify data that must be resubmitted to be included in the RA and RI calculations.
- It is equally important that issuers contact CMS as early as possible to answer questions and provide assistance with data error resolution.
  - Issuers who contact CMS early in the process will be more likely to have successful and timely data submissions.

Outbound Detail File Review

- The outbound detail reports include:
  - A Status (statusTypeCode) for each record submitted.
    - A (accepted), I (informational), R (rejected)
  - An Error Message type (recordedError) for informational and rejected records.
    - Error Code, Error Element, Error Value, Error Message and Error Message Detail
  - Error Codes are composed of three (3) values:
    - XML segment, type of error and specific identifier associated with the message
      - 0.4.5 – Header level, logical edit, File ID previously submitted

Error Code Job Aid Review

- The EDGE Server File Ingest Error Codes Job Aid has been updated to include groupings, actions and Interface Control Document (ICD) / EDGE Server Business Rules (ESBR) references.
  - Groupings classify Error Codes that have failed a specific software edit.
  - Actions provide guidance for resolving errors.
  - ICD / ESBR references direct issuers to additional written guidance.

Enrollee Data related Edits and Messages

Associated Data Element	Error Level	Error Type	Unique ID	Error Code	Error Message	Group	Action	Refer to ICD / ESBR
No associated data element	6	5	6	6.5.6	Enrollment periods for insured member rejected because the insured member failed validation	Higher or Lower Level Error	None - Failure at the enrollee level. This error will be resolved when enrollee level error(s) resolved.	NA
CODE REMOVED	6	5	8	6.5.8	CODE REMOVED	No longer used	NA	NA
Subscriber ID	6	5	28	6.4.28	When the Subscriber Indicator = NULL the subscriber identifier cannot match the insured member identifier	Data Element Cross Reference Error	Verify that the 'subscriberIdentifier' (Subscriber ID) and 'insuredMemberidentifier' (Unique Enrollee ID) are not the same.	ICD - Table 11
Subscriber ID	6	5	13	6.5.13	Subscriber ID must be null when subscriberIndicator is 'S'	Data Element Cross Reference Error	Verify that the 'subscriberIdentifier' (Subscriber ID) is not populated when the 'subscriberIndicator' (Subscriber Indicator) is populated with an "S".	ICD - Table 11 ESBR - Sec 5.4, Table 19

Rejections – Non-Specific Error Codes

Non-Specific Error Codes

- Non-specific Error Codes are listed in the File Ingest Error Codes Job Aid on the **Edit Structure Definition** tab.
  - Unlike the Error Codes listed on the **Enrollee-Edit Messages** and **Claim-Supplemental-Edit Messages** tabs, which return specific Error Messages, the non-specific Error Codes return only one (1) Error Message for multiple data elements.
    - X.1.1 - Required Check Failed
    - X.2.1 - Face Validity Failed
    - X.3.1 - Reference Check Failed

Note: X = value associated with the XML segment (0=header, 1=issuer, 2=plan, etc.)

Non-Specific Error Codes (Continued)

- Required errors (x.1.1) indicate a data value was not submitted.
  - Example: Diagnosis Code is required on all medical claims.
- Face validity errors (x.2.1) indicate the data value submitted was in an incorrect format.
  - Example: Date of Birth (DOB) should be submitted as YYYY-MM-DD.
- Reference errors (x.3.1) indicate the data value submitted was not found in the reference table.
  - The data value may be a submission error (spaces, extra digits, etc.) or may be due to missing values in the reference table.

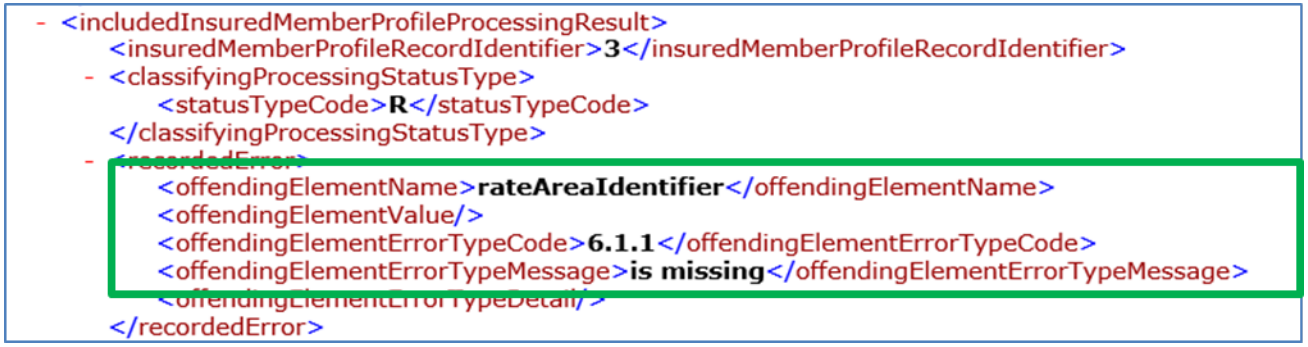
Required Elements

- The ICD identifies the data elements that are required.
  - Most data elements, across all files, are identified as “required”.
    - Any required element that is not populated with a data value will be rejected with an Error Code value of x.1.1 and Error Message - is missing.

Required Data Elements

Enrollment	Pharmacy	Medical	Supplemental
27 elements	31 elements	46 elements	25 elements

  - Issuers should use the **Error Element (‘offendingElementName’)** in the detail report to identify the missing field.



Situational Elements

- The ICD identifies the data elements that are situational.
- 10 data elements are identified as “situational”.

Situational Data Elements

Enrollment	Pharmacy	Medical	Supplemental
Enrollment Period Level: Subscriber Indicator Subscriber ID	Claim Level: Paid Date	Claim Header Level: Bill Type Void/Replace Indicator Discharge Status Code Date Paid Claim Line Level: Service Code Qualifier Service Code Place of Service	None

- Any situational element that is not populated will return a specific Error Code and Error Message if the value fails and is rejected.

```
- <includedClaimProcessingResult>
    <medicalClaimRecordIdentifier>9</medicalClaimRecordIdentifier>
    <medicalClaimIdentifier>650009</medicalClaimIdentifier>
  - <classifyingProcessingStatusType>
      <statusTypeCode>R</statusTypeCode>
    </classifyingProcessingStatusType>
  - <recordedError>
      <offendingElementName>billTypeCode</offendingElementName>
      <offendingElementValue>211</offendingElementValue>
      <offendingElementErrorTypeCode>3.4.32</offendingElementErrorTypeCode>
      <offendingElementErrorTypeMessage>BillTypeCode must be null if the formTypeCode is P</offendingElementErrorTypeMessage>
      <offendingElementErrorTypeDetail/>
    </recordedError>
```

Face Validity Elements

- Many data elements are subject to face validity edits.
  - Any data value that is submitted, and does not meet the specific format requirements, will be rejected with an Error Code value of x.2.1 and Error Message – “Value submitted is not the correct data type or is not in the valid range.”

Face Validity Elements

Enrollment	Pharmacy	Medical	Supplemental
17 elements	19 elements	27 elements	11 elements

  - Issuers should use the Error Element (‘offendingElementName’) in the detail report to identify the element that failed.

```
  </recordedError>
- <includedClaimProcessingResult>
    <medicalClaimRecordIdentifier>10</medicalClaimRecordIdentifier>
    <medicalClaimIdentifier>AAA104</medicalClaimIdentifier>
  - <classifyingProcessingStatusType>
      <statusTypeCode>R</statusTypeCode>
    </classifyingProcessingStatusType>
  - <recordedError>
      <offendingElementName>billingProviderIdentifier</offendingElementName>
      <offendingElementValue>8084012345678893</offendingElementValue>
      <offendingElementErrorTypeCode>3.2.1</offendingElementErrorTypeCode>
      <offendingElementErrorTypeMessage>Value submitted is not the correct data type or is not in the valid range</offendingElementErrorTypeMessage>
    </recordedError>
```

Face Validity Elements (Continued)

- The specific submission format requirements are provided under the Restrictions section in the ICD.
  - Dates must always be in the format: YYYY-MM-DD.
  - Date/Time must always be in the format: YYYY-MM-DDTHH:MM:SS.
  - Dollar values must always include two (2) digits after a decimal point.
  - Diagnosis Codes must never include a decimal, and letters must be capitalized.
  - Length means a precise length.
    - Issuer ID = 5, File ID = 12, etc. and often the restrictions include the precise values required (Execution Zone = T or P, Provider ID Qualifiers = XX or 99, etc.)
  - Min and Max means values may be in between the minimum and maximum values.
    - Note that dollar values are restricted further by a logical edit that restricts negative amounts to only claims that are being voided.

Reference Check Elements

- Reference check errors have been reported as the most challenging of the Error Codes to manage due to their non-specificity.
  - The outbound summary report provides a count of the non-specific Error Codes but does not include the Error Element.
    - Improving the reporting of non-specific errors is a priority for 2016 data submission.
  - Only the outbound detail report will include the Error Code, Error Element and Error Value.
    - Issuers must use the detail report to identify the data element(s) that failed.

Reference Check Elements

- The ICD identifies the data values that must pass a reference check.
- Section 4.5 of the ESBR includes the sources used by CMS to populate the data values in the reference tables.
  - Any data value that is submitted, and is not found on the reference table, will be rejected with an Error Code value of x.3.1 and Error Message – “Reference check failed.”

Reference Check Elements

Enrollment	Pharmacy	Medical	Supplemental
9 elements	9 elements	19 elements	8 elements

- Issuers should use the Error Element (‘offendingElementName’) and the Error Value (‘offendingElementValue’) in the detail report to identify the element and value that failed.
  - These can then be grouped by element and value to identify any patterns.

Reference Check Example

EDGE Server Detail Enrollment Error (ESDEE) Report

Partial file image

```
<includedInsuredMemberProcessingResult>
  <insuredMemberRecordIdentifier>43</insuredMemberRecordIdentifier>
  <insuredMemberIdentifier>P12566002022TRS</insuredMemberIdentifier>
 - <classifyingProcessingStatusType>
    <statusTypeCode>R</statusTypeCode>
  </classifyingProcessingStatusType>
 - <recordedError>
    <offendingElementName>No Associated Data</offendingElementName>
    <offendingElementValue/>
    <offendingElementErrorTypeCode>5.5.5</offendingElementErrorTypeCode>
    <offendingElementErrorTypeMessage>Insured member rejected because all enrollment periods for insured member failed
      validation</offendingElementErrorTypeMessage>
    <offendingElementErrorTypeDetail/>
  </recordedError>
 - <includedInsuredMemberProfileProcessingResult>
    <insuredMemberProfileRecordIdentifier>44</insuredMemberProfileRecordIdentifier>
   - <classifyingProcessingStatusType>
      <statusTypeCode>R</statusTypeCode>
    </classifyingProcessingStatusType>
   - <recordedError>
      <offendingElementName>insurancePlanIdentifier</offendingElementName>
      <offendingElementValue>25032VA013001401</offendingElementValue>
      <offendingElementErrorTypeCode>6.3.1</offendingElementErrorTypeCode>
      <offendingElementErrorTypeMessage>Reference check failed</offendingElementErrorTypeMessage>
      <offendingElementErrorTypeDetail/>
    </recordedError>
   - <recordedError>
      <offendingElementName>rateAreaIdentifier</offendingElementName>
      <offendingElementValue>006</offendingElementValue>
      <offendingElementErrorTypeCode>6.3.1</offendingElementErrorTypeCode>
      <offendingElementErrorTypeMessage>Reference check failed</offendingElementErrorTypeMessage>
      <offendingElementErrorTypeDetail>Rating area for the plan does not exist for the year associated with the enrollment coverage start
        date</offendingElementErrorTypeDetail>
    </recordedError>
```

Record 43

Error Code: 5.5.5

Error Element: No Associated Data

Action: Ignore (Higher/Lower Level Error)

Record 44

Two (2) Reference Check failures

Error Code: 6.3.1

Error Element: Insurance Plan Identifier

Error Value: 25032VA013001401

Error Code: 6.3.1

Error Element: Rate Area Identifier

Error Value: 006

Reference Check Example (Continued)

- If we convert the full XML to Excel, we can see a pattern.
  - Two (2) reference check errors occurred.
    - 19 incorrect Rating Areas – 8 for Rating Area 003 and 11 for Rating Area 006
    - Two (2) incorrect Plan IDs – both for plan 25032VA013001401

1	ns1:insured Member Profile Record Identifie	ns1:statu sType Code	ns1:offending Element Name2	ns1:offending Element Value5	ns1:offending Element Error Type Code6	ns1:offending Element Error Type Message7	ns1:offending Element Error Type Detail 8
7	3	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
10	4	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
17	6	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
24	8	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
31	10	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
35	11	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
42	13	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
49	15	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
56	17	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
81	28	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
87	30	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
93	32	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
100	34	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
106	36	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
113	38	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
119	40	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
126	42	R	rateAreaIdentifier	003	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
132	44	R	insurancePlanIdentifier	25032VA013001401	6.3.1	Reference check failed	
133	44	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date
134	45	R	insurancePlanIdentifier	25032VA013001401	6.3.1	Reference check failed	
135	45	R	rateAreaIdentifier	006	6.3.1	Reference check failed	Rating area for the plan does not exist for the year associated with the enrollment coverage start date

Reference Checks – Identifying the Cause

- Identifying the specific data elements that are subject to reference checks on a file can be useful in narrowing down the possible cause of the rejection prior to data submission.
- The most common data elements that result in a reject due to a reference check error include:
  - Enrollment file: Plan IDs and Rating Areas
    - Error Code(s): 6.3.1
  - Medical file: Diagnosis Codes, Bill Types, Revenue Codes and Service Codes
    - Error Code(s): 3.3.1 and 4.3.1
  - Supplemental file: Diagnosis Codes
    - Error Code(s): 3.3.1

Reference Checks – How To

- The following slides will:
  - Focus on reference checks for each file type at a specific level, except the header and issuer levels.
  - Indicate the number of elements possible to trigger the non-specific Error Code at each level.
  - Identify the most common data elements that cause a non-specific Error Code at each level.
  - Provide guidance on how to avoid and resolve non-specific Error Code rejections.

Enrollment – Reference Errors

- Enrollment File Reference Checks
  - The table below shows the number of data elements that include a reference check at the enrollee and enrollment period level.

Enrollment File Level	# Reference Checks	Non-Specific Error Code	Most Common Cause	EDGE Common Reference Table
Enrollee	1	5.3.1	Gender	GNDR_TYPE
Enrollment Period	3	6.3.1	Plan ID and/or Rating Area	INSRNC_PLAN ISSR_PLCY_RATG_AREA

- Gender is the only value that can trigger Error Code 5.3.1 when a value other than M, F or U is submitted.
- Plan ID, Enrollment Period Activity Indicator (EPAI) and Rating Area will trigger a 6.3.1 Error Code.
  - The most likely reason for 6.3.1 is a missing Plan ID or Rating Area in the reference table or an incorrect Plan ID or Rating Area on the enrollment file.

Plan and Rating Area Error Research

- Issuers can take steps to avoid, minimize or identify potential issues that could result in Plan ID and Rating Area rejects (Error Code 6.3.1) prior to enrollment data submission.
  - Extract Plan IDs and Rating Areas from the INSRNC_PLAN and ISSR_PLCY_RATG_AREA tables.
  - Before submission, identify the Plan IDs and Rating Areas that will be included on the submission file.
  - Cross reference the Plan IDs and Rating Areas on the submission file and the reference table to identify any plans or Rating Areas that are missing in the reference table or are incorrect on the submission file.

Plan and Rating Area Error Research (Continued)

- Since enrollment is a full file submission, issuers can:
  - Identify the number of records expected to reject due to missing plans and Rating Areas.
  - Make corrections to any incorrect values prior to submission.
- Issuers may use the enrollment summary report to compare the number of expected rejections and the actual rejections.
  - This comparison is a good check and balance, but the details of the errors should be reviewed and confirmed as well.
- Using the enrollment detail report, issuers can verify the Error Code, Error Element and Error Values.

Pharmacy – Reference Errors

- Pharmacy File Reference Checks

Pharmacy File Level	# Reference Checks	Non-Specific Error Code	Most Common Cause	EDGE Common Reference Table
Plan	1	2.3.1	Plan ID	INSRNC_PLAN
Claim	2	3.3.1	Null	Null

- Plan ID is the only value that can trigger Error Code 2.3.1.
  - Issuers can use the same steps outlined in the prior slide to identify potential pharmacy rejects due to missing or incorrect Plan IDs.
- Dispensing Provider ID Qualifier and the Derived Amount Indicator are the only values that will trigger Error Code 3.3.1.
  - Rejects related to values submitted for these data elements are rare as only 2 values are possible for each element.
    - Dispensing Provider ID Qualifier = 99 or XX
    - Derived Amount Indicator = Y or N

Medical Claims – Reference Errors

- Medical Claim File Reference Checks

Medical Claim File Level	# Reference Checks	Non-Specific Error Code	Most Common Cause	EDGE Common Reference Table
Plan	1	2.3.1	Plan ID	INSRNC_PLAN
Claim Header	8	3.3.1	Diagnosis Code Bill Type Discharge Status Code	DGNS_CD_TYPE CLAIM_BILL_TYPE DSCHRG_STUS_TYPE
Claim Line	7	4.3.1	Revenue Code Service Code Service Code Modifier Place of Service	REV_CD_TYPE SRVC_CD_TYPE SRVC_CD_MDFR_TYPE SRVC_PLC_TYPE

- Plan ID is included at the plan level and is the only value that could fail a reference check (Error Code 2.3.1).
  - Issuers can use the same steps outlined in the prior slide to identify potential medical claim rejects due to missing or incorrect Plan IDs.

Medical Claim Header Reference Error Code 3.3.1

- There are eight (8) claim header data elements that undergo a reference check.
  - In reviewing the eight (8) elements, there are three (3) that are most often the cause of the reject and Error Code 3.3.1.

Medical File Level	# Reference Checks	Data Elements	Non-Specific Error Code	Most Common Cause	Reference Table
Claim Header	8	Form Type Diagnosis Code Qualifier Diagnosis Code Billing Provider ID Qualifier Derived Amount Indicator Bill Type Void/Replace Indicator Discharge Status Code	3.3.1	Diagnosis Code Bill Type Discharge Status Code	DGNS_CD_TYPE CLAIM_BILL_TYPE DSCHRG_STUS_TYPE

Most Common Claim Header Data Elements Rejected with Error Code 3.3.1

Data Element	Reference Table	Common Problem
Diagnosis Code	DGNS_CD_TYPE	• Verify there are no leading or trailing spaces. • Verify that decimal points are not included. • Letters must be submitted with capital letters (i.e. V221). • Follow the published guidance related to submission of ICD-9 and ICD-10 Diagnosis Codes.
Bill Type	CLAIM_BILL_TYPE	• Bill Type codes must be three (3) digits. • Bill Facility codes defined as “Reserved for Assignment by NUBC” will not be accepted. • Frequency codes other than 1, 7 or 8 will not be accepted. o Issuers should convert all other frequency codes as outlined in the ESBR (Section 7.18).
Discharge Status	DSCHG_STUS_TYPE	• Discharge Status Codes must be two (2) digits. • Discharge Status Codes defined by the NUBC as “Reserved for National Assignment” will not be accepted.

Medical Claim Line Reference Error Code 4.3.1

- There are seven (7) claim line data elements that are subject to a reference check.
  - In reviewing the seven (7) elements, there are four (4) that are most often the cause of the reject and Error Code 4.3.1.

Medical File Level	# Reference Checks	Data Elements	Non-Specific Error Code	Most Common Cause	Reference Table
Claim Line	7	Rendering Provider ID Derived Amount Indicator Revenue Code Service Code Modifier Service Code Qualifier Service Code Place of Service	4.3.1	Revenue Code Service Code Service Code Modifier Place of Service	REV_CD_TYPE SRVC_CD_TYPE SRVC_CD_MDFR_TYPE SRVC_PLC_TYPE

Most Common Claim Line Data Elements Rejected with Error Code 4.3.1

Data Element	Reference Table	Common Problem
Revenue Code	REV_CD_TYPE	• Revenue Codes must be four (4) digits and always begin with a zero (0). o Revenue Codes defined by the NUBC as "Reserved for National Assignment" will not be accepted. • Avoid Error Code 4.3.1 for invalid Revenue Codes by excluding them from data submission. Revenue Codes are not required and are not used for RA or RI purposes.
Service Code	SRVC_CD_TYPE	• Expired or invalid codes submitted. o Only active Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes will be accepted. • Verify there are no leading or trailing spaces. • Verify that letters are submitted with a capital letter. • Dental codes submitted with Service Code Qualifier 03 (CPT/HCPCS) will reject. o Dental codes are not included in the CPT/HCPCS reference table. o To bypass the reference check, for dental services **only**, submit a Service Code Qualifier of 01.

Most Common Claim Line Data Elements Rejected with Error Code 4.3.1 (Continued)

Data Element	Reference Table	Common Problem

Service Code Modifier	SRVC_CD_MDFR_TYPE	• Expired or invalid codes submitted.
		  o Only active CPT and HCPCS modifiers will be accepted.
		• Verify there are no leading or trailing spaces.
		• Verify that letters are submitted with a capital letter.
		• Dental modifiers submitted will be rejected.
		  o Dental modifiers are not included in the reference table and cannot be bypassed. Issuers should exclude dental modifiers from submission.

Place of Service	SRVC_PLC_TYPE	• Expired or invalid codes submitted. o Only active Place of Service codes will be accepted. • Verify there are no leading or trailing spaces.

Avoiding Reference Errors

- As with plan reference data, issuers can compare data values on the inbound file to the common reference table prior to submission to avoid, minimize or identify potential errors prior to submission.
- Issuers can obtain the source codes, independently, which are used to populate the common reference tables.
  - Sources are listed in Section 7.2 of the ESBR.
- Issuers who believe a code is valid on the Date of Service associated with the code should:
  - Review the common problems and verify that the data value was submitted correctly.
  - Contact their FM Service Representative and provide the specific code and Date of Service used.
    - It is helpful to provide a link or documented resource that supports the code was effective on the date in question.

Reference Check Summary

- Identify the data elements that are most frequently causing rejects for your organization.
- Review the Common Problems to prevent data submission errors.
- Proactively review data values populated on the inbound XML against the common reference tables to identify potential rejects before submission.
- Contact CMS, as soon as possible, if you believe a reference code should be added to a reference table.
  - Reference table updates require a maintenance release, therefore, early notification is important.

Duplicate Claim Errors

Error Code Groupings

There are 15 Error Code groupings assigned to one (1) or more detail file.

Error Code Groupings	Enrollment	Medical	Pharmacy	Supplemental
Allowed Amount Error	-	2	-	-
Data Element Cross Reference Error	5	21	2	3
Date/Time Comparison Error	3	9	4	4
Duplicate Error	1	7	2	5
EPAI Error	3	-	-	-
Higher or Lower Level Error	5	7	5	5
Miscellaneous Error	-	1	2	1
NPI Check Digit Error	-	2	1	-
Overlapping Plan Error	2	-	-	-
Paid Amount Error	-	1	1	-
Reported Count Error	4	6	3	3
Submitted Total Paid Error	-	3	3	-
Sequencing Error	2	5	2	2
Supplemental / Medical Association Error	-	-	-	7
Void/Replace Match Error	-	3	3	-

Duplicate Claim Rejections

- Medical claim records rejected as duplicate can be challenging, but manageable.
  - Deprioritize Error Codes that report a higher or lower level error. These will be resolved when the primary reason for the reject is resolved.
    - 3.5.17 – Claim header rejected because all claim lines failed
      - Error Message: Claim header level rejected because all the claim service for the medical submission failed validation
    - 4.5.32 – Claim line rejected because claim header failed
      - Error Message: Claim Service Line level rejected because the claim header for the medical submission failed validation

Duplicate Claim Rejections (Continued)

- Research Error Codes that indicate a duplicate record exists.
  - 3.5.19 – Duplicate Claim ID
    - Error Message: Claim rejected because ‘claimIdentifier’ already exists in the database
  - 3.5.49 – Overlapping Stay
    - Error Message: Claim Header level rejected because the Statement-covers-from and Statement-covers-to dates are overlapping within the file or database
  - 4.5.36 – Claim line duplicate
    - Error Message: Claim Service Line level rejected because the claim service line already exist in the database

Duplicate Claim Rejections (Continued)

Error Code	Error Message	Type of Duplicate	Solution
3.5.19	Claim rejected because 'claimIdentifier' already exists in the database	Claim ID	Perform a query on the MEDICAL_CLAIM table using the Claim ID and look for records that do not include an inactivation date.
3.5.49	Claim Header level rejected because the Statement-covers-from and Statement-covers-to dates are overlapping within the file or database	Overlapping Inpatient Stay	Use CMS provided queries to identify the claim causing the reject. See the Duplicate Claim Logic Webinar (11/20/16), Slides 17 – 21.
4.5.36	Claim Service Line level rejected because the claim service line already exist in the database	Duplicate Line	Use CMS-provided queries to identify the claim causing the reject. See the Duplicate Claim Logic Webinar (11/20/16), Slides 39 – 43 for outpatient facility claims Slides 44 – 48 for professional claims Slides 49 – 53 to identify claims with inclusive services.

Data Management for Reinsurance

Data Management for Reinsurance Overview

- Issuers should validate that enrollees whose paid claim total meets or exceeds the RI attachment point have been successfully loaded to the EDGE server and are included in the RI calculation.
- To accomplish this, issuers should:
  - Proactively identify enrollees eligible for RI.
  - Monitor and prioritize ingest errors and their resolution for RI eligible enrollees.
  - Frequently execute and review the Enrollee (Without) Claims Detail (ECD) Report and the RI Detail Enrollee (RIDE) Report.

Reinsurance: Proactively Identify RI Eligible Enrollees

- Issuers should proactively identify in their source system enrollees and their associated claims with:
  - Enrollment in Individual Market plans.
  - Enrollees with total aggregated claim paid amounts equal to or greater than $45,000 (attachment point).
  - Enrollees with total aggregated claim paid amounts greater than $250,000 (cap).
- Issuers can use this list to monitor and prioritize file processing rejections, identify enrollees and claims on the ECD Report and compare the Enrollee ID and total paid amount for each enrollee to the latest RIDE Report output.

Reinsurance: Monitor and Prioritize Ingest Error Resolution

- Issuers should monitor the enrollment, pharmacy and medical claim file detail error reports and prioritize error resolution for RI eligible enrollees.
  - Enrollment:
    - Confirm RI eligible enrollees and all associated enrollment periods that cover an eligible claim Date of Service are accepted.
      - Subscriber/Dependent Association Errors:
        - » Ensure your subscribers and dependents are enrolled in the same plan and have the same Rating Area and that the coverage dates of the dependent are within the coverage dates of the subscriber.

Reinsurance: Monitor and Prioritize Ingest Error Resolution (Continued)

- Confirm RI eligible enrollees and all associated enrollment periods that cover an eligible claim Date of Service are accepted.
  - Overlapping Plan Errors:
    - » Ensure you do not have overlapping coverage in the same plan for the same enrollee that is a subscriber or a dependent of the same subscriber.
- EPAI Errors:
  - Ensure renewals submitted with an EPAI of 021041 are preceded by an initial issuance (021028) or modification (001) EPAI.
- Ignore higher or lower level errors.
  - These will be resolved when the associated error is resolved.

Reinsurance: Monitor and Prioritize Ingest Error Resolution (Continued)

- Pharmacy and Medical Claims:
  - Confirm RI eligible enrollee claims are accepted.
    - Duplicate Errors:
      - Monitor overlapping stay rejections on institutional inpatient claims, as these will likely be high dollar claims.
      - Monitor duplicate claim lines across institutional outpatient and professional claims.
    - Void and Replace Errors:
      - Verify that your Claim Processed Date Time on your submitted void or replace is later than the active claim you are attempting to void or replace.
      - Be sure to resubmit replacement claims that are rejected for a reason other than the Claim Processed Date Time, as a rejected replacement means the prior claim is inactive and no longer eligible for consideration.

Reinsurance: Monitor and Prioritize Ingest Error Resolution (Continued)

- Pharmacy and Medical Claims:
  - Confirm the Plan ID on the claim matches the Plan ID on the enrollment period that covers the Statement Covers From date on the claim.
    - If they do not match, the claims will not be rejected but will be orphaned and not included in RI calculations.
  - As the April 30, 2016 deadline approaches, prioritize enrollee claims that will result in total aggregated paid amounts between the attachment point and cap.
    - Once the aggregated total paid amount of both pharmacy and medical claims exceeds the $250,000 cap, no additional reinsurance dollars will be included in the RI estimate.
      - Consideration will still need to be given to these claims and how they might effect RA calculations.

Reinsurance: Review ECD Report and Validate RIDE Reports

- Claims listed on the ECD Report (orphan report) will not be included in RI calculations.
- All enrollees and claims that are included in the RI calculations are listed on the RIDE Report.
  - Issuers should compare their list of RI eligible enrollees and claims from their source systems against the ECD Report and RIDE Report to ensure all claims, and the correct aggregated total paid amounts, are included in the RI calculations.
    - **Remember**: For a claim to be selected for RI, an active enrollment period record must be present with Enrollment Start and End Dates that cover the Statement Covers From date on the claim and include the same Plan ID.

Reinsurance: Review ECD Report and Validate RIDE Reports (Continued)

- Issuers can generate orphan (ECS and ECD) and RIDE Reports at any time by running the following commands:
  - ECD and ECS Reports: CLAIM_ENR_REP
  - RIDE Report: edge report RI_Prelim YYYY
- Issuers needing assistance with researching and resolving file ingest errors or information reported on the ECD or RIDE Reports should contact their FM Service Representative at ffm.app.maint.EDGE@accenturefederal.com as soon as possible.

Upcoming Webinars

HTTPS://WWW.REGTAP.INFO/

Upcoming Webinars

Webinar Topic	Scheduled Event Date
Open Q&A Session	December 29, 2015 11:30 a.m. – 12:30 p.m. ET

Questions?

To submit questions by phone:

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

HTTPS://WWW.REGTAP.INFO/

Resources

HTTPS://WWW.REGTAP.INFO/

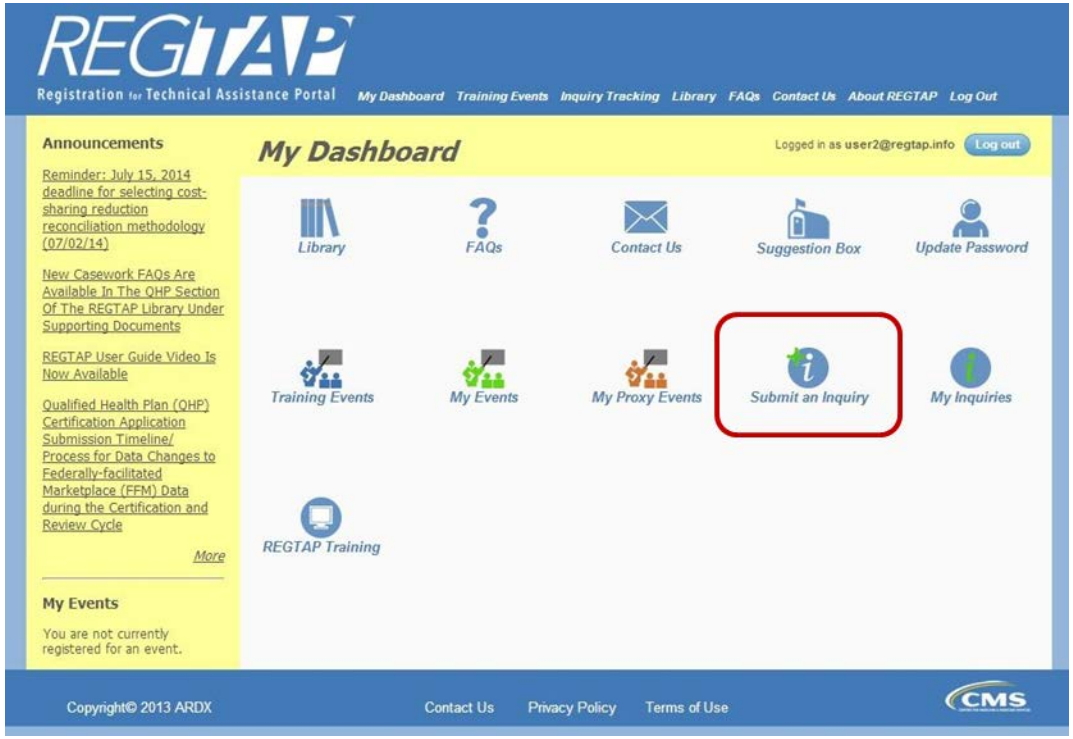
Resources

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)

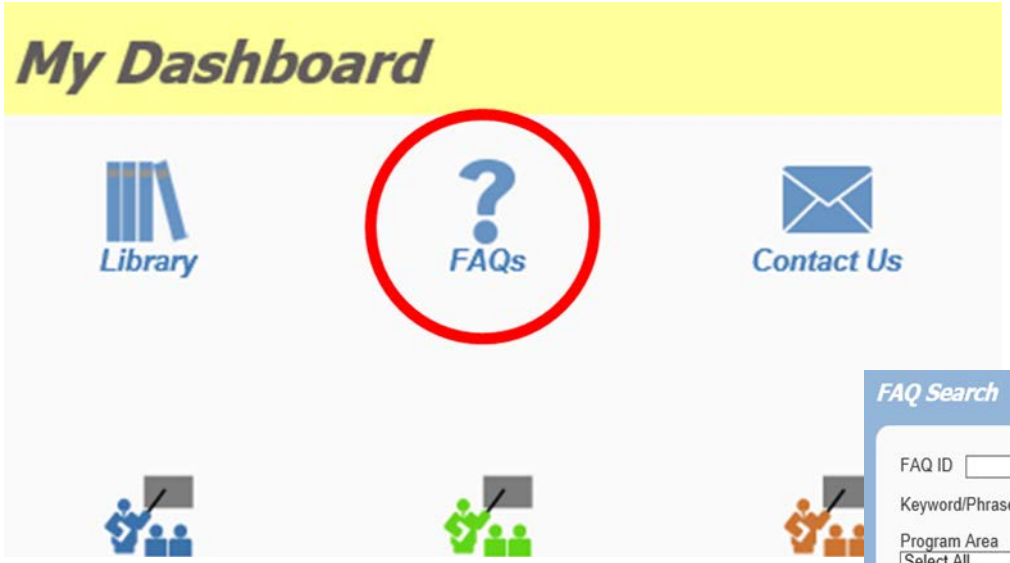
ITMS is available at https://www.regtap.info/

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

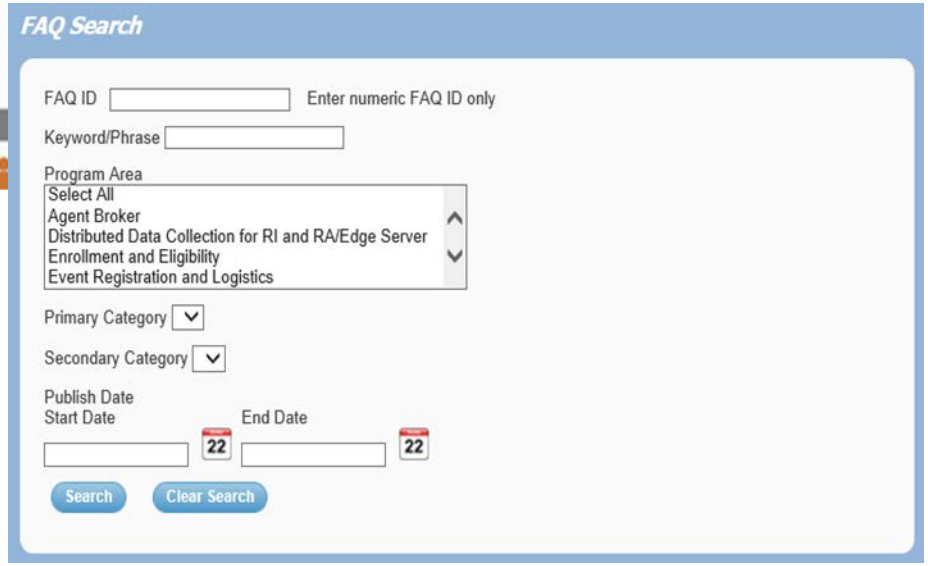


Note: Enter only one (1) question per submission.

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 https://www.regtap.info

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Closing Remarks

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