Distributed Data Collection (DDC) For Reinsurance (RI) and Risk Adjustment (RA): EDGE Server Supplemental Diagnosis File Submission (ESSFS)

1. Introduction

1.1 Distributed Data Collection (DDC) For Reinsurance (RI) and Risk Adjustment (RA): Supplemental Diagnosis File Submission

Welcome to the text-only version of the EDGE Server Supplemental Diagnosis File Submission (ESSFS) Computer Based Training or CBT. The purpose of this training is to inform issuers about the EDGE Server Supplemental Diagnosis File Submission in support of the Reinsurance and Risk Adjustment premium stabilization programs. Note, this training will not provide details on Reinsurance and Risk Adjustment policy.

1.2 Intended Audience

The intended audience for this training includes: Marketplace and non-Marketplace issuers new to 2015 data submission; issuers interested in a refresher course in supplemental diagnosis EDGE server data submission and Third Party Administrators and support vendors.

1.3 Topics to Cover

This training will cover the following topics: review of general file submission and resources, supplemental diagnosis basic file XML structure, submission of supplemental diagnoses for Risk Adjustment, health assessments, supplemental diagnoses file submission (Business Rules), supplemental diagnosis file (overview), supplemental diagnosis file duplicate checks, supplemental diagnoses file (add/delete/void diagnosis codes), supplemental diagnosis file detail record processing date time rules and resources.

2. Review of General File Submission and Resources

2.1 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, or ETL process.

The Department of Health and Human Services (HHS) will provision the EDGE server, which includes overlaying the operating system and downloading the application software and reference tables necessary to process data on the EDGE server.

After file processing, HHS will receive summarized reports to oversee EDGE server processing operations.

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Data coming into the EDGE server, going through validation checks and accepting and storing validated records into the EDGE Server data tables and then generating outbound reports. The issuer will receive both summary level and detailed reports and CMS will receive summary level reports only.

Issuers or their representative will perform an ETL process to pull enrollment and claims data from their proprietary systems to submit to their EDGE server.

2.2 Overview of EDGE Server File Processing

Issuers should be aware that files submitted to the EDGE server must be submitted in XML format.

All files undergo a variety of verification edits depending upon the type of file submitted.

Upon completion of file processing, outbound files are produced with specific results of all records submitted.

This training will provide high-level verification edits and Business Rules for Supplemental Diagnosis Files.

2.3 EDGE Server File Submission Resources

To assist issuers in file submission, CMS has created resources, which include information for all file type submissions to the EDGE server. These resources are the Interface Control Document (ICD), XML and XSD examples and the EDGE Server Business Rules, located in the REGTAP Library at www.REGTAP.info. Issuers should refer to these documents as they contain more in-depth information.

2.4 Interface Control Document

The ICD describes the interface requirements for the transmission of information between an issuer's EDGE server and CMS, 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 and Technical Field/Element Characteristic.

3. Supplemental Diagnosis Basic File XML Structure

3.1 Supplemental Diagnosis Basic File XML Structure

A Supplemental Diagnosis XML file is segmented by levels of data.

All files contain a header, issuer level, plan level and then the Supplemental Diagnosis File Detail Record level.

The Supplemental Diagnosis File XML levels are joined by connectors, which serve to link related data.

These connectors have no business meaning and no data element is required.

All files contain a header level and an issuer level.

There can be multiple plans and multiple supplemental diagnosis detail records within an issuer level.

All three (3) levels are embedded under the Supplemental Diagnosis File header.

3.3 Supplemental File XML Example

In an example of a Supplemental Diagnosis File XML, XML levels are joined by connectors. There are specific data elements within each level.

Under the HEADER LEVEL, 'P' indicates this data is in the Production Zone. If it was a 'T', it would indicate the EDGE Server Test Zone. Additionally, the Submission Type code with the 'S' is for Supplemental Diagnosis File.

In the ISSUER LEVEL, there is also a 5 digit HIOS ID called the Issuer Identifier. Under the PLAN LEVEL, there is a 16 digit plan ID.

Under the Supplemental Diagnosis Detail section, the add/delete/void indicator is an "A", indicating that this record is to ADD a diagnosis to the original claim indicated by the Original Claim Identifier. This example also includes the source of the supplemental diagnosis as "MR" for medical record review.

4. Submission of Supplemental Diagnoses for Risk Adjustment

4.1 Why Supplemental Diagnoses?

The Affordable Care Act Risk Adjustment model predicts annualized plan liability expenditures using age, sex and health status. Health status is derived from Diagnosis Codes submitted on medical claims.

Collecting all relevant diagnoses is important to the accuracy of Risk Adjustment. CMS recognizes that there are limited circumstances for submitting supplemental diagnoses in cases where Diagnosis Codes were missed or omitted during data submission.

CMS provides specific business rules to ensure the data quality of supplemental diagnoses.

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4.2 Supplemental Diagnosis File

The Supplemental Diagnosis file allows issuers to submit Supplemental Diagnosis information to the EDGE server for consideration in the Risk Adjustment Program.

4.3 Acceptable Sources of Supplemental

There are two (2) acceptable sources for supplemental diagnoses: Medical Record and Electronic Data Interchange, or EDI.

Supplemental Diagnosis Codes may be submitted if the discovery of a Supplemental Diagnosis Code is the result of medical record review by the issuer subsequent to medical billing, or through routine medical record review.

OR

Diagnosis Codes that are received via EDI and exceed the number of Diagnosis Codes accepted by the issuer's claims system.

Issuers may submit supplemental diagnoses that were on the submitted claim transaction but truncated in the translator/EDI front-end.

Note: When conducting a medical record review the issuer must evaluate all diagnoses on the original claim and delete any diagnosis not supported by the medical record.

5. Health Assessments

5.1 Guidance on Health Assessments

Diagnosis Codes derived from a health assessment may be used if 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; and

The diagnosis code complies with general medical claim file or Supplemental Diagnosis file submission business rules.

NOTE: All of these conditions must be met in order to utilize a Diagnosis Code from a health assessment.

Unacceptable health assessment sources of Diagnosis Codes include:

A patient reported list of diseases or conditions not related to medical services provided and associated with a patient visit;

Diagnosis Codes that occurred outside the plan enrollment period for the enrollee; or

Diagnosis Codes from paid claims or encounters from a period prior to the benefit year.

Diagnosis Codes from health assessments that comply with CMS requirements related to data submission may be submitted using the medical claim file submission process if an original medical claim does not already exist, or through the Supplemental Diagnosis submission process if an original claim already exists.

6. Supplemental Diagnoses File Submission – Business Rules

6.1 Supplemental Diagnoses

Supplemental files are incremental file submissions.

Each subsequent supplemental diagnosis file should include new diagnoses being added to an original claim, any diagnosis being deleted from an original claim, or any voids of previously submitted supplemental diagnosis records.

Full replacement supplemental diagnosis file submissions will result in claims being rejected as duplicates.

More than one (1) Supplemental Diagnosis Code for an original claim may be submitted on a supplemental record.

The medical service(s) that result in a Supplemental Diagnosis Code must have occurred during the data collection period for a given benefit year.

For example, an original claim is submitted for a service on 8/12/15 and during a record review, the issuer discovers an additional diagnosis that should be included on the claim. The issuer should submit a supplemental diagnosis file in March 2016, which is before the close of the data submission period for the benefit year, for the original claim to add the newly discovered diagnosis.

6.2 Supplemental Diagnoses – Business Rules

A Supplemental Diagnosis Code must be associated with a claim or encounter for services that occurred during an enrollee's period of enrollment in a risk adjustment eligible plan. Therefore, a Supplemental Diagnosis must be linked to a previously submitted and accepted EDGE server medical claim.

Again, Submission of a Supplemental Diagnosis Code must be supported by medical record documentation and comply with standard coding principles and guidelines. The submission of a Supplemental Diagnosis Code must include the original medical Claim ID that was adjudicated and resulted in a paid amount or reported encounter.

Diagnosis Codes from denied claims are not acceptable.

The submission of a Supplemental Diagnosis Code must include service from and to dates for the service that resulted in the Diagnosis Code.

7. Supplemental Diagnosis File- Overview

7.1 Supplemental Diagnosis File Assumptions

Supplemental Diagnosis Files can only contain information for one (1) issuer or one (1) or more plans within an issuer, and one (1) or more detail records within each plan for the issuer. Supplemental Diagnosis Files must also have at least one (1) plan and at least one (1) detail record within that plan included, as well as a Unique Enrollee ID that corresponds to a Unique Enrollee ID in the EDGE Server Enrollment Submission file.

7.2 Supplemental File Definitions

The data elements and definitions are available in the EDGE Server Business Rules where the Supplemental Diagnosis File Submission is discussed, as well as in the ICD.

The Supplemental Diagnosis Detail Record ID is a unique number generated by the issuer to identify the supplemental diagnosis transaction.

The Original Medical Claim ID is the Medical Claim ID to which the supplemental claim is linked and was submitted on a previous medical claim file and was accepted by the EDGE server.

The Detail Record Processed Date Time is the date and time when the supplemental Diagnosis Detail Record was processed.

If the Add/Delete/Void indicator is “A”, then this indicates a supplemental Diagnosis Code is being added to the original claim.

If the Add/Delete/Void indicator is “D”, then this indicates to delete the diagnosis from the original claim that is identified in the supplemental diagnosis record.

If the Add/Delete/Void indicator is a “V”, then this indicates a previously submitted supplemental diagnosis record is being voided.

The Original Supplemental Diagnosis Detail Record ID identifies the original

Supplemental Diagnosis Detail Record ID when processing a void.

The Date of Service - From indicates the first day the service occurred that supports the submission of a supplemental diagnosis.

The Date of Service - To indicates the last day the service occurred that supports the submission of a supplemental diagnosis.

The Supplemental Diagnosis Code Qualifier indicates if the Diagnosis Code on the supplemental Diagnosis Code record is an ICD-9 code or ICD-10 code.

Note, ICD-9 Diagnosis Codes are to be used for claims with Statement Covers Through dates prior to October 1, 2015 and ICD-10 Diagnosis Codes are required for claims with Statement Covers Through dates of October 1, 2015 and forward.

The Supplemental Diagnosis Code is the code value for the Diagnosis Code, and the Supplemental Diagnosis Source identifies the source of the supplemental diagnosis, indicating MR for Medical Record or EDI for Electronic Data Interchange.

7.4 Supplemental Diagnosis File – Header, Issuer and Plan Level Edits

With regard to Supplemental Diagnosis File Header, Issuer, and Plan level edits,

The Total Detail Records reported at the header level must equal the count of all detail records on the file.

The Total Detail Records reported at the issuer level must equal the count of all detail records for all plans for the issuer.

The Total Detail Records reported at the plan level must equal the count of all detail records for the specific plan.

If the Total Detail Records at the header, issuer or plan level does not match the Total Detail Records for the indicated level, then that level and all associated sub-levels will be rejected.

For example: If the header level fails and is rejected, then the issuer and plan levels will also be rejected.

8. Supplemental Diagnosis File – Duplicate Checks

8.1 Supplemental Diagnosis File – Duplicate Checks

Duplicate checks will be performed on all Supplemental Diagnosis Detail Records using the Issuer ID and the Supplemental Diagnosis Detail Record ID reported at the detail record level.

The supplemental detail record being submitted will be rejected:

If the Issuer ID and Supplemental Diagnosis Detail Record ID match a stored active Supplemental Diagnosis Detail Record in the Supplemental Diagnosis Detail Record data table,

If any Supplemental Diagnosis Code on a Supplemental Diagnosis Detail Record indicated as a 'Delete' does not already exist on the original medical Claim ID, or was removed by a previously accepted Supplemental Diagnosis file.

Or, if any Supplemental Diagnosis Code on a Supplemental Diagnosis Detail Record indicated as an 'Add' already exists on the original medical Claim ID, or a previously accepted Supplemental Diagnosis file.

9. Supplemental Diagnoses File – Add/Delete/Void Diagnosis Codes

9.1 Supplemental Diagnosis File – Add Diagnosis Codes

When using a Supplemental Diagnosis File to ADD a Diagnosis Code to previously submitted medical claim, a value of 'A' must be present in the Add/Delete/Void Indicator data field.

Detail Record validation edits will be performed when a Supplemental Diagnosis is submitted as an 'Add': The Date of Service - From and Date of Service - To must be within the Statement Covers From and Statement Covers Through dates at the claim header on the linked original medical claim.

If the diagnosis is not on the original medical claim, then the Supplemental Diagnosis Code will be accepted.

If the diagnosis is present on the original medical claim, then the Supplemental Diagnosis Code will be rejected.

9.2 Supplemental Diagnosis File – Delete Diagnosis Codes

When using a Supplemental Diagnosis file to delete a diagnosis on a previously submitted medical claim, a value of "D" must be present in the Add/Delete/Void Indicator data field.

Detail Record validation edits that will be performed when a Supplemental Diagnosis is submitted as a Delete include the following:

The Date of Service - From and Date of Service - To must be within the statement covers

from and statement covers through dates at the claim header on the linked original medical claim.

If the diagnosis is not on the original medical claim, then the deleted Supplemental Diagnosis code will be rejected.

If the diagnosis is present on the original medical claim, then the deleted Supplemental Diagnosis Code will be accepted.

As a reminder, 'delete' indicates you want to delete a Diagnosis Code from a previously submitted medical claim.

If you want to remove a diagnosis from a previously submitted Supplemental Diagnosis Detail Record, you will need to use the void function.

9.3 Voiding Supplemental Diagnosis Detail Records

To void a Supplemental Diagnosis Detail Record previously accepted in a Supplemental Diagnosis File, 'V' must be present in the Add/Delete/Void Indicator data field.

The Issuer ID and the original Supplemental Diagnosis Detail ID must match a stored Supplemental Detail Record ID and Supplemental Diagnosis Detail Record ID, respectively, and the date time stamp on the void must be later than the date time stamp on the original Supplemental Detail Record ID.

If these three (3) conditions are met, then the matched Supplemental Diagnosis Detail Record is inactivated.

Only the Void/Replace Indicator, Original Supplemental Diagnosis Detail ID and Supplemental Diagnosis Detail Record ID undergo validation edits.

All other data elements on a 'void' will bypass edits and issuers may choose to include or exclude the additional data elements when submitting a void.

The EDGE server software will search the Supplemental Diagnosis File database for a record that matches the Issuer ID and has a Supplemental Diagnosis Detail Record ID that matches the original Supplemental Diagnosis Detail ID on the void record.

If the original Supplemental Diagnosis Detail ID is not matched, then the void will be rejected.

If the original Supplemental Diagnosis detail ID is found, then the Detail Record Processed Date Time of the submitted void will be compared to the Detail Record Processed Date Time of the most current active stored record.

If the Detail Record Processed Date Time of the submitted void record is earlier than or equal to the Detail Record Processed Date Time of the most current active version, then

the submitted void will be rejected and the original Supplemental Diagnosis Detail Record will not be inactivated.

If the Detail Record Processed Date Time of the submitted void record is later than the Detail Record Processed Date Time of the most current active version, then the void will be accepted and the active claim will be changed to inactive.

Once the void is accepted and the stored active supplemental diagnosis detail record is changed to an inactive status, then the supplemental diagnosis detail record is no longer eligible for consideration for Risk Adjustment program. The supplemental diagnosis detail record submitted with the void indicator is also stored as inactive.

An issuer may reactivate a Supplemental Diagnosis Detail Record that has been voided by submitted a new Supplemental Diagnosis Detail Record with a new Supplemental Diagnosis Detail Record ID.

10. Supplemental Diagnosis File Detail Record Processing Date Time Rules

10.1 Supplemental Diagnosis File Detail Record Processing Date Time Rules

All Supplemental Diagnosis Code Adds, Deletes and Voids must include a unique processing 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.

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 as the system is unable to identify the processing order of the records.

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11. Resources

11.1 Resources

HHS maintains several resources with general guidance for any organization working with Exchanges.

11.2 Inquiry Tracking and Management System (ITMS)

REGTAP users can submit questions to ITMS by selecting 'Submit an Inquiry' on the REGTAP Dashboard. Users should enter only one (1) question per submission. For questions related to the EDGE server, issuers should contact their Financial Management Service Representative directly at EDGE_server_data@cms.hhs.gov.

11.3 FAQ Database on REGTAP

REGTAP has a searchable FAQ database which allows users to search FAQs. Users can access the searchable FAQ database by clicking the 'FAQs' button on your REGTAP Dashboard.

12. Conclusion

12.1 Conclusion

For information regarding additional webinars and user group sessions, issuers should log on to REGTAP at www.REGTAP.info for registration details and discussion topics. For questions regarding the Distributed Data Collection Program, issuers should contact their Financial Management Service Representative directly at EDGE_server_data@cms.hhs.gov.