Encounter Data

2018 Regional Technical Assistance

November 28, 2018

Purpose & Roadmap

To provide participants with an understanding of the process of submitting encounter data and to create awareness of the encounter data resources available for future reference.

Encounter Data Submission & Processing Topics

1. Key Definitions and Resources
2. EDI Basics – X12 837 Format
3. CMS's Encounter Data System & Processing
4. File Size Limitations, Submission Frequency, & Deadlines
5. CMS's Instructions for Specific Data Fields

Encounter Data

Key Definitions & Resources

Key Encounter Data Resources

Key CMS Guidance found at **www.csscoperations.com**

- Encounter Data Submission and Processing Guide *(Guide)*
  - Appendices
- MA & Part D Communications Handbook *(Handbook)*
- Edits Spreadsheets
- User Group Slides

Key Industry Resources

- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 Technical Reports found at **www.wpc-edi.com**

CMS Recommendations for Populating an Encounter Data Record or Chart Review Record

When populating fields on EDRs or CRRs, submitters should base their logic on the highest level of specificity:

- Submitters should first consult the TR3, then the edits spreadsheets and finally the guide for instructions on populating MA encounter data 837s.
- If broader options are expressed in the WPC/TR3 or the edits spreadsheets than the options identified in the guide and its appendices, MAOs and other entities must use the rules identified in the guide.

Guide, Chapter 3, Section 3.2.2.

Encounter Data

- Includes both encounter data records and chart review records

What is an Encounter Data Record?

- A report from a MAO or other submitter to CMS about medical items or services a beneficiary received while enrolled in one of the MAO's contracts
- Submitted on the ASC X12 837 Version 5010 format

Guide, Chapter 2, Section 2.1

What is a Chart Review Record?

- Allows MAOs to add risk adjustment eligible diagnoses or delete diagnosis codes previously reported for plan enrollees
- Submitted in the ASC X12 837 Version 5010 format
- Two HPMS memos related to chart review records (April, August 2018)

Guide, Chapter 2, Section 2.2

Encounter Data

EDI Basics – The X12 837 Format

X12 837 5010 Format

- X12 – National set of inter-industry electronic data interchange (EDI) standards for insurance transactions
- 837 – Health Care Claim transactions
- 5010 – Version of 837 transactions
  - Professional/DME X12N/005010X222 837-P
  - Institutional X12N/005010X223 837-I

Guide, Chapter 3, Section 3.2

X12 Format – Definitions

Data Elements: A data element is the smallest named unit of information in the X12 standard.

Delimiter: A delimiter is a character used to separate two data elements or terminate a segment.

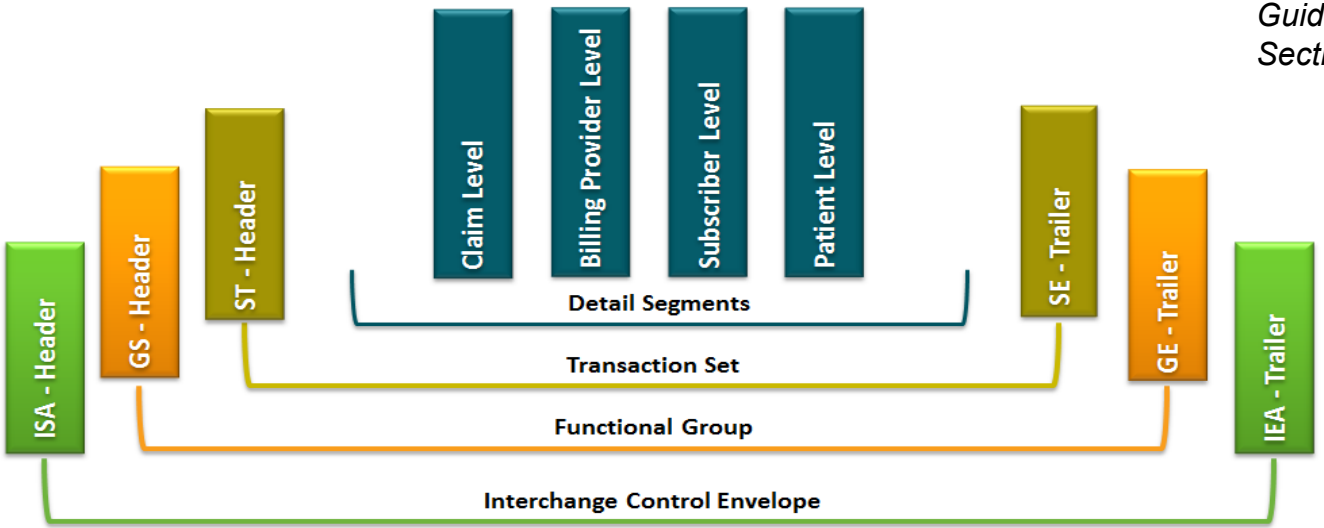
Data Segment: A data segment is an intermediate unit of information in a transaction set. It consists of a segment identifier, one or more data elements separated by delimiters and a segment terminator.

Loop: A block of data segments with data that are inter-dependent to each other.

Guide, Chapter 3, Section 3.2.

X12 Format – Envelope Structure

Guide, Chapter 3, Section 3.2.1



X12 837 Format – Interchange Envelope

Envelope	Header	Trailer
Interchange	ISA – designates Header Segment of Interchange Envelope Contains Sender and Receiver Information 16 data elements Example: ISA*00* *00* *ZZ*ENH9999*ZZ*80881 *181101*1102*^*00501*000000031*1*P*:~	IEA – designates Trailer Segment of Interchange Envelope Closes Interchange 2 data elements Example: IEA*1*000000031~

Appendix 3A: MA Companion Guide

X12 837 Format – Functional Group Envelope

Envelope	Header	Trailer
Functional Group	GS – designates Header Segment of Functional Group Begins Functional Group 8 data elements Example: GS*HC*ENH9999*80881*20181101*1102*123456*X*005010X222A1~	GE – designates Trailer Segment of Functional Group Closes Functional Group 2 data elements Example: GE*1*123456~

Appendix 3A: MA Companion Guide

X12 837 Format – Transaction Set Envelope

Envelope	Header	Trailer
Transaction Set	ST – designates Header Segment of Transaction and type of transaction 3 data elements Examples: (1) ST*837*4801*005010X222A1~ (2) ST*837*4802*005010X222A1~	SE – designates Trailer Segment of Transaction 2 data elements Examples: (1) SE*28*4801~ (2) SE*43*4802~

Appendix 3A: MA Companion Guide

Sample X12 837 5010 Submission

Figure 3.2. Example of X12 837 5010 Submission Format

Note: The file structure overview populated in this figure is an example and does not provide full details for submission of all situational loops, segments, and data elements in the 837-P or 837-I.

Guide, Chapter 3, Section 3.2.1

Encounter Data

CMS's Encounter Data System & Processing

Encounter Data System

The Medicare Advantage Encounter Data System has two sub-systems:

- The Encounter Data Front-End System (EDFES)
- The Encounter Data Processing System (EDPS, also referred to as the back-end system)

Encounter Data System (continued)

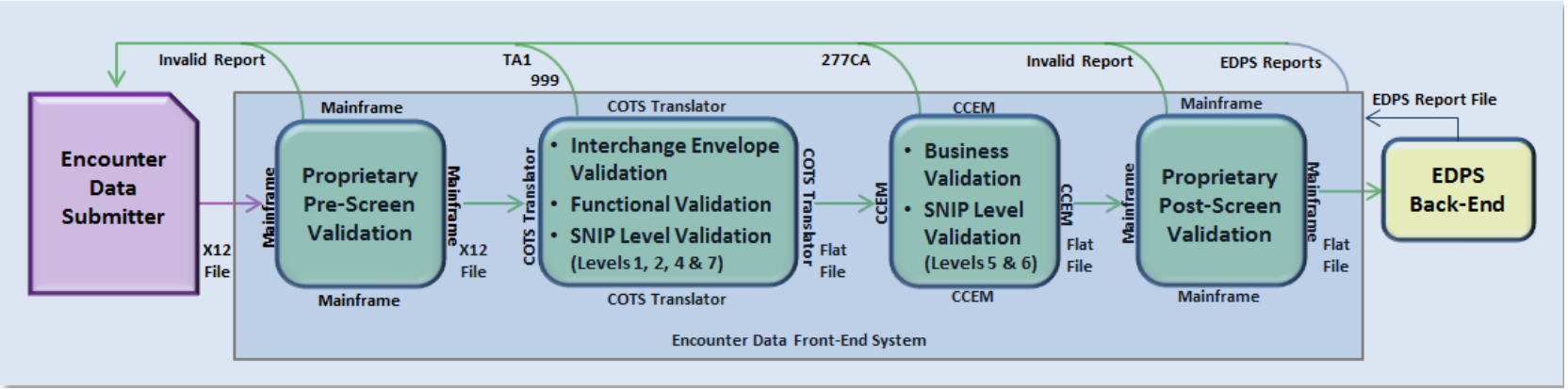
EDFES

- Accepts 837 files from submitters
- File level checks
- Record level checks
- Assigns Internal Control Number (ICN) to all accepted records
- Transmits all transactional reports back to submitters

EDPS

- Receives files from EDFES
- Record and line level checks
- Sends transactional reports to EDFES to be sent to submitters

EDFES Processing Phases



COTS = Commercial Off-the-Shelf; SNIP = Strategic National Implementation Process; CCEM = Combined Common Edits Module; EDPS = Encounter Data Processing System

Guide, Chapter 4, Section 4.4

EDFES Processing & Reports

Processing Phase	Report(s) Generated	Processing
Proprietary Pre-Screening Validation	Pre-Screening Invalid	File level failure. Processing stopped.
Translator	TA1 Acknowledgement 999 Acknowledgement	TA1 Failure – File level. Processing Stopped. 999 Failure – File level or Functional Group/Transaction Set Levels. One edit can affect several records. Only accepted data proceeds to CCEM processing.
CCEM	277CA Acknowledgement	Not File Level, but one edit can affect several records.
Proprietary Post Screen Validation	Post-Screening Validation	File level failure. Processing stopped.

Guide, Chapter 4

Timing of Reports

- Front End Reports are Posted to the SFTP Mailbox within 24 to 48 Hours of Receipt of the File:
  - Pre-Screen Report
  - TA1
  - 999
  - 277CA
  - Post-Screen Report

Timing of Reports (continued)

- MAO Reports are sent to EDFES within 3 days of received date from EDFES. MAO-001 and MAO-002 reports are posted to the SFTP mailbox within 5 business days of receipt of files.
- Unviewed reports are available in the mailbox for 14 business days.
- **Important to note:** *If reports are not downloaded and saved prior to viewing, they will not be available in the mailbox.*

Report Restore

- Report Restoration:
  - EDFES Acknowledgement Reports can be restored if the files are less than 20 business days old
  - MAO Reports can be restored if the files are less than 60 business days old
  - Requests for more than 200 files will not be accepted
  - Contact CSSC Operations to request report restoration

EDPS Processing & Reports

Processing	Reports
Duplicate Edit Checks (98300, 98315, 98320, 98325)	MAO-001 Encounter Data Duplicates
Data Validation Checks	MAO-002 Encounter Data Processing Status

Guide, Chapter 5, Section 5.2

Encounter Data

File Size Limitations, Submission Frequency, & Deadlines

Connectivity

- Organizations contact CMS-approved Network Service Vendors to establish connectivity with Palmetto GBA's secure network.
- GPNet is the EDI gateway to the Front-End System (FES).
- Three data transfer methods:
  - Secure File Transfer Protocol
  - Connect:Direct (PK-ZIP® software version 14+)
  - Gentran is available for contracts with 100,000 or fewer enrollees

Handbook, Overview: Establish Connectivity & Transfer Files, Page 1

Connectivity (continued)

- Organizations submit required documents to Palmetto GBA to obtain security access credentials:
  - Submitter ID
  - User ID
  - Passwords
- Testing and certification is required.

Handbook, Overview: Establish Connectivity & Transfer Files, Page 1

File Size Limitations

- TheTR3 recommends no more than 5,000 claims (or individual transactions) per transaction set (i.e., ST-SE envelope).
- SFTP and Connect:Direct users cannot exceed 85,000 encounters per file for professional and DME encounters.
- Institutional and Gentran files cannot exceed 5,000 encounters per file.

Guide, Chapter 4, Section 4.2

Submission Frequency Recommendations

Number of Medicare Enrollees in a Contract	Recommended Submission Frequency
Greater than 100,000	Weekly
50,000 – 100,000	Bi-weekly
Less than 50,000	Monthly

Upcoming Risk Adjustment Deadlines

Risk Score Run	Dates of Service	Deadline for Submission of Risk Adjustment Data
2019 Initial (RAPS & EDS)	07/01/17 – 06/30/18	Friday, September 7, 2018
2018 Final Run (RAPS & EDS)	01/01/17 – 12/31/17	Thursday, January 31, 2019
2019 Mid-Year (RAPS & EDS)	01/01/18 – 12/31/18	Friday, March 1, 2019
2020 Initial (RAPS & EDS)	**07/01/18 – 06/30/19**	Friday, September 6, 2019

Note: Please be sure to always refer to the latest HPMS memo with deadlines.

Encounter Data

CMS's Instructions for Specific Data Fields – the MA Encounter Data Companion Guide

Loops & Segments Applied to EDRs & CRRs

Loop or Segment ID	Loop or Segment Name
ISA	Interchange Control Header
IEA	Interchange Control Trailer
GS	Functional Group Header
GE	Functional Group Trailer
ST	Transaction Set Header
SE	Transaction Trailer

Appendix 3A: MA Companion Guide

Loops & Segments Applied to EDRs & CRRs (continued)

Loop or Segment ID	Loop or Segment Name
Segment BHT	Begin Hierarchical Transaction
Loop 1000A	Submitter Name
Loop 1000B	Receiver Name
Loop 2000A*	Billing Provider Hierarchical Level
Loop 2010AA	Billing Provider Name
Loop 2000B	Subscriber Hierarchical Level
Loop 2010BA	Subscriber Name

Appendix 3A: MA Companion Guide

** There is no supplemental instruction for Loop 2000A data elements.*

Loop 1000B

Loop 1000B: Receiver Name
NM103 – Receiver Name • Use **EDSCMS**
NM109 – Receiver Primary Identifier • Institutional = 80881 • Professional = 80882 • DME = 80887

Loop 2010AA: Billing Provider

Data Element	TR3 Data Element Name	TR3 Element Description	CMS Supplemental Instruction for EDR and CRR Submissions
NM108	Identification Code Qualifier	Identifies the method/system of code used for NM109. Only available value: XX = CMS NPI	Use XX
NM109	Billing Provider Identifier	The Billing Provider's NPI: Must be populated with a 10-digit number that must begin with "1": (1XXXXXXXXX)	See Chapter 3 for information on use of default NPIs. Default NPIs: Institutional: 1999999976 Professional: 1999999984 DME: 1999999992

Loop 2010AA: Billing Provider (continued)

Data Element	TR3 Data Element Name	TR3 Element Description	CMS Supplemental Instruction for EDR and CRR Submissions
REF02	Billing Provider Tax Identification Number	Identifies Billing Provider's Tax Identification Number.	See Chapter 3 for information on use of Default EINs Default EINs: Institutional: 199999997 Professional: 199999998 DME: 199999999

Atypical Providers, Default NPIs & EINs

Record Type	Payer ID	Default NPI	Default EIN
Institutional	80881	1999999976	199999997
Professional	80882	1999999984	199999998
DME	80887	1999999992	199999999

Guide, Chapter 3, Section 3.5

Loop 2010AA: Billing Provider Name

Data Element	TR3 Data Element Name	TR3 Element Description	CMS Supplemental Instruction for EDR and CRR Submissions
N403	Billing Provider Zip Code	Identifies the Billing Provider's zip code	The full nine digits of the zip code are required. If the last four digits of the zip code are not available, populate a default value of "9998."

Loops & Segments Applied to EDRs & CRRs

Loop or Segment ID	Loop or Segment Name
Loop 2010BA	Subscriber Name
Loop 2010BB	Payer Name
Loop 2300	Claim Information
Loop 2310E**	Ambulance Pick-Up Location
Loop 2310F**	Ambulance Drop-Off Location
Loop 2320	Other Subscriber Information
Loop 2330A	Other Subscriber Name
Loop 2330B	Other Payer Name

Appendix 3A: MA Companion Guide

***Professional EDRs only*

Medicare Beneficiary Identifier (MBI)

- Transition period April 1, 2018 – December 31, 2019, either HICN or MBI may be submitted
- Submit MBI using **Loop 2010BA, NM109 – Subscriber Primary Identifier and Loop 2330A, NM109 – Other Insured Identifier**
- After December 31, 2019, plans are encouraged to use the MBI when possible

Loop 2300 Claim Information

Data Element	TR3 Data Element Name	TR3 Element Description	CMS Supplemental Instruction for EDR and CRR Submissions
CLM05-3	Claim Frequency Type Code	Identifies the frequency for the claim (encounter). Source: National Uniform Billing Data Element Specifications, Type of Bill Position 3.	Use these values 1 = Original EDR or CRR 7 = Correct/Replace EDR or CRR 8 = Void/Delete EDR or CRR

Loop 2300 Claim Information – Replacing a Previously Submitted EDR or CRR

- Submitted when MAO wishes to replace a previously submitted and accepted EDR or CRR
- Replacement submissions will supersede previously accepted records

Loop 2300
• CLM05-3 = ‘7’
• REF01 = ‘F8’
• REF02 = ICN of the original accepted encounter

- Certain data elements must match the previously submitted and accepted encounter

Loop 2300 Claim Information – Voiding a Previously Submitted EDR or CRR

- Submitted when a previously submitted and accepted EDR or CRR must be voided from the EDS
- Void/delete encounters will supersede previously accepted records

Loop 2300
• CLM05-3 = ‘8’
• REF01 = ‘F8’
• REF02 = ICN of the original accepted encounter

- Certain key data elements on the void/delete encounter must match the original encounter submission

Encounter Data

CMS's Instructions for Specific Data Fields

Chart Review Records

Loop 2300 – Claim Information – Chart Review Records

Two types:

- CRR-Adds
- CRR-Deletes

CRRs may be linked to other records (EDRs or CRRs) or unlinked

- All CRR-Deletes must be linked to an EDR or another CRR
- CRR-Adds may be linked or unlinked

A record is designated as a chart review record by using the PWK01 and PWK02 data elements in loop 2300.

No limit on the number of CRRs that may be submitted.

Guide, Chapter 2, Section 2.3

Loop 2300 – Claim Information – Linked Chart Review Records

- Used to add or delete diagnosis codes from a previously-submitted and accepted EDR or CRR
- Linked CRR-Add contains the Internal Control Number of a previously submitted and accepted EDR or CRR. CLM05-3 Claim Frequency Type Code (Loop 2300) must not equal 7 (replace) or 8 (void/delete), unless the intention is to replace (7) or void (8) another previously accepted CRR.
- Linked CRR-Delete contains the Internal Control Number of a previously submitted and accepted EDR or CRR and the patient medical record number equal to 8 in Loop 2300 (REF01=EA / REF02=8)
- CRR-Deletes must be submitted with CLM05-3 (“Claim Frequency Type Code” in Loop 2300) not equal to 7 (replace).

Loop 2300 – Claim Information – Unlinked, Replacement, and Void Chart Review Records

Unlinked CRRs:

- Only used to add risk adjustment-eligible diagnosis codes and does not identify a previously submitted EDR or CRR that the submitted diagnosis should be associated with

Replacement CRRs:

- Replacement CRR-Add (CLM05-3 = 7) can only be used to replace a previously accepted linked or unlinked CRR
- Replacement CRR-Delete cannot be submitted. Void previously accepted Linked CRR-Delete to nullify delete operation

Void CRRs:

- Submitted for previously accepted CRR-Deletes or Linked or Unlinked CRR-Adds. The Linked or Unlinked CRR-Adds can be originals or replacements

Loop 2300: Chart Review Records Summary Table

CRR Type	Linked	Unlinked
Add	PWK01/02 ='09'/'AA' REF01/02 (Payer Claim Control Number) = 'F8'/ ICN of previously accepted record CLM05-3 = '1' or '7' or '8' HI01-1/2 ='BK'/ 'diagnosis code'	PWK01/02 ='09'/'AA' CLM05-3 = '1' HI01-1/2 ='BK'/'diagnosis code'
Delete	PWK01/02 ='09'/'AA' REF01/02 (Payer Claim Control Number) = 'F8'/ ICN of previously accepted record CLM05-3 = '1' or '8' HI01-1/2 ='BK'/ 'delete diagnosis code' REF01/02 (Medical Record Number) = 'EA' / '8'	N/A

A CRR-Delete submitted with CLM05-03 = ‘8’ and linked to a CRR-Delete will result in the reinstatement of diagnosis codes listed on the previously submitted CRR-Delete that is being voided. A CRR-Delete submitted with CLM05-03 = ‘8’ and linked to a CRR-Add will void the CRR-Add and the diagnosis codes on the Add record will be deleted. The diagnosis codes on the CRR-Delete void record will be ignored, in other words only the void action of the CRR-Delete will take effect.

Examples of Data Segments for CRRs

Linked CRR-Add
PWK*09*AA~
REF*F8*1298768987657~
HI*BK:25000*BF:2720~

Linked CRR-Delete
PWK*09*AA~
REF*F8*1298768987657~
REF*EA*8~
HI*BK:25000*BF:2720~

Unlinked CRR-Add
PWK*09*AA~
HI*BK:4475~

Loop 2300: PWK Claim Supplemental Information

Situation	PWK01 Value	PWK02 Value
Paper claims	OZ	AA
4010 format submission	PY	AA

Loops & Segments Applied to EDRs & CRRs

Loop or Segment ID	Loop or Segment Name
Loop 2400	Service Line
Loop 2430	Line Adjudication Information

Appendix 3A: MA Companion Guide

Capitated Submission

- Submit ‘00’ **only** if billed and/or payment information is not available
- If information is available, submit as received from provider

Capitated or Staff Model Arrangements Only	
Institutional and Professional	Loop 2300, CN101 = ‘05’ **where all service lines are covered under capitated or staff model arrangements**
Mix of Capitated and Non-Capitated Service Lines	
Professional	Loop 2300, CN101 = “ “ leave blank Loop 2400, CN101 = ‘05’ for each capitated service line
Institutional	Loop 2300, CN101 = “ “ leave blank Loop 2430, CAS02 = ‘24’ for capitated service lines or Group Reason Code for non-capitated service lines

DME Services

- **DME "Incident to"**
  - Submitted for service(s) provided during a physician or institutional visit
- **DMEPOS Supplier**
  - Submitted for supplies provided by a DME Supplier entity (non-physician/non-institution) under a Medicare agreement

DME “Incident To” Submission

- Must be submitted on the 837-P or 837-I with the appropriate Payer ID for DME encounters that are “incident to” a professional service
- Claims for implanted DME, implanted prosthetic devices, replacement parts, accessories, and supplies for the implanted DME, when considered “incident to,” are part of the encounter
- The NPI on the encounter must be for a provider/physician or institution and not for a DMEPOS Supplier

Professional	Institutional	DME
• 837-P	• 837-I	• 837-P or 837-I
• Payer ID = 80882/80889	• Payer ID = 80881/80888	• Payer ID = 80887

DMEPOS Supplier Guidelines

- Submit on 837-P using following values:
  - ISA08 (Interchange Receiver ID) = 80887/80890
  - GS03 (Application Receiver's Code) = 80887/80890
  - Loop 1000B, NM109 (Receiver's Identifier) = 80887/80890
  - Loop 2010BB, NM109 (Payer's Identifier) = 80887/80890
- If submitted with Payer ID 80887/80890 and DMEPOS supplier = NPI, HCPCS from DMEPOS fee schedule must also be used
- If HCPCS does not exist in fee schedule, use informational edit: '32070-Non-DME HCPCS Code' for the encounter

DMEPOS Special Considerations

- Some submissions require special considerations in order to allow the encounters to pass EDFES and EDDPPS edits
  - Default NPIs
  - Atypical Provider

Summary

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3. CMS's Encounter Data System & Processing
4. File Size Limitations, Submission Frequency, & Deadlines
5. CMS's Instructions for Specific Data Fields

Questions?

- Encounter Data Communications/Inquiry Inbox: encounterdata@cms.hhs.gov