CENTERS for MEDICARE & MEDICAID SERVICES

Encounter Data Participant Guide

2011 Regional IT Technical Assistance

Reddix & Associates

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF TABLES

TABLE OF CONTENTS

LIST OF FIGURES

INTRODUCTION

Purpose

The purpose of this guide is to provide participants with the resources necessary to prepare their systems for the collection, submission, and processing of encounter data. Medicare Advantage Organizations (MAOs) and other entities will also become familiar with the transition to encounter data and CMS compliance requirements.

About this Training

This technical assistance session is organized into five (5) modules:

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1. **Overview**
   Identifies the systems and timelines for the encounter data collection, submission, editing, and reporting processes.

2. **Submission**
   Describes the acceptable sources of encounter data, acceptable formats for submitting encounter data, and the special considerations regarding encounter data submission for specific types of plans or services.

3. **Reports**
   Identifies data integrity logic and error codes, error resolution, and suggestions for avoiding errors with encounter data.

4. **Compliance**
   Provides important compliance guidelines and benchmarks regarding encounter data.

5. **Transition to Encounter Data System**
   Describes the process for transitioning from risk adjustment to encounter data.

This participant guide is designed as the foundation of the technical assistance program. The presentation slides complement the participant guide. Both are used extensively throughout this program to enhance the learning experience. Table A provides a description of the tools used during the technical assistance session. CMS does not provide the printed version of the participant guide or resource guide for this session. However, the documents are accessible through www.csscoperations.com, www.TARSC.info, or the CMS provided flash drive.

TABLE A – TRAINING TOOLS

SECTION	DESCRIPTION
Participant Guide	• Detailed description of relevant encounter data information • Exercises • Answer Keys
Slides	• Organized by module

Companion Guide	• Draft version for:
	  • 837-I (Institutional)
	  • 837-P (Professional)

Other Resources	• Official CMS Notices • List of Acronyms • List of web-based resources

Future Use of This Participant Guide

The participant guide, slides, and companion guide are designed for use when participants return to their organizations. Additional copies of the training materials are available at www.csscoperations.com. While the information provided in the participant guide, slides, and companion guide are current as of the release date, please be aware that CMS revises training materials, as necessary, when decisions or new information that impact these documents are made available. An appropriate label will appear in the footer of the replacement pages affected by revisions. Organizations are encouraged to register at www.csscoperations.com to receive notifications of updates.

Since the collection and submission of encounter data is currently being implemented, organizations can expect to receive notifications monthly, beginning in September 2011, identifying the release of an updated companion guide. This will continue throughout the implementation.

Audience

This technical assistance program is designed for those MAOs and other entities that will submit encounter data. CMS requires the following types of organizations to collect and submit encounter data:

- Medicare Advantage (MA) Plans
- Medicare Advantage-Prescription Drug Plans (MA-PDs)
- Health Maintenance Organizations (HMOs)
- Special Needs Plans (SNPs)
- Local Preferred Provider Organizations (PPOs)
- Regional PPOs
- Employer Group Health Plans
- Programs for All-Inclusive Care for the Elderly (PACE) Plans

- Cost Plans (1876 Cost HMOs/CMPs and 1833 HCPPs)
- Medical Savings Account Plans
- Private Fee-For-Service Plans
- Religious Fraternal Benefit Plans (RFBs)
- Provider Sponsored Organizations (PSOs)

Learning Objectives

At the completion of this technical assistance session, participants will be able to:

- Identify the key terms, flow of data, and implementation schedule of encounter data.
- Explain the acceptable sources of encounter data and data formats for submission.
- Interpret the editing rules and reports for monitoring encounter data.
- Explain CMS' compliance requirements.
- Identify the transition plan to the encounter data system.

In an effort to ensure participating plans have the necessary tools and information to be successful with the encounter data process, the resources described in Table B have been provided for support and technical assistance.

TABLE B – ENCOUNTER DATA PROCESS POINTS OF CONTACT

ORGANIZATION	ROLE	CONTACT INFORMATION
CMS Regional Offices	Provides assistance to MAOs and other entities and beneficiaries regarding various issues related to the Medicare program.	Contact plan manager.
Customer Service and Support Center (CSSC)	Manages the Encounter Data Front-End System (EDFES) and the CSSC.	CSSC Operations: http://www.csscoperations.com/internet/cssc.nsf/Home
A. Reddix & Associates (ARDX)	Provides project integration, industry outreach, business requirements, systems specifications, and is the training contractor responsible for encounter data training initiatives, including regional training programs and work groups.	EDS Inbox: EDS@ardx.net Encounter Data Outreach Registration: www.tarsc.info

MODULE 1 – ENCOUNTER DATA SYSTEM (EDS) PROCESS OVERVIEW

Purpose

Successful implementation of the Encounter Data System (EDS) is dependent upon Medicare Advantage Organizations (MAOs) and other entities understanding the process of collecting and submitting accurate encounter data. The purpose of this module is to provide participants with important terms, key resources, and the implementation schedule.

Learning Objectives

At the completion of this module, participants will be able to:

- Define common encounter data terminology.
- Demonstrate knowledge in interpreting key components of the encounter data process.
- Interpret the encounter data process implementation schedule.
- Identify encounter data outreach efforts available to organizations.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1.1 Common Encounter Data Terms

The implementation of encounter data requires an understanding of key terms related to the collection, submission, and processing of data through EDS. This section introduces new terminology related to EDS processing and establishes common definitions for existing industry terms that are important to understanding the encounter data process.

1.1.1 Claims Processing Systems

The Encounter Data Processing System (EDPS) is comprised of various subsystems, some of which are based on the Medicare Fee-For-Service (FFS) systems. Table 1A provides a definition of the subsystems that are included in EDPS and Medicare FFS shared or base systems.

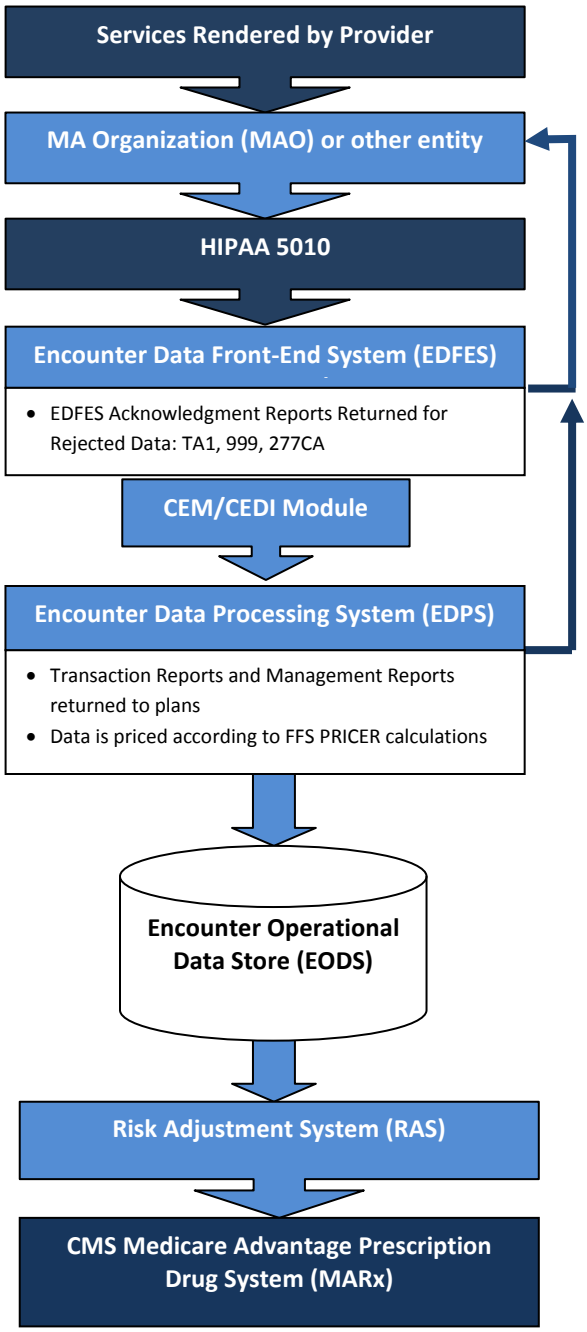
TABLE 1A – CLAIMS PROCESSING SYSTEMS

TERM	DEFINITION
Encounter Data Front-End System (EDFES)	The encounter data system includes the Electronic Data Interchange (EDI) Translator, the Institutional Common Edits and Enhancements Module (CEM), the Professional CEM, and the Durable Medical Equipment (DME) Common Electronic Data Interchange (CEDI).
Encounter Data Processing System (EDPS)	The Encounter Data Processing System is comprised of the Encounter Data Institutional Processing and Pricing System (EDIPPS), the Encounter Data Professional Processing and Pricing System (EDPPPS) and the Encounter Data DME Processing and Pricing System (EDDPPS).
Encounter Data Institutional Processing and Pricing Sub-system (EDIPPS)	The Encounter Data Institutional Processing and Pricing Subsystem will process and price institutional encounter data. The EDIPPS is based on FISS processing.
Encounter Data Professional Processing and Pricing Sub-system (EDPPPS)	The Encounter Data Professional Processing and Pricing Subsystem will process and price professional encounter data. The EDPPPS is based on MCS processing.
Encounter Data DME Processing and Pricing Sub-system (EDDPPS)	The Encounter Data DME Processing and Pricing Subsystem will process and price DME encounter data. The EDDPPS is based on VMS processing.
Encounter Data System (EDS)	A data collections system used for the collection, processing, and pricing of encounter data.
Encounter Data Common Working File (EDCWF)	The EDCWF is a central database containing eligibility and claims history for all Medicare beneficiaries for encounter data purposes. For claims processing, the EDCWF verifies beneficiary enrollment and eligibility for the dates of service of the claim.
Encounter Operational Data Store (EODS)	The CMS repository for encounter data submissions. Encounter data is stored in the EODS after passing all levels of edits.
Fiscal Intermediary Shared System (FISS)	The standard Medicare claims processing system used for all Institutional claims. The EDIPPS is based on FISS processing.
Multi-Carrier System (MCS)	The standard Medicare claims processing system for physician and supplemental services (i.e., lab) claims. The EDPPPS is based on MCS processing.
ViPS Medicare System (VMS)	The standard Medicare claims processing system that processes durable medical equipment (DME) claims from DME suppliers. The EDDPPS is based on VMS processing.

1.2 Encounter Data Flow

- Providers submit claims data to the MAO or other entity submitting encounter data on behalf of the MAO or other entity.
- The MAO or other entity submits the encounter data in the HIPAA compliant version 5010 837X format transaction file to CMS.
- Data is sent to the EDFES to process through the Commercial Off-the-Shelf (COTS) EDI Translator, and then to the CEM or the CEDI module for editing.
- Submitter receives acknowledgement reports based on various levels of editing peformed on the front-end.
- After claims successfully process through the EDFES, they are sent to the EDPS for detailed editing.
- Once processed, the claims may take various paths. If the data are able to be priced, the data are priced and stored.
- If the data falls into exception catergories (i.e. capitated claim, atypical provider) the data will skip the pricing step and move to storage.
- Submitters receive encounter data transaction and management reports based on the results of the EDPS edit checks.
- The EODS stores all finalized encounter data.
- Model diagnoses are extracted and sent to RAS for risk score calculation.
- MARx is used in the calculation and determination of plan payments.

Figure 1A – Encounter Data Flow



1.3 EDS Implementation Schedule

The complete encounter data implementation will span six (6) years, beginning in 2008 and ending in 2014. The following sections identify the details of the EDS Implementation Schedule.

1.3.1 Milestones

To date, the encounter data implementation timeline has marked several major milestones, which are depicted in Table 1B.

TABLE 1B – MILESTONES

YEAR	MILESTONE(S)
2008	• The FY 2009 Inpatient Prospective Payment System (IPPS) Final Rule clarified CMS' authority to collect data from MA organizations for each item and service provided. CMS subsequently obtained support from leadership to develop and implement a system to collect this additional data.
2009	• CMS engaged contractors to initiate project planning for implementation of encounter data collection, and based on discussions with subject matter experts to ensure the appropriate processing and pricing rules to be integrated, developed a Business Process Model to support the needs of encounter data collection and processing. • CMS engaged stakeholders to begin synchronization of the EDS with Fee-For-Service (FFS) processing and methodology. • CMS conducted a gap analysis to explore the incorporation of the current risk adjustment process with the goals for encounter data implementation.
2010	• CMS conducted the Encounter Data (ED) Survey in April 2010 which consisted of 18 phone interviews with health plans to gather information on industry capabilities related to systems and business performance in preparation for encounter data implementation. • CMS established an industry outreach program to obtain information and feedback to determine the next steps towards the implementation of encounter data collection. • CMS conducted a National Encounter Data Meeting with 593 industry attendees to disseminate information regarding high-level requirements for encounter data collection, transition activities, and the targeted implementation schedule. • CMS launched the quarterly distribution of newsletters including information and updates for risk adjustment processes and encounter data implementation to over 1,800 industry members.

TABLE 1B – MILESTONES (CONTINUED)

YEAR	MILESTONE(S)
2011	• CMS recruited six (6) plans to participate in an EDFES Pilot Test. Data from the pilot test will help CMS to identify issues prior to the Front-End implementation, to determine information that will be accepted during processing and testing and to establish which edits to turn on or off for further testing. • CMS conducted pilot testing with five (5) plans. • CMS conducted eight (8) Encounter Data Work Groups of various submission topics with 315 industry attendees to determine and discuss issues and create possible solutions for final implementation of Encounter Data. Work group topics included: Third Party Submitters, Chart Reviews and Data Submission for Chart Audits, Editing and Reporting, PACE Organizations, and Collection Strategies for Capitated and Staff Model Plans. • CMS conducted three (3) Industry-Wide Updates with 609 industry attendees and one (1) Encounter Data Teleconference with 258 industry attendees to provide information to MAOs and other entities regarding the progress of and updates for encounter data implementation. • CMS launched the EDS inbox providing a communication forum for the industry to submit feedback and questions related to encounter data submission and implementation. • CMS collaborated with AHIP to identify, address, and create solutions for issues related to the collection and submission of encounter data through the EDS. • CMS will execute testing of the EDFES to validate processing of the 5010 transmission X12 file format through the EDI Translator and subsequent Institutional and Professional CEMs located at the Front-End. • CMS will execute the EDIPPS and EDPPPS End-to-End Testing and plan certification to submit encounter data.
2012	• CMS will implement the EDS on January 3, 2012 for MAO and other entity submission and processing of production encounter data. • Roll-out of encounter data return reports. • CMS will update industry on the quality of encounter data collected and timeline for phasing out of the Risk Adjustment Processing System (RAPS).
2013	• CMS will update industry on the quality of encounter data collected and enhancements.

1.3.2 Encounter Data Implementation Timeline 2011 – 2012

The current phase of the encounter data implementation includes the preparation of systems and files for front-end testing. Front-end testing is scheduled to run from September 06, 2011, through October 04, 2011. During front-end testing, plans must submit 5010 test files containing at least one (1)

institutional file with a mix of inpatient and outpatient institutional encounters and one (1) professional file with no more than 50-100 claims per file.

Industry outreach efforts will continue throughout the implementation process, allowing submitters to offer feedback and receive assistance while transitioning to the EDS. The EDS will roll-out on January 3, 2012. Although the EDS will be fully implemented in 2012, CMS will continue to run RAPS while validating the encounter data received to ensure that it is of high quality in order to recalibrate the risk adjustment model.

Table 1C provides recent and upcoming events in the encounter data implementation and transition schedule.

TABLE 1C—ENCOUNTER DATA IMPLEMENTATION TIMELINE 2011-2012

EVENT	START DATE	END DATE
Test Case Preparation*	March 30, 2011	September 05, 2011
Plans Submit Front-End Test Data**	September 06, 2011	October 04, 2011
Encounter Data Processing System Test Case Preparation and Education	October 05, 2011	October 28, 2011
Provide Industry with Encounter Data Analytic and Preliminary Error Reports	October 31, 2011	N/A
Execute EDIPPS and EDPPPS End-to-End Testing/certification	October 31, 2011	November 30, 2011
EDS Roll-out	January 03, 2012	N/A
Roll-out of Additional EDS Reports	March 01, 2012	N/A
Industry Status Update on the Quality of Encounter Data Collected and Timeline for Shut Down of RAPS	July 01, 2012	N/A

* All test case preparation should be completed by September 05, 2011. This will allow for a full month of end-to-end testing which is currently scheduled to begin October 31, 2011.

** Front-end test data should be submitted on or as close to September 06, 2011 to allow for a full month of test data remediation.

1.3.3 Encounter Data DME Implementation Timeline

DME supplier claims will be processed through the DME EDPS CEDI module and will be submitted according to a separate implementation timeline. The phase in of submission of DME encounter claims is illustrated in Table 1D. Testing of the DME CEDI module and the EDDPPS starts on February 6, 2012. The EDDPPS rolls-out on May 7, 2012. Therefore, MAOs and other entities must submit DME production data by May 7, 2012.

TABLE 1D – TARGET IMPLEMENTATION DATES FOR DME

EVENT	DATE
MAO and other entity front-end testing of Encounter Data DME CEDI module and EDDPPS begins	February 6, 2012
Roll-out of the EDDPPS	May 7, 2012

1.4 Training and Support

Various industry outreach efforts such as industry updates, encounter data work groups, encounter data calls, the encounter data newsletter, and the EDS inbox have been established to assist submitters and to keep the industry abreast of developments during the implementation and transition phases. To ensure that participating organizations have the necessary tools and information to be successful with the encounter data process, CMS has planned the following outreach efforts, as described in Table 1E.

TABLE 1E – TRAINING AND SUPPORT

INITIATIVE	DESCRIPTION
Customer Service & Support Center (CSSC)	This toll free help line (1-877-534-2772) is available Monday – Friday, 8:00 A.M. EST to 7:00 P.M. EST (with the exception of corporate observed holidays) to provide assistance. The support center provides ongoing encounter data assistance.
www.csscoperations.com	The CSSC website, www.csscoperations.com is the gateway to EDS. Visitors to the site can access information about the EDS, including opportunities to enroll to submit encounter data and obtain comprehensive information about data submission and EDS testing requirements. In addition, the site provides valuable links to CMS instructions and other official resources. Work Group and other training information are regularly posted.
Work Groups and Industry Updates	Conducted as announced. The purpose of the Encounter Data Work Group meetings is to provide a forum for communication between CMS and MAOs and other entities to determine and discuss issues and create possible solutions for implementation of encounter data. The purpose of Industry Updates is to provide information to MAOs and other entities regarding the progress of and updates for encounter data implementation. Meeting notes and Q&As are provided. To register online for scheduled Encounter Data Work Groups and view previous work group notes and Q&As, go to www.tarsc.info.
www.tarsc.info	The website, www.tarsc.info is the website for encounter data training and User Group information. The website includes information about trainings and work groups, training dates, locations, online registration, and encounter data FAQs.
eds@ardx.net	Provides a method for MAOs and other entities to submit encounter data policy and operational questions during the planning and implementation phases of EDS.

1.5 Encounter Data Acronyms

Table 1F provides an excerpted list of commonly used acronyms relevant to the encounter data process. A complete listing of all acronyms of significance for encounter data can be located in the Encounter Data Resources.

TABLE 1F—ENCOUNTER DATA ACRONYMS

ENCOUNTER DATA ACRONYMS	
TERM	**DEFINITION**
A	
ACA	Affordable Care Act
ANSI	American National Standards Institute
ASCA	Administrative Simplification Compliance Act
C	
CAS	Claims Level Adjustment Segment
CEDI	Common Electronic Data Interchange
CEM	Common Edits and Enhancement Module
COTS	Commercial Off-the-Shelf
CPT	Current Procedural Terminology
D	
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment Prosthetics, Orthotics, and Supplies
E	
EDCWF	Encounter Data Common Working File
EDDPPS	Encounter Data DME Processing and Pricing Sub-System
EDFES	Encounter Data Front-End System
EDFESC	Encounter Data Front-End System Contractor
EDI	Electronic Data Interchange
EDIPPS	Encounter Data Institutional Processing and Pricing Sub-System
EDPPPS	Encounter Data Professional Processing and Pricing Sub-System
EDPS	Encounter Data Processing System
EDPSC	Encounter Data Processing System Contractor
EDS	Encounter Data System
EODS	Encounter Operational Data Store
F	
FFS	Fee-For-Service
FISS	Fiscal Intermediary Standard System
FS	Fee Schedule
FTP	File Transfer Protocol

TABLE 1F—ENCOUNTER DATA ACRONYMS (CONTINUED)

ENCOUNTER DATA ACRONYMS	
TERM	**DEFINITION**
H	
HCPC	HCFA Common Procedure Code
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability & Accountability Act of 1996
I	
IG Edits	Implementation Guide Edits
I/OCE	Integrated/Outpatient Code Editor
M	
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MCE	Medicare Code Editor
MCS	Multi-Carrier System
MUE	Medically Unlikely Edits
N	
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NUCC	National Uniform Claim Committee
P	
PACE	Program for All Inclusive Care for the Elderly
PDE	Prescription Drug Event
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
PPS	Prospective Payment System
R	
RAPS	Risk Adjustment Processing System
S	
SNF	Skilled Nursing Facility
T	
TOB	Type of Bill
TOS	Type of Service
V	
VMS	VIPS Medicare System
W	
WPC	Washington Publishing Company

1.6 Summary

The implementation of encounter data is designed to improve the risk adjustment and MA payment system by providing complete and accurate data to allow CMS to accurately measure and analyze MA utilization and cost. The success of encounter data implementation and accurate submission and collection of data is dependent on understanding the terminology and process of encounter data. The complete implementation schedule for encounter data will span six (6) years including preparation, industry outreach efforts, EDS testing and monitoring, and evaluating the quality of encounter data collected. This module provided the common terms associated with the EDS, as well as an index of acronyms specific to encounter data, while also providing participants with an overview of the dataflow process through the EDS.

MODULE 2 – SUBMISSION

Purpose

For the purpose of encounter data, Medicare Advantage Organizations (MAOs) and other entities must collect data from health care facilities and providers, as well as, Durable Medical Equipment (DME) suppliers. The complete submission of all encounter data from these health care sources in the 5010 format is critical for accurate risk adjustment model calibration. This module is designed to provide participants with the data collection and submission principles for encounter data that is in accordance with the CMS requirements.

Learning Objectives

At the completion of this module, participants will be able to:

- Describe acceptable sources of encounter data.
- Understand the submission process requirements and connectivity options.
- Apply Health Insurance Portability and Accountability Act (HIPAA) transaction standards for purposes of encounter data collection.
- Identify risk adjustment filtering logic.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

2.1 Sources of Data

The Health Insurance Portability and Account ability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard and unique health identifier for health care providers. On January 23, 2004, HHS published the Final Rule that adopts the National Provider Identifier (NPI) as the standard unique identifier for health care providers. The NPI is a 10-position, intelligence-free unique numeric identifier and must be used in lieu of legacy provider identifiers.

Encounter data requires the use of a valid NPI for claim submission and processing. MAOs and other entities are responsible for ensuring data collected for submission to the Encounter Data System (EDS) comes from Medicare acceptable sources, as identified by an assigned NPI. MAOs and other entities can use the NPI Registry, located on the National Plan and Provider Enumeration System (NPPES) website to

investigate and validate a provider's NPI. Information in the NPI Registry is updated daily, and there is no charge to use the registry. Eligible providers may also apply for an NPI in this manner.

- Atypical provider claims will be accepted for encounter data submissions. See Section 2.8 for further information.

All health care providers who are HIPAA-covered entities are eligible for and required to obtain an NPI. A covered health care provider under HIPAA, as defined in the Code of Federal Regulations in 45 CFR 160.103, is an entity that transmits health information in electronic form in connection with a transaction for which the Secretary of HHS has adopted a standard, even if the health care provider uses a business associate to do so. Health care providers may be individuals (e.g., physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or organizations (e.g., hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, Health Maintenance Organizations, suppliers of durable medical equipment, pharmacies, etc).

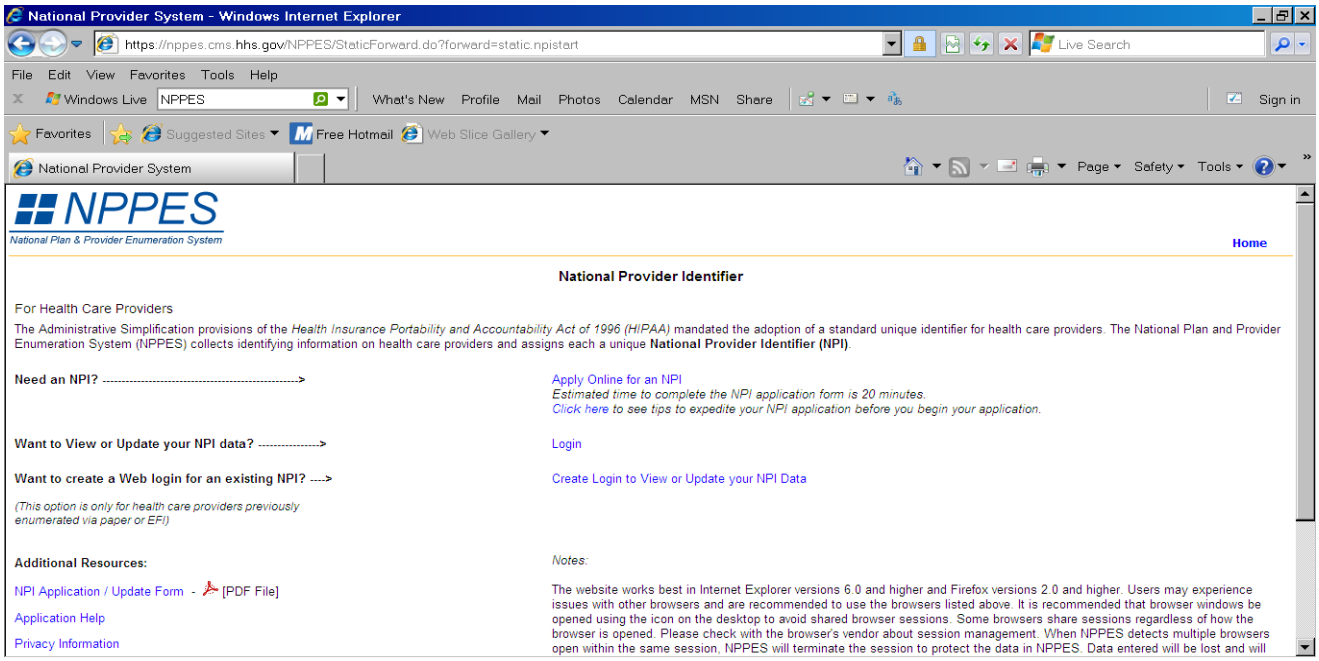
45 CFR 160.103
http://www.gpo.gov/fdsys/ pkg/CFR-2009-title45-vol1/pdf/CFR-2009- title45-vol1-sec160-103.pdf

NPI tool to help establish whether one is a covered entity
http://www.cms.gov/HIPAAGenInfo//06_AreYouaCoveredEntity.asp

NPPES Website
https://nppes.cms.hhs.gov/NPPES/Welcome.do

Figure 2A provides a screen shot of the NPPES website.

Figure 2A – NPPES Website



MAOs and other entities must collect data from the following provider types:

- Facility/Institution
- Professional
- DME Supplier

2.1.1 Facility

Currently in Fee-for-Service (FFS), inpatient institutional, outpatient institutional, skilled nursing facility, and home health agency services are submitted according to Type of Bills (TOBs). Submission of encounter data from facility sources of data will follow FFS methodologies and process according to the TOB code. These facility-based services are further described by the use of revenue center codes (revenue codes), Healthcare Common Procedure Coding System (HCPCS) codes, and diagnosis codes. Revenue Codes are commonly represented by a four (4) digit number where the first digit is a '0' unless it is representing a national code. A revenue code represents a revenue-producing division or unit within a hospital or other institution (e.g., emergency room, pharmacy). Revenue codes are used in facility-based services along with HCPCS and procedure codes to accurately describe the level of care provided. Currently, diagnosis codes are based on the International Statistical Classification of Diseases, Version 9 (ICD-9) codes and describe illnesses and injuries to the current highest level of specificity. These data elements are important for the collection of encounter data, since the processing and pricing of the service provided may vary based on the different data collected.

HCPCS General Information
http://www.cms.gov/MedHCPCSGenInfo/

ICD-9 Diagnosis Codes
http://www.icd9data.com/

2.1.1.1 Inpatient Institutional Facility

The ANSI X12N 837 Institutional (837-I) is the standard for transmitting health care claims electronically, and its Implementation Guide (TR3) requires the use of TOB codes for processing.

An inpatient institutional service is provided by a hospital during which a patient is admitted to the facility for at least one (1) overnight stay. Table 2A provides the full list of inpatient institutional sources of data and their associated TOB codes, from which, MAOs and other entities are responsible for collecting encounter data from for the purpose of submitting to EDS.

TABLE 2A – INPATIENT INSTITUTIONAL SERVICES

ENCOUNTER DATA FACILITY SERVICE	TOB
Inpatient Hospital	11X
Inpatient Rehabilitation Facility	11X
Inpatient Psychiatric Facility	11X
Long-Term Care Hospital	11X
Skilled Nursing Facility Inpatient/Swing Bed	18X, 21X
Critical Access Hospital Inpatient/Swing Bed	11X, 18X
Home Health Facility	32X, 33X

- Under the Social Security Act, certain small, rural hospitals are allowed to enter into a swing bed agreement (TOB 18X), under which the hospital can use its beds, as needed to provide either acute inpatient care or Skilled Nursing Facility (SNF) care.

2.1.1.2 Outpatient Institutional Facility

Outpatient institutional services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization. Table 2B provides the full list of outpatient institutional data sources and their associated TOB codes for collection of encounter data.

TABLE 2B – OUTPATIENT INSTITUTIONAL SERVICES

ENCOUNTER DATA FACILITY SERVICE	TOB
Outpatient Hospital	12X, 13X, 14X
Skilled Nursing Facility Outpatient	22X, 23X
Hospice	81X, 82X
Community Mental Health Center	76X
Home Health Facility	34X
End-Stage Renal Disease Facility	72X
Critical Access Hospital Outpatient	85X
Rural Health Clinic	71X
Federally Qualified Health Center	77X
Outpatient Rehabilitation Facility (CORF/ORF)	74X, 75X
Ambulance	12X, 13X, 22X, 23X, 83X, 85X
Institutional Clinical Laboratory	14X

- Supplies related to Home Health Facility services are billed on an encounter data institutional claim, but are priced according to the DME fee schedule. TOB 34X is used for Home Health Facility Outpatient only.

- Ambulance claims can be processed through TOB 12X and 13X when it is a hospital-based ambulance service. The TOB 12X claims are bundled into the inpatient admission payment; therefore, no additional payment is made for those ambulance services.

2.1.1.3 Skilled Nursing Facility (SNF)

A SNF is a nursing facility with the staff and equipment to provide skilled nursing care and/or skilled rehabilitation services and other related health care services to a Medicare beneficiary who has been admitted to the facility. For SNF services, MAOs and other entities should use the 837-I format and TOB 21X for inpatient services, and 18X for swing bed services.

Revenue code 0022 indicates that the claim should be priced according to the SNF pricing methods and is therefore required on all SNF claims submitted for encounter data. This revenue code can be used as often as necessary on a claim to indicate the changes to the beneficiaries' Health Insurance Prospective Payment System (HIPPS) rates code based on the assessment periods. The HIPPS rate consists of the three-character resource utilization group (RUG-III) code that is obtained from the Grouper software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code. The current RUG-III system consists of eight major resident types (53 groups):

1. Rehabilitation Plus Extensive Services (9 groups)
2. Rehabilitation (14 groups)
3. Extensive Services (3 groups)

4. Special Care (3 groups)
5. Clinically Complex (6 groups)
6. Impaired Cognition (4 groups)
7. Behavior Problems (4 groups)
8. Reduced Physical Function (10 groups)

Each RUG-III group is assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the residents who qualify for the group. The HIPPS Rate code is identified in the HCPCS data element and will fall in this range of appropriate rates AAA00 - SSC79.

Medicare Claims Processing Manual, Chapter 6
http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf

Rug Refinement
http://www.cms.hhs.gov/snfpps/09_rugrefinement.asp

2.1.1.4 Home Health Agencies (HHA)

An HHA provides care to homebound individuals who are ill or injured and require intermittent (part-time) skilled nursing services or skilled therapy provided under a home health plan of care. For HHA services submitted for encounter data, MAOs and other entities must submit encounter data on the 837-I with TOBs 32X, 33X, or 34X. TOB 34X is specifically used for outpatient home health services. In addition, supplies are included in the claim for the episode, but may be priced differently.

The home health unit of service is based on a per episode of care for a homebound Medicare beneficiary. To submit encounter data claims for home health services, at least one service must be provided and the plan of care must be established before submitting a claim for payment. In addition, HHAs submit an Outcome and Assessment Information Set (OASIS) to estimate the expected resource costs per beneficiary. Beneficiaries are assigned a Home Health Resource Group (HHRG) based on clinical and functional status and service use that are represented in the same HIPPS rate codes described for SNF services in section 2.1.1.3.

Medicare Claims Processing Manual, Chapter 10
http://www.cms.gov/manuals/downloads/clm104c10.pdf

HIPPS Codes
http://www.cms.gov/prospmedicarefeesvcpmtgen/02_hippscodes.asp

2.1.1.5 Interim Bill Submission

Interim bills include facility charges incurred during a stay for the dates of service covered, but final bills do not always include all of the services rendered from the admission date to the discharge date. The

industry standard is to submit interim bills in 60-day cycles. Type of Bill (TOB) 112 with a patient status code of 30, which is defined as "still a patient," identifies the first 60-day encounter cycle. Subsequent interim bills are identified by TOB 117 with a patient status code of 30; while subsequent discharge bills are identified by TOB 117 with a patient status code other than 30. As an exception, Skilled Nursing Facilities (SNFs) use TOB 112 for the first interim encounter, followed by TOB 113 or 114 for subsequent interim bills, depending on whether or not the encounter is a continuing or final claim.

For interim bill submissions to the EDS, MAOs and other entities may utilize the following values in the Claim Frequency Type Code, Loop 2300, CLM05-3 depending on the type of interim bill received:

Frequency Type Code	Type of Interim Bill
2	Interim – First Claim
3	Interim – Continuing Claim
4	Interim – Last Claim

2.1.2 Professional/Physician Supplier Services

There are three (3) sources of data included in the professional/physician supplier services category. These include:

- Physician
- Stand Alone Facility
- DME Supplier

Currently in FFS, professional/physician suppliers are billed using Place of Service (POS) codes and HCPCS/Current Procedural Terminology (CPT) codes. Additionally, the Medicare Administrative Contractor (MAC) assigns the Type of Service (TOS) indicator based on the submitted claims data for the POS and HCPCS/CPT data elements. Professional and physician encounter data collected by MAOs and other entities will also be processed according to these FFS methodologies. Therefore, MAOs and other entities are required to submit POS and HCPCS/CPT codes for all professional and physician encounter data claims and the Encounter Data Processing System Contractor (EDPSC) will assign the appropriate TOS.

Table 2C provides a list of sources of data for encounter data professional services.

TABLE 2C – PROFESSIONAL/PHYSICIAN SUPPLIER SERVICES

ENCOUNTER DATA PROFESSIONAL/PHYSICIAN SUPPLIER SERVICES
Ambulatory Surgical Center (Ancillary Services)
Ambulance
Clinical Laboratory Non-Inpatient
Physicians/Professional
Durable Medical Equipment
Durable Medical Equipment Supplier

2.1.2.1 POS Codes

POS codes are two (2) digit codes used on professional encounter data claims to identify the setting in which a service was provided. This code set is required for use in transmitting electronic health care claims according to national standards establish by HIPAA. The ASC X12N 837 Professional (837-P) is the standard for transmitting health care claims electronically, and its implementation guide requires the use of POS codes from the National POS code set which is currently maintained by CMS.

🕮 **National POS Code Set**
http://www.findacode.com/cms1500-claim-form/cms1500-place-of-service-codes.html

Table 2D provides POS codes from the National POS code set.

TABLE 2D – POS CODES

POS CODE	POS NAME	POS DEFINITION
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). Note that for the purposes of receiving durable medical equipment (DME), a homeless shelter is considered the beneficiary's home.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.

TABLE 2D – POS CODES (CONTINUED)

POS CODE	POS NAME	POS DEFINITION
08	Tribal 638 Provider-Based Facility	08 Tribal 638 Provider-Based Facility (January 1, 2003) A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. Special Considerations for Prison/Correctional Facility Settings (Code 09). The addition of code 09 to the POS code set and Medicare claims processing reflects Medicare's compliance with HIPAA laws and regulations.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

TABLE 2D – POS CODES (CONTINUED)

POS CODE	POS NAME	POS DEFINITION
23	Emergency Room-Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance—Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

TABLE 2D – POS CODES (CONTINUED)

POS CODE	POS NAME	POS DEFINITION
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

TABLE 2D – POS CODES (CONTINUED)

POS CODE	POS NAME	POS DEFINITION
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

2.1.2.2 HCPCS Codes

The use of standardized coding systems is essential in the collection of encounter data to ensure that claims data are processed consistently. Healthcare Common Procedure Coding System (HCPCS) is divided into two primary sub-systems, referred to as Level I and Level II. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures as furnished by physicians and other health care professionals. CPT codes consist of five (5) numeric digits. The CPT coding system is maintained by the American Medical Association (AMA) and is updated and published annually.

Level II HCPCS are used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II HCPCS are alphanumeric codes consisting of a single alphabetical letter followed by four (4) numeric digits.

Prior to December 31, 2003, Level III HCPCS were developed and used by Medicaid State Agencies, Medicare contractors, and private insurers in their local areas of jurisdiction. Within the realm of Medicare, these codes came to be known as "local codes" and were used to identify a service for which no Level I or Level II code is available, instead of using a "miscellaneous" or "not otherwise classified" code. The use of local codes has been discontinued since December 31, 2003 and will not be accepted for encounter data collection.

🕮 **For questions on the use of HCPCS codes:**
http://www.cms.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp#TopOfPage

2.1.2.3 TOS Codes

To submit encounter data for professional services, NPI, POS, and HCPCS codes are submitted on the encounter data claim, and then the EDPSC assigns the TOS codes. The processing contractor will use the following list in Table 2E to assign the proper TOS code. Some procedures may have more than one applicable TOS indicator. An all-inclusive list of the POS and TOS coding sets, as well as, the HCPCS range mappings is located within Chapter 26 (sections 10.5 through 10.7) of the Medicare FFS Claims Processing Manual.

Claims Processing Manual, Chapter 26, Section 10.5 – 10.7
http://www.cms.gov/manuals/downloads/clm104c26.pdf

Table 2E provides the full list of TOS codes currently in use.

TABLE 2E – TOS CODES

TOS	DESCRIPTOR	DEFINITION
0	Whole Blood	The term whole blood means human blood from which none of the liquid or cellular components have been removed. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood. https://www.cms.gov/transmittals/downloads/R18GI.pdf Please note that most hospitals obtain blood or blood products from community blood banks that charge only for processing and storage, rather than for the blood itself. http://www.cms.gov/manuals/downloads/clm104c04.pdf
1	Medical Care	"Medical care" refers to the practice of medicine as consistent with State laws and regulations. https://www.cms.gov/transmittals/downloads/R15SOMA.pdf The term "medical care" means amounts paid— (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, (B) for transportation primarily for and essential to medical care, (C) for qualified long-term care services, or (D) for insurance covering medical care https://www.cms.gov/smdl/downloads/US%20Code%20Title%2026A1BVII.pdf
2	Surgery	General surgeons increasingly provide care through the use of minimally invasive and endoscopic techniques. Many general surgeons also possess expertise in transplantation surgery, plastic surgery and cardiothoracic surgery. http://www.wpc-edi.com/content/view/793/1 The practice of treating diseases, injuries, or deformities by manual or operative procedures. www.dictionary.com
3	Consultation	A consultation service is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The intent of a consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge. http://www.cms.gov/transmittals/downloads/R788CP.pdf (Effective January 1, 2010, the consultation codes are no longer recognized for Medicare part B payment.) http://www.cms.gov/manuals/downloads/clm104c12.pdf
4	Diagnostic Radiology	Utilization of x-rays, radionuclides, ultrasound and electromagnetic radiation to diagnose and treat disease. http://www.wpc-edi.com/content/view/793/1 or http://www.abms.org/Who_We_Help/Consumers/About_Physician_Specialties/radiology.aspx

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
5	Diagnostic Laboratory	Diagnostic Laboratory Services include diagnostic X-ray, laboratory, and other diagnostic tests, including materials and the services of technicians. A diagnostic laboratory test is considered a laboratory service for billing purposes, regardless of whether it is performed in a physician's office, by an independent laboratory, by a hospital laboratory for its outpatients or non-patients, in a rural health clinic, or in an HMO or Health Care Prepayment Plan (HCPP) for a patient who is not a member. When a hospital laboratory performs laboratory tests for nonhospital patients, the laboratory is functioning as an independent laboratory. A clinical diagnostic laboratory "service" is synonymous with "test". http://www.cms.gov/manuals/downloads/clm104c16.pdf
6	Therapeutic Radiology	Therapeutic Radiological Physics deals with (1) physical aspects of the therapeutic applications of x-rays, gamma rays, electron and other charged particle beams, neutrons, and radiations from sealed radionuclide sources; and (2) the equipment associated with their production and use, including radiation safety. http://www.abms.org/Who_We_Help/Consumers/About_Physician_Specialties/radiology.aspx
7	Anesthesia	Drugs that a person is given before surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse. (http://www.cms.gov/apps/glossary/search.asp?Term=anesthesia&Language=English)
8	Assistant at Surgery	Carriers may not pay assistants at surgery for surgical procedures in which a physician is used as an assistant at surgery in fewer than five percent of the cases for that procedure nationally. This is determined through manual reviews. (https://www.cms.gov/manuals/downloads/clm104c12.pdf)
9	Other Medical Items or Services	The following medical items, supplies, and services furnished to inpatients are covered under Part A: • Laboratory services (excluding anatomic pathology services and certain clinical pathology services); • Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips; • Radiology services including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital, or radiology clinic; • Total parenteral nutrition (TPN) services; and • Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient. The hospital must include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. It must not show them separately under revenue code 0540. EXCEPTIONS: pneumococcal vaccine, ambulance service, Part B inpatient services, and anesthetist services "incident to" physician services. https://www.cms.gov/manuals/downloads/clm104c03.pdf

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
A	Used DME	DME (Durable Medical Equipment) is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Used equipment is considered routinely purchased equipment and is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator). However, if a beneficiary rented a piece of brand new equipment and subsequently purchased it, the payment amount for the purchase should be high enough so that the total combined rental and purchase amounts at least equal the fee schedule for the purchase of comparable new equipment. The payment amount may be established in this manner only to the extent it does not exceed the actual charge made for the purchase. https://www.cms.gov/manuals/downloads/clm104c20.pdf Durable Medical Products (DME) - Expenditures in this category represent retail sales of items such as contact lenses, eyeglasses and other ophthalmic products, surgical and orthopedic products, medical equipment rental, oxygen and hearing aids. Durable products generally have a useful life of over three years whereas non-durable products last less than three years. Expenditures for Durable Medical Equipment include payments for the retail purchase or rental of DME from Medicare Part B suppliers and payments for oxygen and oxygen-related equipment (Note: these do not include expenditures associated with a provider's purchase or rental of items, such as for a hospital or physician's office). (*https://www.cms.gov/NationalHealthExpendData/downloads/dsm-09.pdf*)
B	High Risk Screening Mammography	For asymptomatic women aged 40 or over whose mothers or sisters have had the disease. A screening mammography is a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure. A screening mammography has limitations as it must be, at a minimum a two-view exposure (cranio-caudal and a medial lateral oblique view) of each breast. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=BAAAgAAAAAAA& High Risk Categories include: a personal history of breast cancer, a mother, sister, or daughter who has breast Cancer, not given birth prior to age 30, and a personal history of biopsy-proven benign breast disease. https://www.cms.gov/Transmittals/Downloads/R426CP.pdf

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
C	Low Risk Screening Mammography	For asymptomatic women aged 50 and over. A screening mammography is a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure. A screening mammography has limitations as it must be, at a minimum a two-view exposure (cranio-caudal and a medial lateral oblique view) of each breast. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=BAAAgAAAAAAA&
D	Ambulance	An emergency vehicle used for transporting patients to a health care facility after injury or illness. Types of ambulances used in the United States include ground (surface) ambulance, rotor-wing (helicopter), and fixed-wing aircraft (airplane). http://www.wpc-edi.com/content/view/793/1 A land, air, or water vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured. (http://www.cms.gov/apps/glossary/search.asp?Term=ambulance&Language=English)
E	Enteral/ Parenteral Nutrients/ Supplies	Parenteral nutrients are covered under the prosthetic benefit. They are available to beneficiaries who cannot absorb nutrition through their intestinal tract. Parenteral nutrition is administered intravenously and is regulated as a drug by the FDA. https://www.cms.gov/MLNMattersArticles/downloads/SE0570.pdf There are patients who, because of chronic illness or trauma, cannot be sustained through oral feeding. These people must rely on either enteral or parenteral nutritional therapy, depending upon the particular nature of their medical condition. Daily parenteral nutrition is considered reasonable and necessary for a patient with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition. Enteral nutrition is considered reasonable and necessary for a patient with a functioning gastrointestinal tract who, due to pathology to, or nonfunction of, the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=242&ncdver=1&bc=BAAAgAAAAAAA&
F	Ambulatory Surgical Center (Facility Usage for Surgical Services)	A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night. (http://www.cms.gov/apps/glossary/search.asp?Term=ambulatory+surgical+center&Language=English)
G	Immunosuppressive Drugs	Transplant drugs used to reduce the risk of rejecting the new kidney after transplant. Transplant patients will need to take these drugs for the rest of their lives. (http://www.cms.gov/apps/glossary/search.asp?Term=immunosuppressive+drugs&Language=English&SubmitTermSrch=Search)

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
H	Hospice	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance). (http://www.cms.gov/apps/glossary/search.asp?Term=anesthesia&Language=English)
I		
J	Diabetic Shoes	Coverage of therapeutic shoes (depth or custom-molded) along with inserts for individuals with diabetes is available as of May 1, 1993. These diabetic shoes are covered if the requirements as specified in this section concerning certification and prescription are fulfilled. In addition, this benefit provides for a pair of diabetic shoes even if only one foot suffers from diabetic foot disease. Each shoe is equally equipped so that the affected limb, as well as the remaining limb, is protected. Claims for therapeutic shoes for diabetics are processed by the Durable Medical Equipment Regional Carriers (DMERCs). The following items may be covered under the diabetic shoe benefit: Custom-Molded Shoes, Depth Shoes, and Inserts. Therapeutic shoes for diabetics are not DME and are not considered DME nor orthotics, but a separate category of coverage under Medicare Part B. *Medicare Benefits Policy Manual*, Chapter 15, Section 140, https://www.cms.gov/manuals/Downloads/bp102c15.pdf
K	Hearing Items and Services	Hearing and balance assessment services are generally covered as "other diagnostic tests" under section 1861(s) (3) of the Social Security Act. Hearing and balance assessment services furnished to an outpatient of a hospital are covered as "diagnostic services" under section 1861(s) (2) (C)... Treatment related to hearing may be covered under the speech-language pathology benefit when the services are provided by speech-language pathologists. Treatment related to balance (e.g., services described by "always therapy" codes 97001-97004, 97110, 97112, 97116, and 97750) may be covered under the physical therapy or occupational therapy benefit when the services are provided by therapists or their assistants, where appropriate.... Medicare does not cover hearing aids....*Medicare Benefits Policy Manual*, Chapter 15 https://www.cms.gov/manuals/Downloads/bp102c15.pdf
L	ESRD Supplies	Home dialysis supplies include all durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis. Supplies include (but are not limited to): dialyzers, forceps, sphygmomanometer with cuff and stethoscope, scales, scissors, syringes, alcohol wipes, sterile drapes, needles, topical anesthetics, and rubber gloves. Supplies necessary to perform all modalities of home dialysis are covered, including such items as alcohol wipes, sterile drapes, gloves, telfa pads, bandages, etc. Instruments and nonmedical supplies, such as scales, stopwatches, and blood pressure apparatus are covered, regardless of whether provided separately or as part of a start-up kit. The beneficiary has the option of having the facility provide the supplies under the composite rate or of purchasing them directly from a supplier. All supplies required to perform CAPD are covered. These include start-up durable supplies (whether or not they are part of a start-up kit) such as weight scales, sphygmomanometer, I.V. stand, and dialysate heaters; and consumable and disposable supplies such as dialysate, tubing, and gauze pads. https://www.cms.gov/manuals/Downloads/bp102c11.pdf

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
M	Monthly Capitation Payment for Dialysis	Medicare pays physician's services furnished in connection with dialysis sessions for outpatients who are on maintenance dialysis in a facility or at home by the monthly capitation payment method or the initial method. (See the Medicare Claims Processing Manual, Chapter 8, "Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims," for payment instructions.) The professional component of the procedure is included in the monthly capitation payment (MCP). The professional component is denied if billed by the MCP physician. Medically necessary services that are included or bundled into the MCP (e.g., test interpretations) are separately payable when furnished by physicians other than the MCP physician. The MCP physician is identified by the performing provider number that billed MCP services identified by the HCPCS code 90995. https://www.cms.gov/manuals/Downloads/bp102c11.pdf
N	Kidney Donor	The [kidney] donor is covered for an unlimited number of days of care in connection with the kidney removal operation. Days of inpatient hospital care used by the donor should not be charged against either party's utilization record. However, the program's assumption of liability is limited to those donor expenses that are incurred directly in connection with the kidney donation. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly attributable to the surgery. Coverage of kidney donor services includes postoperative recovery services directly related to the kidney donation. The period of postoperative recovery ceases when the donor no longer exhibits symptoms related to the kidney donation. Claims for services rendered more than three months after donation surgery will be reviewed carefully. However, follow-up examinations may be covered up to six months after the donation to monitor for possible complications. The requirement that additional payment cannot be made for services included in the donor nephrectomy charge still applies. Note that services furnished to kidney donors are covered under the account of the recipient. Expenses for physicians' services to the donor are treated as though the recipient had incurred them. If the recipient dies, donor expenses actually incurred after death of the recipient will be treated as incurred before the death of the recipient. https://www.cms.gov/manuals/Downloads/bp102c11.pdf

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
P	Lump Sum Purchase of DME, Prosthetics, Orthotics	DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Contractors pay on a lump-sum, as needed basis based on their individual consideration for each item. https://www.cms.gov/manuals/downloads/clm104c20.pdf DME - Expenditures in this category represent retail sales of items such as contact lenses, eyeglasses and other ophthalmic products, surgical and orthopedic products, medical equipment rental, oxygen and hearing aids. Durable products generally have a useful life of over three years whereas non-durable products last less than three years. Expenditures for Durable Medical Equipment include payments for the retail purchase or rental of DME from Medicare Part B suppliers and payments for oxygen and oxygen-related equipment (Note: these do not include expenditures associated with a provider's purchase or rental of items, such as for a hospital or physician's office). (*https://www.cms.gov/NationalHealthExpendData/downloads/dsm-09.pdf*)
Q	Vision Items or Services	Broad category grouping of services or products related to the human eye and visual systems. http://www.wpc-edi.com/content/view/793/1
R	Rental of DME	DME (Durable Medical Equipment) is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. For rental DME, contractors pay the fee schedule amounts on a rental basis until medical necessity ends. https://www.cms.gov/manuals/downloads/clm104c20.pdf Durable Medical Products (DME) - Expenditures in this category represent retail sales of items such as contact lenses, eyeglasses and other ophthalmic products, surgical and orthopedic products, medical equipment rental, oxygen and hearing aids. Durable products generally have a useful life of over three years whereas non-durable products last less than three years. Expenditures for Durable Medical Equipment include payments for the retail purchase or rental of DME from Medicare Part B suppliers and payments for oxygen and oxygen-related equipment (Note: these do not include expenditures associated with a provider's purchase or rental of items, such as for a hospital or physician's office). (*https://www.cms.gov/NationalHealthExpendData/downloads/dsm-09.pdf*)

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
S	Surgical Dressings or Other Medical Supplies	Under Part B, coverage for surgical dressings is limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions on the skin or on openings to the skin required as the result of surgical procedures. (Items such as Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are used as secondary coverings and therefore are not covered as surgical dressings.) Although surgical dressings usually are covered as "incident to" a physician's service in a physician's office setting, in the ASC setting, such dressings are included in the facility's services. However, surgical dressings may be reapplied later by others, including the patient or a member of his family. When surgical dressings are obtained by the patient on a physician's order from a supplier, e.g., a drugstore, the surgical dressing is covered under Part B. The same policy applies in the case of dressings obtained by the patient on a physician's order following surgery in an ASC; the dressings are covered and paid as a Part B service by the DMERC. Similarly, "other supplies, splints, and casts" include only those furnished by the ASC at the time of the surgery. Additional covered supplies and materials furnished later are generally furnished as "incident to" a physician's service, not as an ASC facility service. The term "supplies" includes those required for both the patient and ASC personnel, e.g., gowns, masks, drapes, hoses, and scalpels, whether disposable or reusable. Payment for these is included in the rate for the surgical procedure. https://www.cms.gov/manuals/downloads/clm104c14.pdf
T	Outpatient Mental Health Treatment Limitation	Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. This limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out. (https://www.cms.gov/manuals/downloads/clm104c12.pdf)
U	Occupational Therapy	An occupational therapist provides interventions based on evaluation and which emphasize the therapeutic use of everyday life activities (i.e., occupations) with individuals or groups for the purpose of facilitating participation in roles and situations and in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and are provided to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapists address the physical, cognitive, psychosocial, sensory, and other aspects of occupational performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life. http://www.wpc-edi.com/content/view/793/1

TABLE 2E – TOS CODES (CONTINUED)

TOS	DESCRIPTOR	DEFINITION
V	Pneumococcal /Flu Vaccine	Separate vaccinations to prevent influenza and pneumococcal disease.
W	Physical Therapy	Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage. (http://www.cms.gov/apps/glossary/search.asp?Term=physical+therapy&Language=English)
X		
Y	Second opinion on elective surgery	(obsolete 1/97)
Z	Third opinion on elective surgery	(obsolete 1/97)

2.1.2.4 Dental

Currently, Medicare covers dental services that are an integral part of either a covered procedure (i.e., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare also covers oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be processed in the Encounter Data Institutional Processing and Pricing (EDIPPS) sub-system if performed by a dentist on the hospital's staff or under the Encounter Data Professional Processing and Pricing (EDPPPS) sub-system if performed by a physician, and thus populated on the 837-I and 837-P, respectively.

All claims meeting the definition of a covered dental service will be stored and priced in the Encounter Operational Data Store (EODS).

Example

Mrs. Smith is admitted into Hope Hospital. While she's in the hospital, she undergoes jaw reconstruction surgery. Hope Hospital submits the claim to Live Well Health Plan. When submitting encounter data, Live Well Health Plan will populate and submit the 837-I with the applicable fields and values.

2.1.2.5 Vision

Vision data covered under Medicare and submitted on the applicable 837-I or 837-P are those services that must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements, according to the Medicare Benefit Policy Manual, Chapter 16 "General Exclusions from Coverage." MAOs and other entities must use the 837-I or 837-P formats to submit vision encounter data as necessary.

Medicare Benefit Policy Manual, Chapter 16
http://www.cms.gov/manuals/Downloads/bp102c16.pdf

Example

Mrs. Smith underwent cataract surgery and purchased glasses from Dr. Jones. She chooses to purchase the deluxe frame, which is only partially covered by Medicare. Dr. Jones submits the claim to Live Well Health Plan, which identifies the Medicare allowable coverage as well as Mrs. Smith's out-of-pocket expenses for the upgrade to the deluxe frame. When submitting encounter data, Live Well Health Plan will submit the 837-P with the applicable fields and values.

2.1.3 Durable Medical Equipment

A provider of services means a hospital, CAH, skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency or a hospice. A supplier is a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare. A provider of supplies (POS) that enrolls as a DME supplier is considered a supplier for DMEPOS billing. These DEMPOS Suppliers must enroll in the Medicare program using the Form CMS-855S to be eligible to receive payment for covered services provided to Medicare beneficiaries.

DME Supplier Guidelines
http://www.cms.gov/MedicareProviderSupEnroll/Downloads/DMEPOSSupplierStandards.pdf

2.1.3.1 Physician Durable Medical Equipment (DME) Services

If the DME service is incident to a service from a health care provider (physician/facility) it should be submitted on the applicable 837-I or 837-P. The DME product would be listed as an item provided by the institution (hospital) or the professional (physician) as part of the service delivered. Claims for implanted DME, implanted prosthetic devices, replacement parts, accessories, and supplies for the implanted DME when considered "incident to" a health care provider are part of the provider/physician's encounter.

Prosthetic devices are medical or other health services and are devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. Replacements or repairs of such DME devices when considered furnished incident to physicians' services are part of the provider/physician's encounter.

Prosthetic and orthotic devices (leg, arm, back, and neck braces, and artificial legs, arms, and eyes) are medical or other health service and when considered furnished incident to a physicians' services are part of the provider/physician's encounter.

DME provider determination is made by the associated HCPCS codes, which describe categories of services delivered. To determine which services are incident to physician services, CMS maintains and updates a table of services by HCPCS codes that indicates the HCPCS codes associated to the service. CMS updates this list as needed by a One-Time Special Notification.

Medicare DMEPOS Specific Program Transmittals
http://www.cms.gov/DMEPOSFeeSched/DMEPOSTrans/list.asp

Medicare Claims Processing Manual, Chapter 20
http://www.cms.gov/manuals/downloads/clm104c20.pdf

Table 2F provides examples of DME encounter data that are incident to physician services.

TABLE 2F –DME ENCOUNTERS INCIDENT TO PHYSICIAN SERVICES

HCPCS CODE	DESCRIPTION
V2787 – V2788	Intraocular lens - inserted when cataract surgery is performed. This claim is processed through the CEM because the lens was used by the surgeon. This is not an item a beneficiary can obtained directly from a DME supplier.
A6010 – A6024	Surgical dressings – when used by a physician in his/her office, the encounter is recorded by the physician's office and would be processed by the Professional claims processing system which uses the CEM. If, however, the beneficiary goes to a DME Supplier and buys a dressing to use later, the claim would be submitted by the Supplier to the DME claims processor which uses the CEDI.
A7041	Chest drainage – always used by a doctor. These cannot be purchased from a DME supplier and taken home, thus all claims will be processed through the CEM.
E0615	Implantable cardiac event recorder – must be placed by a physician. These cannot be purchased at a drug store, taken home, and implanted; therefore, the claim will be processed through the CEM.

Example

Jane needs knee surgery. Dr. Waters provides Jane with crutches prior to the surgery so they will be available following surgery. Since the crutches were incident to the physician visit, Care4U Plan will submit the claim on an 837-P to be processed by the MCS, which uses the Common Edits and Enhancements Module (CEM) to prepare the claim for pricing.

2.1.3.2 DMEPOS

Claims meeting the definition of a DME supply must be submitted beginning May 2012 for dates of service January 1, 2012 forward. DME supplies submitted on a separate 837-P are medical or other health services and equipment that meet the following definitions:

- Can withstand repeated use.

- Primarily and customarily used to serve a medical purpose.
- Generally is not useful to a person in the absence of an illness or injury.
- Appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

Parenteral and enteral nutrition, and related accessories and supplies, are covered under the Medicare program as a prosthetic device. All Parenteral and Enteral (PEN) services furnished are considered as a DME supplier claim. If a provider provides PEN items, it must qualify for, and receive a supplier number and bill as a supplier.

DMEPOS suppliers are required to obtain an NPI for every location. The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the supplier may have. The requirement for Medicare DME suppliers to obtain NPIs for every practice location applies also to those Medicare DME suppliers who do not send electronic claims to Medicare. Federal regulations require the unique enumeration of every location of a Medicare DME supplier regardless of how claims are submitted.

DME supplier determination is made by the associated HCPCS codes, which describe categories of services. To determine which services are DME supplier services, CMS maintains and updates a table of services by HCPCS code that indicates the HCPCS codes associated to the service. CMS updates this list by a One-Time Special Notification as needed. Table 2G provides DME supplier services.

TABLE 2G – DME SUPPLIER ENCOUNTERS

HCPCS CODE	DESCRIPTION
A4490 – A4510	Surgical stockings
A4610 – A4613	Oxygen equipment batteries and supplies
A4651 – A4932	ESRD supplies
A5500 – A5513	Therapeutic Shoes
A9274 – A9278	Glucose Monitoring

Example

Sally is a member of Happy Heart Plan and went to MedStore (an approved Medicare supplier) to purchase a wheelchair to use in her home on May 27, 2012. MedStore sent a claim to Happy Heart Plan for the sale of Sally's wheelchair. Happy Heart Plan adjudicates the claim with an accepted disposition and sends it for risk adjustment processing and payment. Happy Heart Plan will submit a separate 837-P with the DME supplier information so it can process through the Common Electronic Data Interchange (CEDI).

2.1.4 Drug and Biological Data

Drugs and biologicals are covered by Medicare Part A and Medicare Part B contingent on meeting the coverage criteria. When submitting encounter data, it is important to distinguish between Medicare Part A or Medicare Part B drug and biological data, and Medicare Part D prescription drug event (PDE) data. MAOs and other entities will need to submit data on drugs or biologicals that meet the Medicare Part A or B coverage requirements so that CMS can estimate the cost of these drugs and biologicals.

With the implementation of risk adjusted payment methodologies for MAOs and other entities, accurate submission and tracking of EDS drug data and PDE data are critical. FFS claims and EDS encounter data will be the basis of the risk scores that CMS calculates for each member (for both Part C and Part D payments) and will support risk adjustment model development. PDE data drives the retroactive reconciliation of Part D payments as well as ongoing benefit/adjudication levels for members.

2.1.4.1 EDS Drug Data

Medicare bundled payments made to hospitals and SNFs generally cover all drugs provided during an inpatient stay. Under the hospice benefit, beneficiaries receive drugs that are medically necessary for symptom control or for pain relief. Traditional Medicare does not cover most outpatient prescription drugs. There are five (5) major categories of outpatient prescription drugs covered by Medicare Part B:

- Drugs billed by physicians and typically provided in physicians' offices (such as chemotherapy drugs);
- Drugs billed by pharmacy suppliers and administered through DME such as respiratory drugs given through a nebulizer;
- Drugs billed by pharmacy suppliers and self-administered by the patient (such as immunosuppressive drugs and some oral anti-cancer drugs);
- Separately billable drugs provided in Hospital Outpatient Departments; and
- Separately billable ESRD drugs such as erythropoietin (EPO).

Other drug categories covered under Part B include:

- Drugs not self-administered and furnished incidental to a physician's service, such as prostrate cancer drugs.
- Certain cancer and antinausea drugs available in pill form.
- Blood clotting factor.
- Immunosuppressive drugs used following organ transplants.
- Drugs or biological administered by infusion or injection.

Despite the limitation on coverage for drugs under Part B, the law specifically authorizes coverage for certain types of drugs. Table 2H provides examples of EDS drug data included on an 837-P.

TABLE 2H – EDS DRUG DATA

DRUG TYPE	EXPLANATION
DME Supply Drugs	Drugs that require administration by the use of a piece of covered DME (nebulizer, external or implantable pump). DME drugs are not explicitly covered; they are covered as a supply necessary for the DME to perform its function.
Immunosuppressive Drugs	Drugs used in immunosuppressive therapy (e.g., cyclosporine) for a beneficiary who has received a Medicare covered organ transplant.
Hemophilia clotting factors	Hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors.
Oral Anti-cancer drugs	Drugs taken orally during cancer chemotherapy provided they have the same active ingredients and are used for the same indications as chemotherapy drugs that would be covered if they were not self-administered and were administered as incident to a physician's service.
Oral Anti-emetic drugs	Oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen as a full therapeutic replacement for an intravenous anti-emetic drug within 48 hours of chemotherapy administration.
Pneumococcal vaccine	The vaccine and its administration to a beneficiary if ordered by a physician.
Hepatitis B vaccine	The vaccine and its administration to a beneficiary who is at high risk or intermediate risk of contracting Hepatitis B.
Influenza vaccine	The vaccine and its administration when furnished in compliance with any applicable state law.
Antigens	Prepared by a physician (usually an allergist) for a specific patient. The physician or physician's nurse generally administers them in the physician's office. In some cases, the physician prepares antigens and furnishes them to a patient who has been taught to self-administer them at home.
Erythropoietin (EPO)	Treatment for anemia for persons with chronic renal failure who are on dialysis.
Intravenous Immune Globulin (IVIG) Provided in the Home	Coverage is provided if a physician determines that the administration of IVIG in the patient's home is medically appropriate.
Drugs furnished incident to a physician's service	These are injectable or intravenous drugs that are administered predominately by a physician or under a physician's direct supervision as incident to a physician's service.
Drugs covered as supplies or integral to a procedure	Some drugs are covered as supplies that are an integral part of a procedure, which is a diagnostic or therapeutic service, including radiopharmaceuticals (both diagnostic and therapeutic) and low osmolar contrast media. Another example of a drug covered under the integral to a procedure provision includes eye drops administered before cataract surgery.
Blood	Medicare does make separate payment for blood and the FDA regulates blood products and these products as biological agents.

MAOs and other entities must submit Part B drugs that are submitted on medical claims to EDS. Pharmacy claims processed by a Pharmacy Benefit Manager (PBM) are considered to be PDE data and should not be submitted to EDS.

Example

Pat goes to Dr. Johnson because she wants to obtain a flu vaccine. Dr. Johnson gives Pat a flu vaccine. This drug should be submitted through the 837-P in conjunction with the physician's charge for either the office visit or the administration of the flu vaccine.

2.1.4.2 PDE Data

Every time a beneficiary fills a prescription under Medicare Part D, a prescription drug plan sponsor must submit a summary record, called PDE data, to CMS. The PDE data are not the same as individual drug claim transactions. The PDE record contains prescription drug cost and payment data that enables CMS to make payments to plans and otherwise administer the Part D benefit. A Part D covered drug is available only by prescription, is a drug approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically acceptable indication. A covered Part D drug includes prescription drugs, biological products, insulin, and vaccines listed under Section 351 of the Public Health Service Act. In general, prescriptions for drugs that are filled by a pharmacy for a beneficiary enrolled in Medicare Part D will require PDE data. Encounters consisting of PDE data should not be submitted to EDS. Table 2I provides examples of PDE data.

TABLE 2I – PDE DATA

DRUG TYPE	EXAMPLES
Insulin and injection supplies	Syringes, needles, alcohol, swabs, and gauze
Vaccines	Herpes Zoster (shingles) Vaccine
Biological products	Etanercept – an injection used to treat autoimmune disorders like rheumatoid arthritis
All drugs available by prescription only and approved by the FDA, and used for a medically accepted indication not covered by Part A or Part B.	Flovent – an inhaler used to treat asthma.

Example

On May 20, 2012, Mrs. Smith is given insulin through a pump by Dr. Jones. Dr. Jones submits the data to New Day Plan. For encounter data submission, Dr. Jones will populate the 837-P with the applicable fields and values since this was incident to the physician's visit.

Although the Medicare Part D program provides beneficiaries with coverage for pharmaceutical care, Medicare Part B may also cover some of the same drugs, when furnished "incident to a physician's service" or administered using a DME, and specifically covered by statute. As a result, a drug may be covered by either Part B or Part D depending on the beneficiary's health condition or form of the drug. Table 2J details the drug categories that may have overlapping EDS drug data and PDE data.

TABLE 2J – OVERLAPPING EDS DRUG DATA AND PDE DATA

DRUG TYPE	EDS DRUG DATA	PDE DATA
Oral Anticancer and Antiemetic Drugs	If associated with cancer treatment	May cover in all other circumstances
Vaccinations	Influenza and pneumonia for all beneficiaries and Hepatitis B for medium and high risk beneficiaries. Other immunizations only if the beneficiary has been exposed to the relevant disease	Required to provide coverage for many other vaccinations
Insulin	If dispensed by a pump	If injected with a syringe

2.2 Getting Started

In preparation for encounter data implementation in January 2012, MAOs and other entities must successfully complete end-to-end testing and receive certification.

The purpose of the EDS Front-End industry testing is to validate the transmission of the X12 5010 file format. The 837-I and the 837-P transmission files will be processed by an Electronic Data Interchange (EDI) Commercial Off-the-Shelf (COTS) Translator, which will perform file structure and Implementation Guide (IG) edits and transmit acknowledgements. Valid claims data will then process through Institutional and Professional Common Edits and Enhancement Modules (CEMs) located at the front-end system. Transmission files will be processed based on format and rules using either the ANSI 837-I or 837-P 5010 format.

2.2.1 Submitter Requirements

MAOs and other entities must complete an EDI Agreement with CMS and submit that Agreement to the Customer Service and Support Center (CSSC) prior to submitting encounter data. The EDI Agreement is a contract between the MAOs and other entities or Third Party submitter and CMS attesting to the accuracy of data submitted. MAOs and other entities must also complete the Encounter Data Online Submitter Application, which upon acceptance will provide a new Submitter Identification number (EN followed by the contract ID number). Existing Risk Adjustment Processing System (RAPS) submitter IDs will remain active. File Transfer Protocol (FTP) users will have an additional mailbox established specifically for encounter data purposes. Connect:Direct (NDM) users must complete the Connect:Direct specifications found in the submitter application package.

MAOs and other entities must make special arrangements to use a Third Party submitter. If the submitter is an entity other than the MAOs and other entities, the submitter must complete the Submitter ID Application Form, and an EDI Agreement form. MAOs and other entities must complete, sign, and return the EDI Agreement for each contract number submitting data. MAOs and other entities must also complete, sign, and return a letter of authorization on company letterhead allowing the Third Party to submit on the MAOs and other entities' behalf. CMS holds the MAOs and other entities accountable for the content of submissions regardless of who submits the data.

After CSSC receives the completed package, CSSC will send an email containing the new submitter ID within five (5) business days. In addition, FTP users will receive a second email containing a password.

Test files can be submitted immediately following receipt of the Submitter ID and password. It is unnecessary to contact CSSC prior to sending test files after a user name and password has been issued.

2.2.2 Testing Requirements

MAOs and other entities are required to participate in EDS front-end and end-to-end testing. Front-end and end-to-end testing will be evaluated per Submitter ID; therefore, each Submitter ID must meet all testing requirements to receive certification.

2.2.2.1 Front-End Testing Requirements

Front-end testing will ensure MAOs and other entities' systems are structured to successfully submit encounter data using the 837-I and 837-P. Front-end test files must include valid format values. Table 2K provides examples of formatting edits that will be applied in front-end testing.

TABLE 2K – FRONT-END FORMATTING EDITS

Layout of File	Field Values
Version Numbers	Record Sequencing
Balancing	Batch Type
Batch Type to Files	Batch ID
Duplicate Batches	Numeric Fields
Date Fields	Relationship Edits

The daily submission cut-off time during testing will be at 5:00 P.M. EST. Submissions received after 5:00 P.M. EST time will be considered submitted as of the next business day. All submissions must have a minimum of 50 and maximum of 100 claims per transmission file. MAOs and other entities must include at least one (1) institutional and one (1) professional test file. The institutional test file must contain a mix of inpatient institutional and outpatient institutional encounters.

2.2.2.2 End-to-End Testing Requirements

End-to-end testing will include institutional and professional processing edits to ensure the claims submitted meet editing, processing, and pricing logic according to FFS PRICERs and fee schedules. All submissions must have a minimum of 50 and maximum of 100 claims per transmission file and include a mix of facility/institutional, professional, chart review, and adjustment claims. Complete instructions regarding end-to-end testing will be posted on the CSSC Operations website during the end-to-end test case preparation period.

2.2.2.3 Certification

MAOs and other entities will receive a certification when error reports are received demonstrating 90% of the claims submitted successfully completed end-to-end testing. Certification per Submitter ID will be dependent upon successful completion of end-to-end testing based on the requirements for the claim submitted. MAOs and other entities, as identified by Submitter IDs, will receive a certification email within two (2) business days of successful completion of end-to-end testing.

2.2.3 Connectivity

Connectivity refers to the electronic connection between the MAO or other entities and CMS. There are three (3) connectivity application options, which are displayed in Table 2L. MAOs and other entities use the electronic applications to submit encounter data to CMS and receive information in return. As CMS transitions from AT&T to Verizon for the Business Partner Network, there is no additional setup necessary for those MAOs or other entities that are currently connected for submission of RAPS and PDE data. This same connectivity can be used to submit Encounter Data. For new users, please contact Shawn McGirl at (203) 905-7331.

TABLE 2L – CONNECTIVITY APPLICATION OPTIONS

Connect:Direct (NDM)	Mainframe-to-mainframe connection
FTP	Modem-to-modem (dial-up) or lease line connection
Gentran	Two connectivity options: • Secure File Transfer Protocol (SFTP); standards based protocol through a vendor • Secure Hyper Text Transfer Protocol (HTTPS); secure web interface.

2.2.4 Production Submission

Effective January 2012, MAOs and other entities will be expected to submit institutional and professional encounters according to CMS guidelines.

2.2.4.1 Timely Filing

MAOs and other entities must submit encounter data within 13 months of the claim's dates of service. If an encounter is submitted after 13 months of the dates of service, it will be rejected. The current RAPS filing guidelines will remain the same for chart review data.

2.2.4.2 Submission Frequency

MAOs and other entities must also adhere to minimum submission frequency standards based on MAOs and other entities enrollment size and established by a tiered scale. MAOs and other entities are encouraged to submit encounter data more frequently. Table 2M provides implementation submission frequency standards.

TABLE 2M – EDS IMPLEMENTATION SUBMISSION FREQUENCY STANDARDS

NUMBER OF MEDICARE ENROLLEES	MINIMUM SUBMISSION FREQUENCY
Greater than 100,000	Weekly
50,000 – 100,000	Bi-weekly
Less than 50,000	Monthly

- The number of Medicare enrollees is based on the contract level.

2.2.4.3 File Size Limitations

Due to system limitations, the combination of all ST-SE transaction sets cannot exceed certain thresholds depending upon the connectivity method of the submitter. Gentran and FTP users cannot exceed 5,000 ST-SE transaction sets per file. NDM users cannot exceed 15,000 ST-SE transaction sets per file.

2.3 Adjudicated Claims

Following collection and review within MAOs and other entities internal claims processing system, only fully adjudicated encounter data claims with a final disposition of "accepted" or "denied" will be submitted to the EDS for processing and pricing. Table 2N defines claim disposition types that are acceptable and unacceptable for encounter data submission.

TABLE 2N – CLAIM DISPOSITIONS

TERM	DEFINITION	ACCEPTABLE FOR EDS?
Accepted	Claims deemed processable and given final disposition of "payment" within the MAOs and other entities claims processing system. Accepted claims will be submitted to the EDS.	YES
Finalized	Adjudicated claims that have reached a final disposition in the MAO or other entity's claims processing system. In a capitated arrangement, this is still considered a finalized claim.	YES
Denied	Claims deemed processable and given a final disposition of "no payment" within the MAOs and other entities claims processing system. Denied claims have appeal rights. Denied claims will be submitted to the EDS.	YES
Pending	Claims that have been processed but have not been released for payment within the MAOs and other entities claims processing system. These claims are not acceptable for encounter data submission.	NO
Rejected	Claims deemed unprocessable at any stage in the MAOs and other entities adjudication process. Rejected claims have no appeal rights, but may be corrected and submitted as a new claim. Rejected claims are not acceptable for encounter data submission.	NO

- MAOs or other entities should submit adjudicated claims if at least one (1) line on the claim was accepted. If a claim is denied in the MAO or other entity's adjudication system, MAOs and other entities should populate the NTE field (free-form note field) in Loop 2300 (Claim Information) to identify the denial reason.

2.4 File Structure

CMS will collect and price MAOs and other entities encounter data for the purpose of recalibrating the CMS-Hierarchical Condition Category (HCC) model based on MAOs and other entities utilization. Encounter data must be collected from MAOs and other entities or Third Party submitters on the ANSI 837X V5010.

2.4.1 Resources

Several resources are currently available to guide MAOs and other entities in building the 837-I, 837-P, and 276/277 file. The framework for MAOs and other entities to build an EDS 5010 file is the EDI TR3, commonly referred to as the Washington Publishing Company (WPC).

2.4.1.1 WPC

The WPC has a grouping of documents that address the 837-I and 837-P. It provides rules that MAOs and other entities must support in order to submit encounter data. It is intended to be compliant with the data standards mandated by HIPAA.

WPC Website
www.wpc-edi.com

2.4.1.2 CMS Edits Spreadsheet

CMS provides X12 5010 file format technical edit spreadsheets for the 837-I and 837-P. The edits included in the spreadsheet are intended to clarify the WPC instructions or add Medicare specific requirements. Table 2O provides information included on the 837-I and 837-P edits spreadsheet.

TABLE 2O – EDITS SPREADSHEET ATTRIBUTES

Spreadsheet Attributes
837 Edit Reference
Segment or Element Description
Segment or Element ID
Usage Requirement
Minimum/Maximum Usage
Loop
Loop Repeat
5010 Values
Accept/Reject Status
Proposed 5010 Edits
Acknowledgement Report Type
Disposition/Error Code
Miscellaneous Notes

CMS Edits Spreadsheet
http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

In order to pass COTS EDI translator and CEM level edits and move forward to be processed, priced, and stored in the EDS, the submitted file must be populated by reconciling the WPC, CMS edit spreadsheet, and encounter data specific field population within the WPC TR3. The CMS edit spreadsheet provides a list of proposed EDS edits. However, there may be instances that the CMS edit spreadsheet differs from the EDS specific guidance.

2.4.2 Roles

According to the WPC Business Usage, the 837-I and 837-P are used to submit health care claim billing and encounter information from providers of health care services to payers, either directly or by intermediary billing services, and claims clearinghouses. Table 2P provides definitions of roles within the ANSI ASC X12 Standard TR3 for encounter data submission.

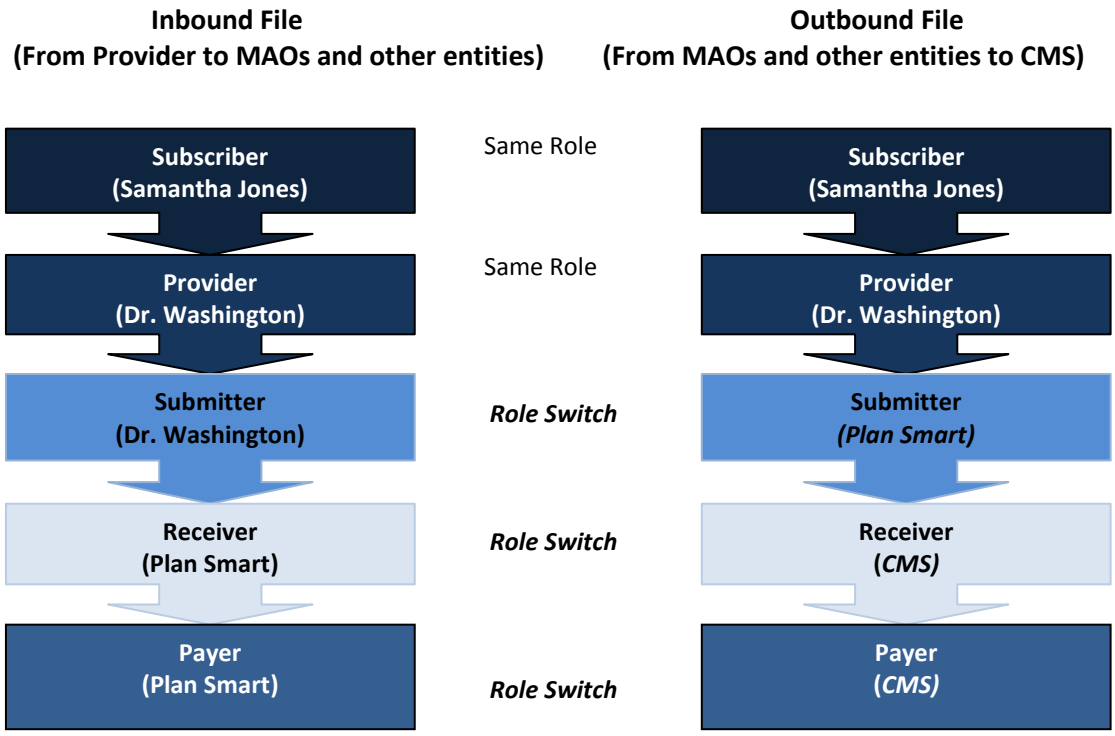
TABLE 2P – WPC ROLES

ROLE	EDS DESCRIPTION
Destination Payer	The Entity responsible for processing and pricing the adjudicated claim. (CMS)
Payer	The MAO and/or other entity is considered the payer only when populating the payer paid amounts and payer paid amount associated fields.
Submitter	The entity that owns the Submitter ID associated with the health care data being submitted. (MAO or other entities)
Subscriber	The person whose name is listed in the health insurance policy, or who has a unique member identification number. In some cases, the subscriber is the person receiving services.
Billing Provider	A provider is either a person or organizational entity who has either provided or participated in some aspect of the service described in the transaction.
Receiver	Any entity responsible for the receipt of the transaction. (CMS)

When submitting encounter data, MAOs and other entities must consider their role when preparing the inbound (from Provider to MAOs and other entities) 5010 X12 837-I or 837-P file to the outbound (from MAOs and other entities or Third Party submitter to CMS) 5010 X12 837-I or 837-P file. In the outbound file, MAOs and other entities are considered to have several functions within the WPC. For encounter data purposes, MAOs and other entities are the Submitter, and should place their information in the Submitter Loop ID-2000A. Loop ID-2010BB (Payer Information) should be changed to reflect CMS as the destination payer.

Figure 2B illustrates the reformatted outbound (from MAOs and other entities to CMS) X12 Standard 5010 837X file.

Figure 2B – Inbound (Provider to MAOs and other entities) vs. Outbound (MAOs and other entities to CMS) 5010 File



Example

In Figure 2B, Plan Smart's inbound file will indicate Samantha Jones received health care services from Dr. Washington. Dr. Washington is the billing provider that submitted the claim. Plan Smart received and paid the claim. When Plan Smart submits the claim to the EDS, Samantha Jones and Dr. Washington's roles do not change. However, the MAOs and other entities is now the submitter and CMS is the receiver and payer.

- CMS is considered the payer only as it relates to roles within the WPC. CMS, at the claim level, is processing, pricing, and storing the encounter data and is not providing payment to the MAOs or other entities.

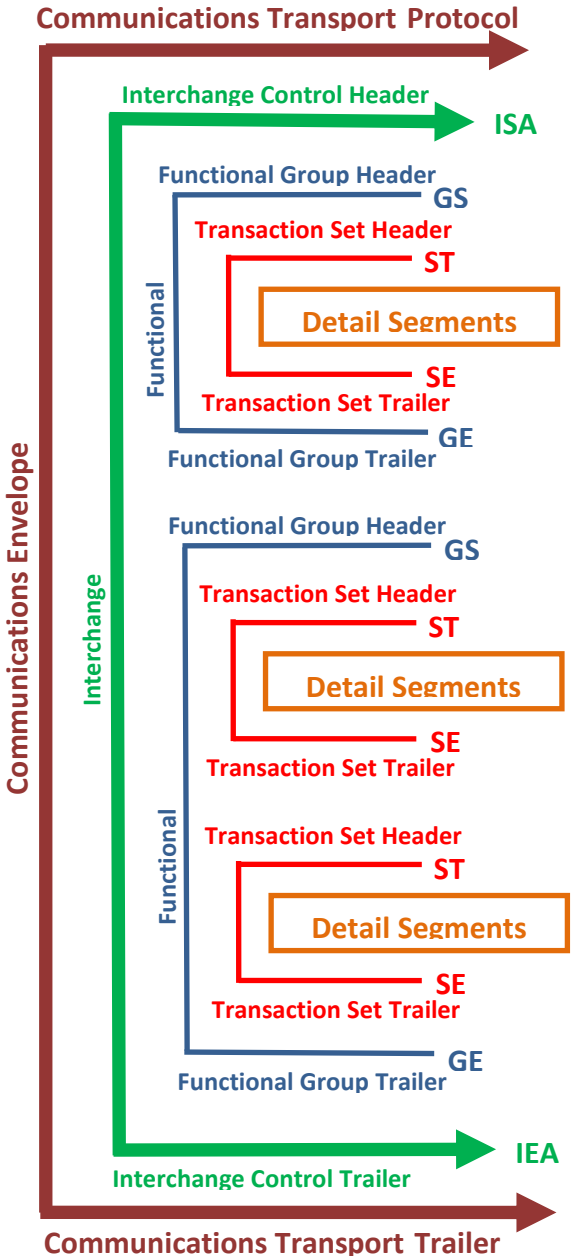
2.4.3 File Overview

The transmission of data is structured according to standard format rules to ensure the file integrity and to maintain the efficiency of the interchange. One (1) or more similar transaction sets, called functional groups, are prefaced by an interchange header and followed by an interchange trailer (ISA-IEA). The interchange header and trailer segments envelop one (1) or more functional groups. Each functional

group is introduced with a functional group start segment and is concluded with a functional group end segment.

Each grouping of data are called a transaction set (ST-SE). Each transaction set contains groups of related data in units called segments and each transaction set contains multiple segments. Figure 2C illustrates the enveloping and looping structure.

Figure 2C – ENVELOPING AND LOOPING STRUCTURE



The 837-I and 837-P file is structured to include multiple loops, segments, and data elements, some of which are required, situational, or not used.

The WPC's general usage of required, situational, and not used loops, segments, and data elements are as follows:

MAOs and other entities would use situational segments when the patient's data denotes its use. When situational segments are used all required data elements within that segment must be used.

⌦ **Example:** John Smith is admitted to Hope Hospital as a result of a car accident. Hope hospitals submit the claim to My Managed Care Organization. My Managed Care submits the claim to CMS using the 2300 loop, the REF "Auto Accident State" situational segment, populating the REF01 and REF02 required data elements.

⌦ **Example**

Loop 2300 (Claim Information), **composite** element HI03 (Patient's Reason for Visit) is situational; therefore **component** element HI03-1 (ICD-9/ICD-10 code) is required only when **composite** element HI03 is used.

⌦ **Example**

The first segment in Loop 2010BB (Payer Name), is NM (Payer Name) and is required; therefore, the Loop is required.

- Situational – Use of this loop, segment, and/or data element varies, depending on data content as described in the defining rule. The defining rule is documented in the situational rule attached to the item.

⌦ **Example**

The first segment in Loop 2000C (Patient Hierarchical Level) is HL (Patient Hierarchical Level) and is situational. It is populated only if the patient is different from the subscriber; therefore, the entire Loop 2000C is a situational loop.

Loop requirements depend on the context or location of the loop within the transaction. Per the WPC, loop requirements are as follows:

- The usage of a loop is the same as the usage of its beginning segment.
  - If a loop's beginning segment is required, the loop is required and must occur at least once.
  - If a loop's beginning segment is situational, the loop is situational.
- Subsequent segments within a loop can be sent only when the beginning segment is used.
- Required segments in situational loops occur only when the loop is used.

Example

Loop 2300, segment HI (Admitting Diagnosis) is a situational field. If Loop 2300, segment HI is used, THEN HI01-1 and HI01-2 must be used, as these are required data elements within the situational segment.

2.4.4 WPC Claim Submission Layout

The WPC loops can be categorized into three levels (3): Header, Detail, and Trailer. Header and Trailer levels are not associated with loops. While the Header and Trailer levels do not include loops, they provide the overall framework for the file. The loops provide the details of the file and group segments that may be repeated.

WPC refers to Washington Publishing Company 5010 Implementation Guides.

2.4.4.1 837-I Claim Submission Layout

The claim submission layout provides the highest level of the hierarchical structure of the WPC. The table is not inclusive of all segments and data elements within the header, detail, and trailer records. The usage indicator notifies the submitter of the required status of the data elements.

Table 2Q provides a high-level 837-I claim submission layout.

TABLE 2Q – 837-I CLAIM SUBMISSION LAYOUT

HEADER RECORD			
Identifier	**Name**	**Usage**	**Description**
ISA	Interchange Control Header	R	To start and identify an interchange of zero or more functional groups and interchange-related control segments.
GS	Functional Group Header	R	To indicate the beginning of a functional group and to provide control information.
ST	Transaction Set Header	R	To indicate the start of a transaction set and to assign a control number.
BHT	Beginning of Hierarchical Transaction	R	Defines the business hierarchical structure of the transaction set and identifies the business application purpose and reference data, i.e., number, date, and time.
DETAIL RECORD			
Loop Number	**Loop Name**	**Usage**	**Description**
1000A	Submitter Name	R	Contains MAOs and other entities information.

TABLE 2Q – 837-I CLAIM SUBMISSION LAYOUT (CONTINUED)

DETAIL RECORD			
Loop Number	**Loop Name**	**Usage**	**Description**
1000B	Receiver Name	R	Contains CMS information.
2000A	Billing Provider Hierarchical Level	R	Identifies dependencies among and the content of hierarchically related groups of data segments, to specify the identifying characteristics of a provider, and to specify the currency used in a transaction.
2010AA	Billing Provider Name	R	Contains information about the billing provider.
2010AB	Pay-to Address Name	N/U	Populate when the address for payment is different than that of the Billing Provider. This loop should not be populated when submitting an outbound file to CMS.
2010AC	Pay-to Plan Name	N/U	Populated when the subrogation payment requests are made. This loop should not be populated when submitting an outbound file to CMS.
2000B	Subscriber Hierarchical Level	R	Identifies dependencies among and the content of hierarchically related groups of data segments, and to record information specific to the primary insured and the insurance carrier for that insured.
2010BA	Subscriber Name	R	Identifies the health insurance subscriber.
2010BB	Payer Name	R	Identifies CMS as the Destination Payer and provides information about the Contract Plan ID.
2000C	Patient Hierarchical Level	S	Only populated if the patient is different than the subscriber.
2010CA	Patient Name	S	Identifies if the patient is different than the subscriber.
2300	Claim Information	R	Identifies claim level information about the patient and associated services.
2310A	Attending Provider Name	S	Contains information about the attending provider.
2310B	Operating Physician Name	S	Contains information about the operating physician name.

TABLE 2Q – 837-I CLAIM SUBMISSION LAYOUT (CONTINUED)

DETAIL RECORD			
Loop Number	**Loop Name**	**Usage**	**Description**
2310C	Other Operating Physician Name	S	Contains information about any other operating physician name.
2310D	Rendering Provider Name	S	Contains information if the rendering provider is different than the attending provider.
2310E	Service Facility Location Name	S	Contains information if the service facility location is different than the address provided in the Billing Provider information.
2310F	Referring Provider Name	S	Contains information if the referring provider is different than the attending provider.
2320	Other Subscriber Information	R	COB fields that provides MAO and other entity's paid amounts.
2330A	Other Subscriber Name	R	COB fields that provide information about the subscriber when MAOs and other entities paid amounts are populated.
2330B	Other Payer Name	R	COB fields that identify the payer when MAOs and other entities paid amounts are populated
2330C	Other Payer Attending Provider	S	COB fields that identify other payer of attending providers who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2330D	Other Payer Operating Physician	S	COB fields that identify other payer of operating physicians who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2330E	Other Payer Other Operating Physician	S	COB fields that identify other payer of other operating physicians who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).

TABLE 2Q – 837-I CLAIM SUBMISSION LAYOUT (CONTINUED)

DETAIL RECORD			
Loop Number	**Loop Name**	**Usage**	**Description**
2330F	Other Payer Service Facility Location	S	COB fields that identify the full name, address, and identifying information of the non-destination (COB) other payer's service facility location's identification number.
2330G	Other Payer Rendering Provider Name	S	COB fields that identify other payer of rendering providers who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2330H	Other Payer Referring Provider	S	COB fields that identify other payer of referring providers who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2330I	Other Payer Billing Provider	S	COB fields that identify other payer of billing providers who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2400	Service Line Number	R	Contains service line information.
2410	Drug Identification	S	Contains compound drug components, quantities, and prices.
2420A	Operating Physician Name	S	Contains information if a surgical procedure is listed on the claim and the operating physician for the line is different than the operating physician listed on the claim level (Loop 2310B)
2420B	Other Operating Physician	S	Contains information if another operating physician is involved and the other operating physician for the line is different than the other operating physician on the claim level (Loop 2310C)

TABLE 2Q – 837-I CLAIM SUBMISSION LAYOUT (CONTINUED)

DETAIL RECORD			
Loop Number	**Loop Name**	**Usage**	**Description**
2420C	Rendering Provider Name	S	Contains information if the rendering provider is different than the attending provider and the rendering provider for the line is different than the rendering provider on the claim level (Loop 2310D).
2420D	Referring Provider Name	S	Contains information if the referring provider is different than the attending provider and the referring provider for the line is different than the referring provider on the claim level (Loop 2310F)
2430	Line Adjudication Information	R	COB fields that identify service line level MAOs and other entities paid amounts.
TRAILER RECORDS			
Loop Number	**Loop Name**	**Usage**	**Description**
IEA	Interchange Control Trailer	R	Defines the end of an interchange of zero or more functional groups and interchange-related control segments.
GE	Functional Group Trailer	R	Indicates the end of a functional group and to provide control information.
SE	Transaction Set Trailer	R	Indicates the end of the transaction set and provides the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).

2.4.4.2 837-P Claim Submission Layout

Table 2R provides a high-level 837-P claim submission layout.

TABLE 2R – 837-P CLAIM SUBMISSION LAYOUT

HEADER RECORDS			
Identifier	**Name**	**Usage**	**Description**
ISA	Interchange Control Header	R	To start and identify an interchange of zero or more functional groups and interchange-related control segments.
GS	Functional Group Header	R	To indicate the beginning of a functional group and to provide control information.

TABLE 2R – 837-P CLAIM SUBMISSION LAYOUT (CONTINUED)

HEADER RECORDS			
Identifier	**Name**	**Usage**	**Description**
ST	Transaction Set Header	R	To indicate the start of a transaction set and to assign a control number.
BHT	Beginning of Hierarchical Transaction	R	To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time.
1000A	Submitter Name	R	Contains MAOs and other entities identifying information
1000B	Receiver Name	R	Contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
DETAIL RECORD			
Loop Number	**Loop Name**	**Usage**	**Description**
2000A	Billing Provider Hierarchical Level	R	Identifies dependencies among and the content of hierarchically related groups of data segments, to specify the identifying characteristics of a provider, and to specify the currency used in a transaction.
2010AA	Billing Provider Name	R	Contains information about entities that apply to all claims in Loop 2300.
2010AB	Pay-to Address Name	S	Contains information about entities that apply to all claims in Loop 2300.
2010AC	Pay-to Plan Name	S	Contains information about entities that apply to all claims in Loop 2300.
2000B	Subscriber Hierarchical Level	R	Identifies dependencies among and the content of hierarchically related groups of data segments, and to record information specific to the primary insured and the insurance carrier for that insured.
2010BA	Subscriber Name	R	Contains information about entities that apply to all claims in Loop 2300.
2010BB	Payer Name	R	Contains information about entities that apply to all claims in Loop 2300.
2000C	Patient Hierarchical Level	S	Only populated if the patient is different than the subscriber.
2010CA	Patient Name	S	Contains information about entities that apply to all claims in Loop 2300.

TABLE 2R – 837-P CLAIM SUBMISSION LAYOUT (CONTINUED)

DETAIL RECORDS			
Identifier	**Name**	**Usage**	**Description**
2300	Claim Information	R	Identifies claim level information about the patient and associated services
2310A	Referring Provider Name	S	Loop 2310 contains information about the rendering, referring, or attending provider.
2310B	Rendering Provider Name	S	Loop 2310 contains information about the rendering, referring, or attending provider.
2310C	Service Facility Location Name	S	Loop 2310 contains information about the rendering, referring, or attending provider.
2310D	Supervising Provider Name	S	Loop 2310 contains information about the rendering, referring, or attending provider.
2310E	Ambulance Pick Up Location	S	Loop 2310 contains information about the rendering, referring, or attending provider.
2310F	Ambulance Drop Off Location	S	Loop 2310 contains information about the rendering, referring, or attending provider.
2320	Other Subscriber Information	R	Contains insurance information about paying and other insurance carriers for that subscriber, subscriber of the other insurance carriers, and school or employer information for that subscriber.
2330A	Other Subscriber Name	R	Identifies a subscriber that can be uniquely identified to the Other Payer indicated in this iteration of Loop 2320 by a unique Member Identification Number.
2330B	Other Payer Name	R	To identify the full name, address, claim check or remittance date, and identifying information of the other payer.
2330C	Other Payer Referring Provider	S	Identifies other payer of attending providers who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2330D	Other Payer Rendering Provider	S	Identifies other payer of operating physicians who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).

TABLE 2R – 837-P CLAIM SUBMISSION LAYOUT (CONTINUED)

DETAIL RECORDS			
Identifier	**Name**	**Usage**	**Description**
2330E	Other Payer Service Facility Location	S	Identifies other payer of other operating physicians who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2330F	Other Payer Supervising Provider	S	Identifies the full name, address, and identifying information of the non-destination (COB) other payer's service facility location's identification number.
2330G	Other Payer Billing Provider Name	S	Identifies other payer of rendering providers who are not health care providers when the provider is sent in the corresponding Loop 2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop 2330B).
2400	Professional Service	R	Loop 2400 contains service line information.
2410	Drug Identification	S	Loop 2410 contains compound drug components, quantities, and prices.
2420A	Rendering Provider Name	S	Contains information about the rendering, referring, or attending provider on a service line level.
2420B	Purchased Service Provider Name	S	Contains information about the rendering, referring, or attending provider on a service line level.
2420C	Service Facility Location Name	S	Contains information about the rendering, referring, or attending provider on a service line level.
2420D	Supervising Provider Name	S	Contains information about the rendering, referring, or attending provider on a service line level.
2420E	Ordering Provider Name	S	Contains information about the rendering, referring, or attending provider on a service line level.
2420F	Referring Provider Name	S	Contains information about the rendering, referring, or attending provider on a service line level.
2420G	Ambulance Pick Up Location	S	Contains information about the rendering, referring, or attending provider on a service line level.
2420H	Ambulance Drop Off Location	S	Contains information about the rendering, referring, or attending provider on a service line level.
2430	Line Adjudication Information	R	COB fields that identify service line level MAOs and other entities paid amounts.

TABLE 2R – 837-P CLAIM SUBMISSION LAYOUT (CONTINUED)

DETAIL RECORDS			
Identifier	**Name**	**Usage**	**Description**
2440	Form Identification Code	S	Loop 2440 provides certificate of medical necessity information for the procedure identified in SV101 in position 2/3700.
TRAILER RECORDS			
Identifier	**Name**	**Usage**	**Description**
IEA	Interchange Control Trailer	R	Defines the end of an interchange of zero or more functional groups and interchange-related control segments.
GE	Functional Group Trailer	R	Indicates the end of a functional group and to provide control information. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize the functional group integrity. The control number is the same as that used in the corresponding header.
SE	Transaction Set Trailer	R	Indicates the end of the transaction set and provides the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).

2.4.3.1 ISA-IEA

The term interchange denotes the ISA-IEA envelope that is transmitted. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element IEA02 of the IEA segment.

All elements in the ISA-IEA Interchange must be populated. There are several elements within the ISA-IEA interchange that must be populated specifically for encounter data purposes. Table 2S provides EDS Interchange Control (ISA-IEA) specific elements.

TABLE 2S – EDS INTERCHANGE CONTROL HEADER AND TRAILER ELEMENTS (ISA/IEA)

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
ISA01	Interchange Control Header	Identifies the type of information in ISA02	R
ISA02	Authorization Information	Must be populated with 10 spaces	R
ISA03	Security Information Qualifier	Identifies the type of information in ISA04	R
ISA04	Security Information	Must be populated with 10 spaces	R

TABLE 2S – EDS INTERCHANGE CONTROL HEADER AND TRAILER ELEMENTS (ISA/IEA) (CONTINUED)

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
ISA05	Interchange ID Qualifier	"ZZ"	R
ISA06	Interchange Sender ID	MAO or other entities Submitter ID (EN followed by Contract ID)	R
ISA07	Interchange ID Qualifier	"ZZ"	R
ISA08	Interchange Receiver ID	CMS Payer ID: • 80881 – Institutional • 80882 – Professional	R
ISA09	Interchange Date	YYMMDD format	R
ISA10	Interchange Time	HHMM format	R
ISA11	Repetition Separator	Must be different than the value in ISA16. A carat (^) is the preferred repetition separator.	R
ISA12	Interchange Control Version Number	00501	R
ISA13	Interchange Control Number	Must match IEA02	R
ISA14	Acknowledgement Requested	1	R
ISA15	Interchange Usage Indicator	"T" to indicate a test claim file "P" to indicate a production file	R
ISA16	Component Element Separator	Identifies a delimiter and must be different than the data element separator and the segment terminator	R
IEA01	Number of Included Functional Groups	Identifies the number of GS-GE functional groups	R
IEA02	Interchange Control Number	Must match ISA13	R

2.4.3.2 GS-GE

The functional group is outlined by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

All elements in the GS-GE Functional Group must be populated. There are several elements within the GS-GE that must be populated specifically for encounter data collection. Table 2T provides EDS Functional Group (GS-GE) specific elements.

TABLE 2T – EDS FUNCTIONAL GROUP HEADER AND TRAILER ELEMENTS (GS/GE)

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
GS01	Functional Identifier Code	Two (2) character Functional Identifier Code assigned to each transaction set.	R
GS02	Application Sender's Code	MAOs and other entities or Third Party Submitter ID (EN followed by Contract ID)	R
GS03	Applications Receiver's Code	CMS Payer ID: • 80881 – Institutional • 80882 – Professional	R
GS04	Date	CCYYMMDD format	R
GS05	Time	HHMMSS format	R
GS06	Group Control Number	Must be identical to the control number in GE02	R
GS07	Responsible Agency Code	X=Accredited Standards Committee X12	R
GS08	Version/Release/Identifier Code	Transaction Version: • 005010X223A2 – Institutional • 005010X222A1 – Professional	R
GE01	Number of Transaction Sets Included	Total number of transaction sets included	R
GE02	Group Control Number	Must be identical to the control number in GS06	R

2.4.3.3 ST-SE

The transaction set (ST-SE) contains required, situational, and not used loops, segments, and data elements. The transaction set is outlined by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments. There are several elements that must be populated specifically for encounter data purposes. Table 2U provides EDS Transaction (ST/SE) specific elements.

TABLE 2U – EDS TRANSACTION HEADER AND TRAILER ELEMENTS (ST/SE)

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
ST01	Transaction Set Identifier Code	837	R
ST02	Transaction Set Control Number	Must be identical to SE02	R

TABLE 2U – EDS TRANSACTION HEADER AND TRAILER ELEMENTS (ST/SE) (CONTINUED)

ANSI FIELD	NAME	EDS DESCRIPTION	USAGE
ST03	Implementation Convention Reference	Transaction Version: • 005010X223A2 – Institutional • 005010X222A1 – Professional	R
SE01	Number of Included Segments	Must contain the actual number of segments within the ST-SE.	R
SE02	Transaction Set Control Number	Must be identical to ST02	R

Within the ST-SE transaction set, there are multiple loops, segments, and data elements that provide billing provider, subscriber, and patient level detail information. As stated previously, if the first segment of the loop is required, then all required and situational applicable data elements must be populated. If the first segment of the loop is situational and the situational calls for the MAOs and other entities or Third Party submitter to populate the segment, all required and situational applicable data elements must be populated. Table 2V provides the billing provider detail for the 837-I. Although this table illustrates 837-I billing provider detail, the included loops and segments displayed are identical on the 837-P.

TABLE 2V –837-I BILLING PROVIDER DETAIL

ANSI FIELD	NAME	USAGE
LOOP ID - 2000A BILLING PROVIDER HIERARCHICAL LEVEL		
HL	Billing Provider Hierarchical Level	R
PRV	Billing Provider Specialty Information	S
CUR	Foreign Currency Information	S
LOOP ID - 2010AA BILLING PROVIDER NAME		
NM1	Billing Provider Name	R
N3	Billing Provider Address	R
N4	Billing Provider City, State, Zip Code	R
REF	Billing Provider Tax Identification	R
PER	Billing Provider Contact Information	S
LOOP ID - 2010AB PAY-TO ADDRESS NAME		
NM1	Pay-to Address Name	S
N3	Pay-to Address - Address	R
N4	Pay-to Address - City, State, Zip Code	R
LOOP ID - 2010AC PAY-TO PLAN NAME		
NM1	Pay-to Plan Name	S
N3	Pay-to Plan Address	R
N4	Pay-to Plan City, State, Zip Code	R
REF	Pay-to Plan Secondary Identification	S
REF	Pay-to Plan Tax Identification Number	R

Example
If Loop ID-2010AB, NM1 segment is populated, then segments N3 and N4 MUST be populated.

- Data elements within each segment may be required, situational, or not used and should be populated according to the WPC, the 837-I or 837-P Companion Guide, and the CMS edits spreadsheet.

Example
If Loop ID-2010AC, segment NM1 is populated, then segments N3, N4, and REF (Pay-to Plan Tax Identification Number) MUST be populated. However, REF (Pay-to Plan Secondary Identification) MAY be populated if the situation applies.

Table 2W provides subscriber detail loops and segments.

TABLE 2W – 837-I SUBSCRIBER DETAIL

ANSI FIELD	NAME	USAGE
LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL		
HL	Subscriber Provider Hierarchical Level	R
SBR	Billing Provider Specialty Information	R
LOOP ID – 2010BA SUBSCRIBER NAME		
NM1	Subscriber Name	R
N3	Subscriber Address	S
N4	Subscriber City, State, Zip Code	R
DMG	Subscriber Demographic Information	S
REF	Subscriber Secondary Identification	S
REF	Property and Casualty Claim Number	S
LOOP ID – 2010BB PAYER NAME		
NM1	Payer Name	R
N3	Payer Address	S
N4	Payer City, State, Zip Code	R
REF	Payer Secondary Identification	S
REF	Billing Provider Secondary Identification	S

Table 2X provides patient detail information.

TABLE 2X – 837-I PATIENT INFORMATION

ANSI FIELD	NAME	USAGE
LOOP ID-2000C PATIENT HIERARCHICAL LEVEL		
HL	Patient Hierarchical Level	S

TABLE 2X – 837-I PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
PAT	Patient Information	R
LOOP ID - 2010CA PATIENT NAME		
NM1	Patient Name	R
N3	Patient Address	R
N4	Patient City, State, Zip Code	R
DMG	Patient Demographic Information	R
REF	Property and Casualty Claim Number	S
LOOP ID - 2300 CLAIM INFORMATION		
CLM	Claim Information	R
DTP	Discharge Hour	S
DTP	Statement Dates	R
DTP	Admission Date/Hour	S
DTP	Date - Repricer Received Date	S
CL1	Institutional Claim Code	R
PWK	Claim Supplemental Information	S
CN1	Contract Information	S
AMT	Patient Estimated Amount Due	S
REF	Service Authorization Exception Code	S
REF	Referral Number	S
REF	Prior Authorization	S
REF	Payer Claim Control Number	S
REF	Repriced Claim Number	S
REF	Adjusted Repriced Claim Number	S
REF	Investigational Device Exemption Number	S
REF	Claim Identifier for Transmission Intermediaries	S
REF	Auto Accident State	S
REF	Medical Record Number	S
REF	Demonstration Project Identifier	S
REF	Peer Review Organization (PRO) Approval Number	S
K3	File Information	S
NTE	Claim Note	S
NTE	Billing Note	S
CRC	EPSDT Referral	S
HI	Principal Diagnosis	R
HI	Admitting Diagnosis	S
HI	Patient's Reason for Visit	S

TABLE 2X – 837-I PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
HI	External Cause of Injury	S
HI	Diagnosis Related Group (DRG) Information	S
HI	Other Diagnosis Information	S
HI	Principal Procedure Information	S
HI	Other Procedure Information	S
HI	Occurrence Span Information	S
HI	Occurrence Information	S
HI	Value Information	S
HI	Condition Information	S
HI	Treatment Code Information	S
HCP	Claim Pricing/Repricing Information	S
LOOP ID - 2310A ATTENDING PROVIDER NAME		
NM1	Attending Provider Name	S
PRV	Attending Provider Specialty Information	S
REF	Attending Provider Secondary Identification	S
LOOP ID - 2310B OPERATING PHYSICIAN NAME		
NM1	Operating Physician Name	S
REF	Operating Physician Secondary Identification	S
LOOP ID - 2310C OTHER OPERATING PHYSICIAN		
NM1	Other Operating Physician Name	S
REF	Other Operating Physician Secondary Identification	S
LOOP ID - 2310D RENDERING PROVIDER NAME		
NM1	Rendering Provider Name	S
REF	Rendering Provider Secondary Identification	S
LOOP ID - 2310E SERVICE FACILITY LOCATION NAME		
NM1	Service Facility Location Name	S
N3	Service Facility Location Address	R
N4	Service Facility Location City, State, Zip Code	R
LOOP ID - 2310E SERVICE FACILITY LOCATION NAME		
REF	Service Facility Location Secondary Identification	S
LOOP ID - 2310F REFERRING PROVIDER NAME		
NM1	Referring Provider Name	S
REF	Referring Provider Secondary Identification	S
LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION		
SBR	Other Subscriber Information	S

TABLE 2X – 837-I PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
CAS	Claim Level Adjustments	S
AMT	Coordination of Benefits (COB) Payer Paid Amount	S
AMT	Remaining Patient Liability	S
AMT	COB Total Non-Covered Amount	S
OI	Other Insurance Coverage Information	R
MIA	Inpatient Adjudication Information	S
MOA	Outpatient Adjudication Information	S
LOOP ID - 2330A OTHER SUBSCRIBER NAME		
NM1	Other Subscriber Name	R
N3	Other Subscriber Address	S
N4	Other Subscriber City, State, Zip code	R
REF	Other Subscriber Secondary Identification	S
LOOP ID - 2330B OTHER PAYER NAME		
NM1	Other Payer Name	R
N3	Other Payer Address	S
N4	Other Payer City, State, Zip Code	R
DTP	Claim Check or Remittance Date	S
REF	Other Payer Secondary Identifier	S
REF	Other Payer Prior Authorization Number	S
REF	Other Payer Referral Number	S
REF	Other Payer Claim Adjustment Indicator	S
REF	Other Payer Claim Control Number	S
LOOP ID - 2330C OTHER PAYER ATTENDING PROVIDER		
NM1	Other Payer Attending Provider	S
REF	Other Payer Attending Provider Secondary Identification	R
LOOP ID - 2330D OTHER PAYER OPERATING PHYSICIAN		
NM1	Other Payer Operating Physician	S
REF	Other Payer Operating Physician Secondary Identification	R
LOOP ID - 2330E OTHER PAYER OTHER OPERATING PHYSICIAN		
NM1	Other Payer Other Operating Physician	S
REF	Other Payer Other Operating Physician Secondary Identification	R
LOOP ID - 2330F OTHER PAYER SERVICE FACILITY LOCATION		
NM1	Other Payer Service Facility Location	S

TABLE 2X – 837-I PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
REF	Other Payer Service Facility Location Secondary Identification	R
LOOP ID - 2330G OTHER PAYER RENDERING PROVIDER NAME		
NM1	Other Payer Rendering Provider Name	S
REF	Other Payer Rendering Provider Secondary Identification	R
LOOP ID - 2330H OTHER PAYER REFERRING PROVIDER NAME		
NM1	Other Payer Referring Provider	S
REF	Other Payer Referring Provider Secondary Identification	R
LOOP ID - 2330I OTHER PAYER BILLING PROVIDER		
NM1	Other Payer Billing Provider	S
REF	Other Payer Billing Provider Secondary Identification	R
LOOP ID - 2400 SERVICE LINE NUMBER		
LX	Service Line Number	R
SV2	Institutional Service Line	R
PWK	Line Supplemental Information	S
DTP	Date - Service Date	S
REF	Line Item Control Number	S
REF	Repriced Line Item Reference Number	S
REF	Adjusted Repriced Line Item Reference Number	S
AMT	Service Tax Amount	S
AMT	Facility Tax Amount	S
NTE	Third Party Organization Notes	S
HCP	Line Pricing/Repricing Information	S
LOOP ID - 2410 DRUG IDENTIFICATION		
LIN	Drug Identification	S
CTP	Drug Quantity	R
REF	Prescription or Compound Drug Association Number	S
LOOP ID - 2420A OPERATING PHYSICIAN NAME		
NM1	Operating Physician Name	S
REF	Operating Physician Secondary Identification	S
LOOP ID - 2420B OTHER OPERATING PHYSICIAN NAME		
NM1	Other Operating Physician Name	S
REF	Other Operating Physician Secondary Identification	S

TABLE 2X – 837-I PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
LOOP ID - 2420C RENDERING PROVIDER NAME		
NM1	Rendering Provider Name	S
REF	Referring Provider Secondary Identification	S
LOOP ID - 2420D REFERRING PROVIDER NAME		
NM1	Referring Provider Name	S
REF	Referring Provider Secondary Identification	S
LOOP ID - 2430 LINE ADJUDICATION INFORMATION		
SVD	Line Adjudication Information	S
CAS	Line Adjustment	S
DTP	Line Check or Remittance Date	R
AMT	Remaining Patient Liability	S
SE	Transaction Set Trailer	R

TABLE 2Y –837-P BILLING PROVIDER DETAIL

ANSI FIELD	NAME	USAGE
LOOP ID - 2000A BILLING PROVIDER HIERARCHICAL LEVEL		
HL	Billing Provider Hierarchical Level	R
PRV	Billing Provider Specialty Information	S
CUR	Foreign Currency Information	S
LOOP ID - 2010AA BILLING PROVIDER NAME		
NM1	Billing Provider Name	R
N3	Billing Provider Address	R
N4	Billing Provider City, State, Zip Code	R
REF	Billing Provider Tax Identification	R
PER	Billing Provider Contact Information	S
LOOP ID - 2010AB PAY-TO ADDRESS NAME		
NM1	Pay-to Address Name	S
N3	Pay-to Address - Address	R
N4	Pay-to Address - City, State, Zip Code	R
LOOP ID - 2010AC PAY-TO PLAN NAME		
NM1	Pay-to Plan Name	S
N3	Pay-to Plan Address	R
N4	Pay-to Plan City, State, Zip Code	R
REF	Pay-to Plan Secondary Identification	S
REF	Pay-to Plan Tax Identification Number	R

Table 2Z provides subscriber detail loops and segments.

TABLE 2Z – 837-P SUBSCRIBER DETAIL

ANSI FIELD	NAME	USAGE
LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL		
HL	Subscriber Provider Hierarchical Level	R
SBR	Billing Provider Specialty Information	R
PAT	Patient Information	S
LOOP ID – 2010BA SUBSCRIBER NAME		
NM1	Subscriber Name	R
N3	Subscriber Address	S
N4	Subscriber City, State, Zip Code	R
DMG	Subscriber Demographic Information	S
REF	Subscriber Secondary Identification	S
REF	Property and Casualty Claim Number	S
PER	Property and Casualty Subscriber Contact Information	S
LOOP ID – 2010BB PAYER NAME		
NM1	Payer Name	R
N3	Payer Address	S
N4	Payer City, State, Zip Code	R
REF	Payer Secondary Identification	S
REF	Billing Provider Secondary Identification	S

Table 2A1 provides patient detail information.

TABLE 2A1 – 837-P PATIENT INFORMATION

ANSI FIELD	NAME	USAGE
LOOP ID-2000C PATIENT HIERARCHICAL LEVEL		
HL	Patient Hierarchical Level	S
PAT	Patient Information	R
LOOP ID - 2010CA PATIENT NAME		
NM1	Patient Name	R
N3	Patient Address	R
N4	Patient City, State, Zip Code	R
DMG	Patient Demographic Information	R
REF	Property and Casualty Claim Number	S
PER	Property and Casualty Patient Contact Information	S

TABLE 2A1 – 837-P PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
	LOOP ID - 2300 CLAIM INFORMATION	
CLM	Claim Information	R
DTP	Date – Onset of Current Illness or Symptom	S
DTP	Date – Initial Treatment Date	S
DTP	Date – Last Seen Date	S
DTP	Date – Acute Manifestation	S
DTP	Date – Accident	S
DTP	Date – Last Menstrual Period	S
DTP	Date – Last X-Ray Date	S
DTP	Date – Hearing and Vision Prescription Date	S
DTP	Date – Disability Dates	S
DTP	Date – Last Worked	S
DTP	Date – Authorized to Return to Work	S
DTP	Date – Admission	S
DTP	Date – Discharge	S
DTP	Date – Assumed and Relinquished Care Dates	S
DTP	Date – Property and Casualty Date of First Contact	S
DTP	Date – Repricer Received Date	S
PWK	Claim Supplemental Information	S
CN1	Contract Information	S
AMT	Patient Amount Paid	S
REF	Service Authorization Exception Code	S
REF	Mandatory Medicare (Section 4081) Crossover Indicator	S
REF	Mammography Certification Number	S
REF	Referral Number	S
REF	Prior Authorization	S
REF	Payer Claim Control Number	S
REF	Repriced Claim Number	S
REF	Adjusted Repriced Claim Number	S
REF	Investigational Device Exemption Number	S
REF	Claim Identifier for Transmission Intermediaries	S
REF	Auto Accident State	S
REF	Medical Record Number	S
REF	Demonstration Project Identifier	S
REF	Care Plan Oversight	S
K3	File Information	S

TABLE 2A1 – 837-P PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
LOOP ID - 2300 CLAIM INFORMATION		
NTE	Claim Note	S
CR1	Ambulance Transport Information	S
CR2	Spinal Manipulation Service Information	S
CRC	Ambulance Certification	S
CRC	Patient Condition Information: Vision	S
CRC	Homebound Indicator	S
CRC	EPSDT Referral	S
HI	Health Care Diagnosis Code	R
HI	Anesthesia Related Procedure	S
HI	Condition Information	S
CP	Claim Pricing/Repricing Information	S
LOOP ID - 2310A REFERRING PROVIDER NAME		
NM1	Referring Provider Name	S
REF	Referring Provider Secondary Identification	S
LOOP ID - 2310B RENDERING PHYSICIAN NAME		
NM1	Rendering Provider Name	S
REF	Rendering Provider Secondary Identification	S
LOOP ID - 2310C SERVICE FACILITY LOCATION NAME		
NM1	Service Facility Location Name	S
N3	Service Facility Location Address	R
N4	Service Facility Location City, State, Zip Code	R
REF	Service Facility Location Secondary Identification	S
REF	Service Facility Contact Information	S
LOOP ID – 2310D SUPERVISING PROVIDER NAME		
NM1	Referring Provider Name	S
REF	Referring Provider Secondary Identification	S
LOOP ID – 2310E AMBULANCE PICK-UP LOCATION		
NM1	Ambulance Pick-up Location	S
N3	Ambulance Pick-up Location Address	S
N4	Ambulance Pick-up Location City, State, ZIP Code	S
LOOP ID – 2310F AMBULANCE DROP-OFF LOCATION		
NM1	Ambulance Drop-off Location	S
N3	Ambulance Drop-off Address	S
N4	Ambulance Drop-off Location City, State, ZIP Code	S

TABLE 2A1 – 837-P PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION		
SBR	Other Subscriber Information	S
CAS	Claim Level Adjustments	S
AMT	Coordination of Benefits (COB) Payer Paid Amount	S
AMT	Remaining Patient Liability	S
AMT	COB Total Non-Covered Amount	S
OI	Other Insurance Coverage Information	R
MOA	Outpatient Adjudication Information	S
LOOP ID - 2330A OTHER SUBSCRIBER NAME		
NM1	Other Subscriber Name	R
N3	Other Subscriber Address	S
N4	Other Subscriber City, State, Zip code	R
REF	Other Subscriber Secondary Identification	S
LOOP ID - 2330B OTHER PAYER NAME		
NM1	Other Payer Name	R
N3	Other Payer Address	S
N4	Other Payer City, State, Zip Code	R
DTP	Claim Check or Remittance Date	S
REF	Other Payer Secondary Identifier	S
REF	Other Payer Prior Authorization Number	S
REF	Other Payer Referral Number	S
REF	Other Payer Claim Adjustment Indicator	S
REF	Other Payer Claim Control Number	S
LOOP ID - 2330C OTHER PAYER REFERRING PROVIDER		
NM1	Other Payer Referring Provider	S
REF	Other Payer Attending Provider Secondary Identification	R
LOOP ID - 2330D OTHER PAYER RENDERING PROVIDER		
NM1	Other Payer Rendering Provider	S
REF	Other Payer Rendering Provider Secondary Identification	R
LOOP ID - 2330E OTHER PAYER SERVICE FACILITY LOCATION		
NM1	Other Payer Service Facility Location	S
REF	Other Payer Service Facility Location Secondary Identification	R

TABLE 2A1 – 837-P PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
LOOP ID - 2330F OTHER PAYER SUPERVISING PROVIDER		
NM1	Other Payer Supervising Provider	S
REF	Other Payer Service Facility Location Secondary Identification	R
LOOP ID - 2330G OTHER PAYER BILLING PROVIDER		
NM1	Other Payer Billing Provider	S
REF	Other Payer Billing Provider Secondary Identification	R
LOOP ID - 2400 SERVICE LINE NUMBER		
LX	Service Line Number	R
SV1	Professional Service	R
SV5	Durable Medical Equipment Service	S
PWK	Line Supplemental Information	S
PWK	Durable Medical Equipment Certificate of Medical Necessity Indicator	S
CR1	Ambulance Transport Information	S
CR3	Durable Medical Equipment Certification	S
CRC	Ambulance Certification	S
CRC	Hospice Employee Indicator	S
DTP	Date - Service Date	R
DTP	Date – Prescription Date	S
DTP	Date – Certification Revision/Recertification Date	S
DTP	Date – Begin Therapy Date	S
DTP	Date – Last Certification Date	S
DTP	Date – Last Seen Date	S
DTP	Date – Shipped Date	S
DTP	Date – Last X-Ray Date	S
DTP	Date – Initial Treatment Date	S
QTY	Ambulance Patient Count	S
QTY	Obstetric Anesthesia Additional Units	S
MEA	Test Result	S
CN1	Contract Information	S
REF	Repriced Line Item Reference Number	S
REF	Adjusted Repriced Line Item Reference Number	S
REF	Prior Authorization	S
REF	Line Item Control Number	S
REF	Mammography Certification Number	S

TABLE 2A1 – 837-P PATIENT INFORMATION (CONTINUED)

ANSI FIELD	NAME	USAGE
LOOP ID - 2400 SERVICE LINE NUMBER		
REF	Clinical Laboratory Improvement Amendment (CLIA) Number	S
REF	Immunization Batch Number	S
REF	Referral Number	S
AMT	Service Tax Amount	S
AMT	Postage Claimed Amount	S
K3	File Information	S
NTE	Line Note	S
NTE	Third Party Organization Notes	S
PS1	Purchased Service Information	S
HCP	Line Pricing/Repricing Information	S
LOOP ID - 2410 DRUG IDENTIFICATION		
LIN	Drug Identification	S
CTP	Drug Quantity	R
REF	Prescription or Compound Drug Association Number	S
LOOP ID - 2420A RENDERING PROVIDER NAME		
NM1	Rendering Provider Name	S
REF	Rendering Provider Secondary Identification	S
LOOP ID - 2420B PURCHASED SERVICE PROVIDER NAME		
NM1	Purchased Service Provider Name	S
REF	Purchased Service Provider Secondary Identification	S
LOOP ID - 2420C SERVICE FACILITY LOCATION		
NM1	Service Facility Location Name	S
N3	Service Facility Location Address	R
N4	Service Facility Location City, State, ZIP Code	R
REF	Service Facility Location Secondary Identification	S
LOOP ID - 2420D SUPERVISING PROVIDER NAME		
NM1	Supervising Provider Name	S
REF	Referring Provider Secondary Identification	S
LOOP ID – 2420E ORDERING PROVIDER NAME		
NM1	Ordering Provider Name	S
N3	Ordering Provider Address	S
N4	Ordering Provider City, State, ZIP Code	R
REF	Ordering Provider Secondary Identification	S
PER	Ordering Provider Contact Information	S

TABLE 2A1 – 837-P PATIENT INFORMATION (CONTINUED)

LOOP ID – 2420F REFERRING PROVIDER NAME		
NM1	Referring Provider Name	S
REF	Referring Provider Secondary Identification	S
LOOP ID – 2420G AMBULANCE PICK-UP LOCATION		
NM1	Ambulance Pick-Up Location	S
N3	Ambulance Pick-Up Address	R
N4	Ambulance Pick-Up City, State, ZIP Code	R
LOOP ID – 2420H AMBULANCE DROP-OFF LOCATION		
NM1	Ambulance Drop-Off Location	S
N3	Ambulance Drop-Off Address	R
N4	Ambulance Drop-Off City, State, ZIP Code	R
LOOP ID - 2430 LINE ADJUDICATION INFORMATION		
SVD	Line Adjudication Information	S
CAS	Line Adjustment	S
DTP	Line Check or Remittance Date	R
AMT	Remaining Patient Liability	S
LOOP ID – 24240 FORM IDENTIFICATION CODE		
LQ	Form Identification Code	S
FRM	Supporting Documentation	R

2.5 Duplicates and Duplicate Logic

In order to ensure claims submitted are not duplicates of claims previously submitted, file and claim level duplicate checking will be performed. If the file and/or claim level duplicate checking determines the file is a duplicate, the file will be rejected as a duplicate, and an error report will be returned to the submitter.

2.5.1 File Level

When a file (ISA – IEA) is received, the system assigns a hash total to the file based on the entire ISA-IEA interchange. Hash totals are a method for ensuring the accuracy of processed data. The hash total is a total of several fields or data in a file, including fields not normally used in calculations, such as account number. At various stages in the processing, the hash total is recalculated and compared with the original. If a file comes in later in a different submission or a different submission of the same file, and gets the same hash total, it will be rejected as a duplicate. There will be other duplicate edits in the processing system.

Example:

On July 6, 2012, a submitted ISA – IEA interchange has a hash total of 800,000. On August 10, 2012, another ISA – IEA interchange is submitted with the exact same hash total of 800,000. This would cause on error in the front-end and would trigger an edit for a duplicate claim. This would be rejected and sent back to the submitter using a 999R.

2.5.2 Claim Level

Once a claim passes through the institutional or professional processing and pricing system, it is stored in an internal repository, the EODS. If a new claim is submitted that matches specific values to another stored claim, the claim will be rejected and will be considered a duplicate claim. The claim will be returned to the submitter with an error message identifying it as a duplicate claim. Currently the following values are the minimum set of items being used for matching a claim in the EODS:

Institutional	**Professional**
Beneficiary HIC Number	Beneficiary HIC Number
Beneficiary Name	Beneficiary Name
Date of Service	Date of Service
Type of Bill	**Place of Service**
Rendering Provider NPI	Rendering Provider NPI
Procedure Codes	Procedure Codes

2.6 Chart Reviews

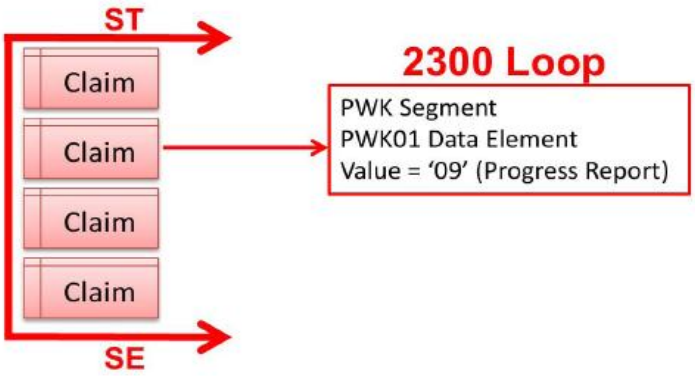
CMS will collect chart review data as part of the encounter data process. The PWK segment, PWK01 report type code within the 2300 loop of the 5010 format will be used to identify chart review data submissions for collection of encounter data. Figure 2D displays the chart review submission process and the required data elements to be populated for the 5010.

MAOs and other entities must submit encounter data received from their providers to CMS in the HIPAA 5010 format. There may be occasions for MAOs and other entities to submit supplemental data such as chart reviews. Supplemental data to include chart reviews must be submitted using the PWK segment. The PWK segment must not be used to add diagnosis to the encounter.

The PWK01 data element should be populated with a value of '09.' Currently, the value '09' is defined as *Progress Reports*. However, for the purposes of encounter data, this value will be redefined to identify *Chart Review* data submitted by MAOs and other entities or Third Party submitters.

- The term "chart review" refers to all medical reviews.

Figure 2D – Chart Review Submission



2.6.1 Linking Chart Review Data to an Original Encounter

In order to link the chart review data to the original encounter, when available, MAOs and other entities or Third Party submitters must use the ICN that CMS provides on the 277CA transaction report returned to plans. The ICN is located in the 277CA in loop 2200D, REF01 (Reference Identification Qualifier) with a value of '1K' (Payer's Claim Number) and REF02 (Reference Identification) with a value 'Claim Number' (Payer Claim Control Number). Table 2B1 provides the minimum chart review data elements that must be populated with a linked ICN.

- CMS will determine if MAOs and other entities will need to submit additional supplemental data. This information will be communicated to MAOs and other entities as it becomes available.

TABLE 2B1 – CHART REVIEW REQUIRED ELEMENTS – LINKED BY ICN

LOOP	SEGMENT	SEGMENT NAME	DATA ELEMENT	DATA ELEMENT NAME	EDS NOTES
2010BA	NM1	Subscriber Name	NM108	Identification Code Qualifier (HIC Qualifier)	NM108=MI
2010BA	NM1	Subscriber Name	NM109	Subscriber Primary Identifier (HIC)	
2300 (Institutional only)	DTP	Statement Date	DTP02	Date Time Period Format Qualifier	DTP02=D8 CCYYMMDD
2300 (Institutional only)	DTP	Statement Date	DTP03	Statement Date	

TABLE 2B1 – CHART REVIEW REQUIRED ELEMENTS – LINKED BY ICN (CONTINUED)

LOOP	SEGMENT	SEGMENT NAME	DATA ELEMENT	DATA ELEMENT NAME	EDS NOTES
2300	HI*	Principal Diagnosis*	HI01-1	Principal Diagnosis Type Code	
2300	HI*	Principal Diagnosis*	HI01-2	Principal Diagnosis Code	
2300	CLM	Claim Information	CLM01	Patient Control Number	
2300	CLM	Claim Information	CLM05-3	Claim Frequency Type Code	CLM05-3=7 (add) 8 (delete)
2300	PWK	Claim Supplemental Information	PWK01	Attachment Report Type Code ("09"=Progress Report)	PWK01=09
2300	PWK	Claim Supplemental Information	PWK02	Attachment Transmission Code	PWK02=AA (Chart review certification available at site)
2300	REF	Payer Claim Control Number	REF01	Reference Identification Qualifier	REF01=F8
2300	REF	Payer Claim Control Number	REF02	Claim Original Reference Number	(ICN on the 277CA)
2310B (Professional only)	NM1	Rendering Provider Name	NM108	Identification Code Qualifier (NPI Qualifier)	NM108=XX
2310B (Professional only)	NM1	Rendering Provider Name	NM109	Rendering Provider Identifier (NPI)	
2310D (Institutional only)	NM1	Rendering Provider Name	NM108	Identification Code Qualifier (NPI Qualifier)	NM108=XX
2310D (Institutional only)	NM1	Rendering Provider Name	NM109	Rendering Provider Identifier (NPI)	
2320	CAS	Claim Level Adjustments	CAS01	Claim Adjustment Group Code	CAS01=OA (delete), CO (add)

*** All applicable diagnoses must be populated.**

If there is no original encounter to link data then the chart review data should be submitted with the PWK01 segment populated to flag it as chart review data. Table 2B1 provides the minimum chart review data elements that must be populated with no linked ICN.

TABLE 2C1 – CHART REVIEW REQUIRED ELEMENTS – NO LINKED ICN

LOOP	SEGMENT	SEGMENT NAME	DATA ELEMENT	DATA ELEMENT NAME	EDS NOTES
2010BA	NM1	Subscriber Name	NM108	Identification Code Qualifier (HIC Qualifier)	NM108=MI
2010BA	NM1	Subscriber Name	NM109	Subscriber Primary Identifier (HIC)	
2300 (Institutional only)	DTP	Statement Date	DTP02	Date Time Period Format Qualifier	DTP02=D8 CCYYMMDD
2300 (Institutional only)	DTP	Statement Date	DTP03	Statement Date	
2300	HI*	Principal Diagnosis*	HI01-1	Principal Diagnosis Type Code	
2300	HI*	Principal Diagnosis*	HI01-2	Principal Diagnosis Code	
2300	CLM	Claim Information	CLM01	Patient Control Number	
2300	CLM	Claim Information	CLM05-3	Claim Frequency Type Code	CLM05-3=1 (Original)
2300	PWK	Claim Supplemental Information	PWK01	Attachment Report Type Code (“09”=Progress Report)	PWK01=09
2300	PWK	Claim Supplemental Information	PWK02	Attachment Transmission Code	PWK02=AA (Chart review certification available at site)
2310B (Professional Only)	NM1	Rendering Provider Name	NM108	Identification Code Qualifier (NPI Qualifier)	NM108=XX
2310B (Professional Only)	NM1	Rendering Provider Name	NM109	Rendering Provider Identifier (NPI)	
2310D (Institutional Only)	NM1	Rendering Provider Name	NM108	Identification Code Qualifier (NPI Qualifier)	NM108=XX
2310D (Institutional Only)	NM1	Rendering Provider Name	NM109	Rendering Provider Identifier (NPI)	

*** All applicable diagnoses must be populated.**

2.6.2 Timing of Chart Review Data Submissions

Encounter data chart reviews must be submitted within 25 months of the beginning of the data collection period.

Example

Happy Health Plan submits an encounter on September 25, 2012. If the data collection period begins on January 1, 2012, Happy Health Plan may submit a chart review for that encounter up until January 31, 2014.

2.7 Amount Fields

In order to ensure file integrity, amounts reported on the 837-I or 837-P must balance at two (2) different levels – the claim and the service line level.

2.7.1 Claim Billed Amounts

The total claim billed amount populated in Loop 2300, CLM02 must balance to the sum of all service line billed amounts reported in Loop 2400, SV2 (Institutional) and SV1 (Professional).

Example

A claim has the following line level charges; therefore, the total in CLM02 must be $136.00
Line 1 Charge - $40.00
Line 2 Charge – $46.00
Line 3 Charge – $50.00

If CLM02 was populated with any total other than $136.00, the file would reject and would require resubmission with the balanced service line and total claim billed amounts.

2.7.2 Claim Paid Amounts

Similarly, the total claim paid amount reported in Loop 2320, AMT02 must balance to the paid amount SVD2 (Institutional) and SVD1 (Professional) service lines. At the claim level, the total amount paid is reported in Loop 2320, AMT (Payer Paid Amount).

Example

A claim has the following line level payments. MAOs and other entities must report paid amounts at the line level.

Line 1 Charge – $80.00 (SV101 or SV201)
Line 1 Payment - $70.00 (SVD02)
Line 2 Charge - $20.00 (SV101 or SV202)

Line 2 Payment - $15.00 (SVD02)

The 2320, 2330, and 2430 loops will be sent with each encounter submitted to CMS in an 837 format. The first iteration of the COB loops will reflect the MAOs and other entities payment information, and the subsequent iterations will reflect the other payer's payment information. For example, the AMT segment in the 2320 loop will reflect the MAOs and other entities paid amount, and if there is a COB on record, the subsequent 2320, 2330, and 2430 loops will reflect the COB information.

2.8 Atypical Providers

Providers who are not considered health care providers and do not provide health care services are referred to as "atypical service providers." Examples of atypical service providers include, but are not limited to:

- Non emergency transportation providers such as taxis
- Personal Care Attendants
- Building Contractors
- Language Interpreters

All entities, both individuals and organizations, that do not meet the HIPAA definition of a "health care provider" per the Code of Federal Regulations (45 CFR 160.103) are ineligible to obtain an NPI. According to the Code of Federal Regulations (45 CFR 160.103):

- **Health care provider** means a "provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x (u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business."

- **Covered entity** means:
  - A health plan;
  - A health care clearinghouse;
  - A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter (45 CFR 160.103).

- **Health care** means "care, services, or supplies related to the health of an individual. Health care includes, but is not limited to:
  - Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
  - Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription."

If the entity or individual meets the definition of **Health care provider**, then they are eligible for an NPI. If the entity or individual meets the definition of **Health care provider** AND **Covered entity**, then they are required to obtain an NPI. Appendix A provides examples of atypical provider types.

2.8.1 Default NPI

CMS is currently developing the editing logic for submission of encounter data from atypical provider types. A valid NPI is required to be populated to submit encounter data; therefore, atypical provider types will be issued a default NPI. The default NPI is determined by the Payer ID populated on the file. MAOs and other entities should populate the following default NPIs for atypical provider encounters:

- Receiver ID 80881 - 7777777773
- Receiver ID 80882 - 8888888889

Diagnoses captured from atypical provider types (as notated by the default atypical provider NPI) will not be stored for risk adjustment calculation.

2.8.2 Rules on Determining Atypical Providers

Both the provider and the service provided must be evaluated to determine if a provider is ineligible to obtain an NPI and/or considered to be “atypical.” The following questions can be used as a guide for evaluation of whether a provider meets the criteria of an atypical service provider:

1) Is the provider within the health care provider definition according to the Code of Federal Regulations (45 CFR 160.103)?
   - If *yes*, then the provider is not considered an atypical service provider and is eligible to obtain an NPI.
   - If *not*, then continue to question 2:
2) Does the provider deliver health care services as defined by the Code of Federal Regulations (45 CFR 160.103)?
   - If *yes*, then the provider is also not an atypical service provider and is eligible for a NPI.
   - If *not*, then the provider is considered an atypical service provider and is not eligible for a NPI.

2.9 Submitting Data from Capitated Encounters

Capitated providers are physicians, hospitals, or other health care providers that provide services based on a contracted rate for each member assigned, referred to as "per-member-per-month" (PMPM) rate, regardless of the number or nature of services provided.

Capitated and staff model arrangements must populate and submit valid CPT codes on the 5010, as this is necessary for accurate encounter data pricing.

2.9.1 Amount Fields

Amount fields on claims submitted by capitated providers do not always have the accurate pricing amount populated. For capitated or staff model arrangements submitting encounter data, "0.00" should be populated in amount fields, if no amount information is available, before submitting to CMS. If pricing information is available on the encounter collected, then it should be submitted as is; however, the sum of the SV1 (Professional) and SV2 (Institutional) service lines must balance to the total amount populated on Loop ID-2300, CLM02. Capitated claims submitted with "0" in the amount fields will be priced according to 100% of the Medicare allowable amount when processed through the EDS.

2.9.2 Flagging Capitated Encounters

There are instances in which capitated and non-capitated service lines can be present on one (1) claim. If this is the case, MAOs and other entities must populate Loop ID-2400, segment CN, data element CN101 with a value of "05" to indicate the service line is from a capitated arrangement, for professional encounters only. Institutional capitated encounters must be indicated at the claim level, Loop ID-2300, data element CN101 with a value of "05". All service lines must continue to balance to the total claim amount.

Example

MetroPlan has a capitated arrangement with Dr. Smith for all services. In order for MetroPlan to submit Dr. Smith's claim to EDS, MetroPlan must submit a file using Loop 2400, data element CN101 and enter a value of "05" for each service line. MetroPlan will populate "0.00" in CLM02. SV1 (Professional) or SV2 (Institutional) will also equal "0.00".

2.9.3 Edits Suppressed due to Capitation

If the capitated contract code of "05" is populated in Loop 2300 or Loop ID-2400, data element CN101, indicating the encounter data submission is from a capitated or staff model arrangement, amount field edits will be suppressed.

2.10 Special Considerations for Cost Plans

The Social Security Act (the Act) stipulates that Cost plans are required to submit encounter data. In a memorandum dated September 30, 2004, CMS required all §1876 Cost HMOs/CMPs to submit diagnostic data (medical and drug-related) for dates of service on and after July 1, 2004. The 2012 Advance Notice refers to this memo and explains the authority CMS has to collect encounter data from both types of Cost plans beginning in 2012.

2012 Announcement, page 5
http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf

2.11 Adjustments

Adjustment data are submitted at the claim level within the ST—SE transaction set of the transmission file. The adjustment claim submitted will supersede the original claim. Therefore, the adjustment claim must be submitted as the finalized claim. The REF segment, REF01 data element will identify the Claim Control Number. REF01 data element of the 2300 loop must be populated with a value of 'F8' (Original Reference Number). REF02 data element must be populated with the Claim Number received on the 277CA. Adjustment data must be resubmitted with the correct original claims data.

The CAS segment, CAS01 data element, within the 2300 loop of the 5010 will be used to submit adjustment data.

Two (2) value options will be redefined so that plans may submit adjustment data using the CAS segment. Figure 2E illustrates the 5010 population requirements for submitting adjustment data. Table 2D1 provides adjustment processes comparison between the 5010 population and redefined purposes for encounter data submission.

Figure 2E – Submitting Adjustment Data

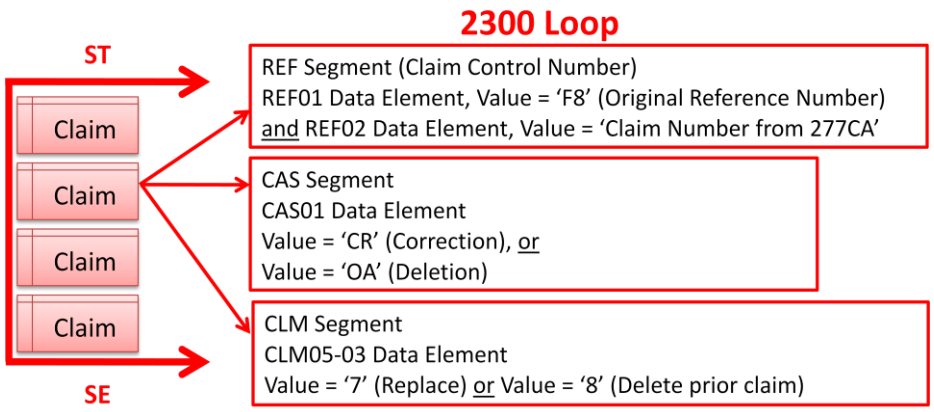


TABLE 2D1 – EDS REPURPOSED ADJUSTMENT VALUES

LOOP	DATA ELEMENT	VALUE	X12 5010 STANDARD	EDS USAGE
2320	CAS01	CR	Correction and Reversals	Correction
2320	CAS01	OA	Other Adjustment	Deletion

The CLM segment (CLM05-03 data element) within the 2300 loop of the 5010 will be populated with value '7' for replacing a prior claim. This corresponds to the CAS01 values of 'CR.' The CLM05-03 data element an also be populated with a value '8' for deleting a prior claim. This corresponds to the CAS01 value of 'OA.'

2.11.1 Deletions

Loop 2320, segment CAS, data element CAS01=OA (Deletion) allows MAOs and other entities or Third Party submitters to delete previously submitted encounter data. A deletion indicator ('OA') is submitted to delete an entire claim. Line level (2400 level loop) deletions cannot be processed.

Example

Urban Care Plan determines that they mistakenly sent a claim that was not adjudicated. In order to delete the entire claim, Urban Care Plan will submit an 837 encounter using Loop ID-2300, CLM05-3="8," REF01=F8 and REF02=ICN, and Loop ID-2320, CAS01="OA."

2.11.2 Correction

Loop 2320, segment CAS, data element CAS01 = CR (Correction) overwrites the submitted encounter and will replace any previously submitted data. An adjustment indicator ('CR') within the CAS segment can only be used within the 2300 level loop. Line level corrections (2400 level loop) cannot be processed for encounter data purposes.

Example

Urban Care Plan determines that the NPI for the rendering provider was populated on the encounter instead of the NPI for the billing provider. In order to replace the encounter, Urban Care Plan will submit an 837 encounter using Loop-ID 2300, CLM05-3="7", REF01=F8 and REF02=ICN, and Loop ID-2320, CAS01="CR", and the correct rendering provider NPI populated along with all other correct information from the original encounter.

Example

Urban Care Plan determines that they mistakenly populated a line on the claim so they want to delete the line. How should Urban Care Plan delete the line from the claim?

Answer: Urban Care Plan cannot submit adjustment data on the line level. If the plan wants to delete the line only, they must populate Loop ID-2320, CAS01 with a value of 'CR' to correct the entire claim. The corrected claim with the deleted line becomes the final picture of the claim.

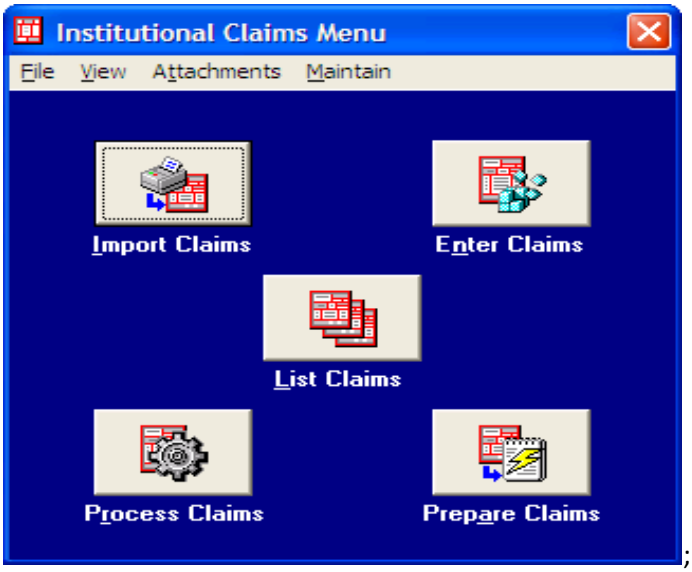
- When the MAO or entity submits a "CR", it overlays the previous encounter, including the previous diagnoses; therefore, those diagnoses would not be used for the calculation of the risk score.

2.12 PC ACE Pro-32 Software

CMS is not accepting paper claims for encounter data processing. PC ACE Pro-32 is a Windows-based claims processing software for electronic health care claim submission in the HIPAA-compliant format.

The software is free and designed for providers to transmit claims directly to the Medicare carrier and is an option for MAOs or other entities that do not have the capacity to build the 5010 and accept paper claims. Right now, the 5010 version of the Pro-32 is still being tested. Information will be posted on the CSSC Operations Web site once it becomes available. Figure 2F provides a screen shot of the Pro-32 tool.

Figure 2F – PC ACE Pro-32



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2.13 Pricing

Encounter data pricing methodologies were developed based on FFS pricing methods. All collected encounter data will be processed and priced in the appropriate EDPS sub-system. There are three (3) sub-systems to the EDPS:

- Institutional,
- Professional, and
- DME.

In each of these sub-systems, data elements on the claim, specifically NPI, TOB, POS, and HCPCS, determine the appropriate claims processing path. After the encounter data has been processed, the claim will then be priced according to FFS PRICERs and/or Fee Schedules (FS). PRICERs are also known as Prospective Payment Systems (PPS) and are used solely for pricing institutional services. There are nine (9) PRICERs used for encounter data. For some institutional services, where a PRICER has not been established, MA Encounter Data Rates and Reasonable Costs will be used to price the encounter data. Fee Schedules are used specifically for pricing of professional and DME services. There are five (5) FS that will be used to price data.

2.13.1 Encounter Data Institutional Processing and Pricing (EDIPPS)

Institutional facility types of service, both inpatient and outpatient, must be submitted with these data elements in order to process accurately:

- NPI,
- TOB,
- Occurrence codes,
- Value codes,
- Conditions codes,
- Revenue codes,
- HCPCS codes,
- Diagnosis codes,
- Beneficiary ID number (HIC number),
- Age,
- Gender, and
- Dates of service.

Facility-based encounter data services will process through the EDIPPS and will be priced according to a PPS (PRICER). In FFS, each distinct type of service has a specific PPS pricing methodology that is used and different elements are unique to each.

Prospective Payment Systems, General Information
http://www.cms.gov/ProspMedicareFeeSvcPmtGen/

There are some institutional services that will be priced using a FS. This occurs through the use of abstract files, pulled from the professional sub-system, in order to determine the correct pricing amounts for facility-based services, such as ambulance, laboratory, physician, or DME. These types of service will still process through the EDIPPS; however, select data elements will be priced with a FS instead of a PRICER.

Those services that are provided by facilities or providers that are not acceptable for risk adjustment must be submitted for encounter data. However, these services will not provide diagnosis codes for risk adjustment.

2.13.2 Encounter Data Professional Processing and Pricing (EDPPPS)

Professional types of service must be submitted to the EDS with the following data elements in order to process in the approved manner:

- NPI,
- POS code,
- HCPCS codes,
- CPT codes,
- Diagnosis codes,
- Diagnosis pointers,
- Zip codes,
- Beneficiary ID number,
- Age,
- Gender, and
- Dates of service.

The NPI is linked in NPPES to the primary specialty of the provider. Therefore, when processing in EDPPPS, edits will verify that the NPI is appropriate for the HCPCS code identified on the encounter data claim. The crosswalk of NPI primary specialties to HCPCS codes is updated annually. This data can then be cross walked to the List of Acceptable Physician Specialties that is used in risk adjustment and is provided in section 2.14.2.1 in this guide.

These professional encounter data services will process through the EDPPPS and will be priced according to a FS. In FFS, there are five (5) different FS that are used to price claims:

- Ambulance FS,
- Ambulatory Surgical Center FS,
- Clinical Laboratory FS,
- Medicare Physician FS, and
- DME FS.

Each of the FS has unique data elements of importance that determine the pricing amounts. In example, ambulance services must include a Point of Pick-Up (POP) zip code in all submitted encounters in order to determine the appropriate mileage to be paid. These same FFS methodologies will be used to price encounter data professional services.

Fee Schedules, General Information
http://www.cms.gov/FeeScheduleGenInfo/

Those services that are provided by professionals/physicians that are not acceptable for risk adjustment must be submitted for encounter data. However, diagnosis codes from these services will not be used for risk adjustment.

2.13.3 Encounter Data DME Processing and Pricing (EDDPPS)

DME supplier data must be submitted to the EDS with the appropriate POS, HCPCS code, CPT code, diagnosis codes, diagnosis pointers, zip codes, and the necessary demographic information such as beneficiary ID number, age, gender, and dates of service. These supplier-based encounter data DME services will process through the Encounter Data DME Processing and Pricing System (EDDPPS) and will be priced according to the DME FS.

Medicare uses FS to set prices for equipment, prosthetics, and orthotics. Items are assigned to categories and product groups. Table 2E1 identifies the category codes used to determine payment rates.

Those DME supplier services that are not acceptable under risk adjustment must be submitted for encounter data. However, diagnosis codes from these services will not be used for risk adjustment.

TABLE 2E1 – DME CATEGORY CODES

CATEGORY CODES			
IN	Inexpensive and Other Routinely Purchased Items	SD	Surgical Dressings
FS	Frequently Serviced items	PO	Prosthetics & Orthotics
CR	Capped Rental items	SU	Supplies
OX	Oxygen and Oxygen Equipment	TE	Transcutaneous Electrical Nerve Stimulators
OS	Ostomy, Tracheostomy & Urological Items	TS	Therapeutic Shoes

Medicare Claims Processing Manual, Chapter 20
http://www.cms.gov/manuals/downloads/clm104c20.pdf

2.14 Risk Adjustment Filtering Logic

As the industry transitions to the collection and submission of all encounter data into the EDS, the filtering logic used by CMS will affect the risk adjustment risk score calculation used to determine plan payment amounts. MAOs and other entities are responsible for submitting data from all data sources to the EDS. However, only data from acceptable risk adjustment sources will be used to calculate the risk score in the risk adjustment payment. A filtering process will be applied to identify the data that will be used to calculate the risk score.

2.14.1 Institutional Filtering Logic

Once the collected encounter data has been processed according to the EDIPPS for institutional services, then it will be considered for use in risk adjustment. For facility services, the filtering logic is based on the TOB submitted on each claim.

Table 2F1 identifies the filtering logic to be used with institutional encounter data services to determine those applicable for risk adjustment payments. Those rows highlighted within the table are not acceptable for the risk adjustment models. This data must still be submitted to the EDS; however, it will not be used for risk score calculations or payments.

TABLE 2F1 – UNDERSTANDING FILTERING LOGIC – INSTITUTIONAL

ENCOUNTER DATA SERVICE	TOB	CROSSWALK TO RISK ADJUSTMENT SOURCE OF DATA	PAYMENT IN RISK ADJUSTMENT	TRANSLATOR PROCESSEING	EDPS SUB-SYSTEM	PRICING
Inpatient Hospital	11X	Short-term (general and specialty) Hospitals	Yes	CEM	EDIPPS	IPPS

TABLE 2F1 – UNDERSTANDING FILTERING LOGIC – INSTITUTIONAL (CONTINUED)

ENCOUNTER DATA SERVICE	TOB	CROSSWALK TO RISK ADJUSTMENT SOURCE OF DATA	PAYMENT IN RISK ADJUSTMENT	TRANSLATOR PROCESSEING	EDPS SUB-SYSTEM	PRICING
Inpatient Rehabilitation Facility	11X	Rehabilitation Hospitals	Yes	CEM	EDIPPS	IRF PPS
Inpatient Psychiatric Facility	11X	Psychiatric Hospitals	Yes	CEM	EDIPPS	IPF PPS
Long-Term Care Hospital	11X	Long-term Hospitals	Yes	CEM	EDIPPS	LTCH PPS
Religious Non-Medical Healthcare Institutions (RNHCI)	41X, 51X	Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	Yes	CEM	EDIPPS	Encounter Rate, DME FS
Outpatient Hospital	12X, 13X, 14X	Short-term (general and specialty) Hospitals	Yes	CEM	EDIPPS	OPPS, MPFS
Community Mental Health Center	76X	Community Mental Health Centers	Yes	CEM	EDIPPS	OPPS
Critical Access Hospital Inpatient	11X	Medical Assistance Facilities/Critical Access Hospitals	Yes for Inpatient	CEM	EDIPPS	Reasonable Cost, MPFS
Critical Access Hospital Outpatient	85X	Medical Assistance Facilities/Critical Access Hospitals	Yes	CEM	EDIPPS	Reasonable Cost, MPFS
Rural Health Clinic	71X	Rural Health Clinic (Free-standing and Provider-Based)	Yes	CEM	EDIPPS	Encounter Rate, MPFS
Federally Qualified Health Center	77X	Federally Qualified Health Centers 2/ Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	Yes	CEM	EDIPPS	Encounter Rate
Outpatient Rehabilitation Facility (CORF/ORF)	74X, 75X	Rehabilitation Hospital	Yes	CEM	EDIPPS	MPFS

2.14.2 Professional and DME Filtering Logic

For professional and DME services, once the collected encounter data has been processed according to the EDPPPS or EDDPPS, respectively, then it will be considered for use in risk adjustment. For professional and DME services, the filtering logic is based on the NPI submitted on each claim, which will then map to a specialty code indicator as assigned by the EDPSC.

Table 2G1 identifies the filtering logic to be used with professional and DME encounter data to determine those applicable for risk adjustment payments. In order to promote understanding of the filtering logic, in the table below, sample data that would need to be populated on the 837-P format have been completed. These examples are explained further below the table. Those rows highlighted in orange within the table are not acceptable for the risk adjustment. This data must be submitted to the EDS; however, it will not be used for risk score calculations or payments.

TABLE 2G1 – UNDERSTANDING FILTERING LOGIC – PROFESSIONAL AND DME

Encounter Data Service	Specialty Code	Crosswalk to Risk Adjustment Source of Data	Payment in Risk Adjustment	Translator Processing	Encounter Data Processing System	Pricing
General Practitioner	01	**See Acceptable Physician Specialty List	Yes	CEM	EDPPPS	MPFS

2.14.2.1 Acceptable Physician Specialties

Professional data requires face-to-face visits with those professionals listed on the CMS specialty list, as identified by a specialty code. Any specialty code not listed on the most current specialty list must still be submitted to EDS but will not contribute to risk adjustment payment determination.

Table 2H1 provides current EDS professional sources of data and acceptable for risk adjustment payment.

TABLE 2H1 – PROFESSIONAL RISK ADJUSTMENT PAYMENT

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
01	General Practice	26	Psychiatry	67	Occupational Therapist
02	General Surgery	27**	Geriatric Psychiatry	68	Clinical Psychologist
03	Allergy/Immunology	28	Colorectal Surgery	72*	Pain Management
04	Otolaryngology	29	Pulmonary Disease	76*	Peripheral Vascular Disease

TABLE 2H1 – PROFESSIONAL RISK ADJUSTMENT PAYMENT (CONTINUED)

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
05	Anesthesiology	33*	Thoracic Surgery	77	Vascular Surgery
06	Cardiology	34	Urology	78	Cardiac Surgery
07	Dermatology	35	Chiropractic	79	Addiction Medicine
08	Family Practice	36	Nuclear Medicine	80	Licensed Clinical Social Worker
09**	Interventional Pain Management (IPM)	37	Pediatric Medicine	81	Critical care (intensivists)
10	Gastroenterology	38	Geriatric Medicine	82	Hematology
11	Internal Medicine	39	Nephrology	83	Hematology/Oncology
12	Osteopathic Manipulative Therapy	40	Hand Surgery	84	Preventive Medicine
13	Neurology	41	Optometry	85	Maxillofacial Surgery
14	Neurosurgery	42	Certified Nurse Midwife	86	Neuropsychiatry
15	Speech Language Pathologist	43	Certified Registered Nurse Anesthetist	89*	Certified Clinical Nurse Specialist
16	Obstetrics/Gynecology	44	Infectious Disease	90	Medical Oncology
17**	Hospice And Palliative Care	46*	Endocrinology	91	Surgical Oncology
18	Ophthalmology	48*	Podiatry	92	Radiation Oncology
19	Oral Surgery	50*	Nurse Practitioner	93	Emergency Medicine
20	Orthopedic Surgery	62*	Psychologist	94	Interventional Radiology
22*	Pathology	64*	Audiologist	97*	Physician Assistant
24*	Plastic And Reconstructive Surgery	65	Physical Therapist	98	Gynecologist/Oncologist
25	Physical Medicine And Rehabilitation	66	Rheumatology	99	Unknown Physician Specialty

* Indicates that a number has been skipped.

** Effective as of 10/1/2010.

2.15 Summary

During this module, test submission requirements and acceptable data sources for encounter data submission were identified. Participants were provided information to support the development and submission of encounter data into the EDS.

Appendix A: Atypical Provider Types

Atypical Provider Type	Definition	Comments
Adult Companion	An individual who provides supervision, socialization, and non-medical care to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. These services are provided in accordance with a therapeutic goal in the plan of care. (NUCC)	Not a healthcare provider and does not provide healthcare.
Adult Foster Care Facility	A custodial care facility providing supportive and personal care services to disabled and/or elderly individuals who cannot function independently in most areas of activity and need assistance and monitoring to enable them to remain in a home like environment. (NUCC) "Adult foster care services" means supervision, assistance with eating, bathing, toileting, dressing, self-medication and other routines of daily living or services. Provided in a residential setting that includes room and board. The sponsor or manager resides with the residents and provides a family setting.	On taxonomy list as "adult care home". There is no medical component. Medical services may be provided in this setting, however they are normally provided by another entity such as a home health agency or a physician or visiting nurse, therapist, etc.
Au Pairs	(From Merriam Webster): A young foreigner who does domestic work for a family in exchange for room and board and a chance to learn the family's language.	Does not provide healthcare
Behavioral Respite Services	**From NUCC: Respite Care, Mental Retardation and/or Developmental Disabilities, Child** A facility or distinct part of a facility that provides short term, residential care to children, diagnosed with mental retardation and/or developmental disabilities as respite for the regular caregivers.	CMS has specified that respite care is not healthcare
Blood Bank	An institution (organization or distinct part thereof) that performs, or is responsible for the performance of, the collection, processing, storage and/or issuance of human blood and blood components, intended for transfusion. The institution may also collect, process, and/or distribute human tissue, including bone marrow and peripheral blood progenitor cells, intended for transplantation. (NUCC)	Per Privacy Rule preamble (82477) not considered healthcare and the organizations performing the service are not considered healthcare providers.
Boarding Home	A boarding home provides personal care, respite care and homemaker services.	Requirements on licensure may vary between states. May also be referred to as a custodial care facility, adult foster care, assisted living, etc. (see under assisted living) If no medical component is provided, then not eligible for NPI.
Chore Provider	**Chore Provider -** An individual who provides home maintenance services required to sustain a safe, sanitary living environment for individuals who because of age or disabilities are unable to perform the activities. These services include heavy household chores such as	Not a healthcare provider and does not provide healthcare

Atypical Provider Type	Definition	Comments
	washing floors, windows, and walls; tacking down loose rugs and tiles; and moving heavy items of furniture in order to provide safe access and egress. (NUCC)	
Coding Specialist, Hospital or Physician Office Based	No definition by NUCC yet. A Coding Specialist analyzes health information and assigns codes to index diagnoses and procedures to support clinical care, to assist medical research and to provide information for reimbursement purposes.	Not a healthcare provider and does not provide healthcare
Custodial Care Facility	**Custodial Care Facility -** A facility providing care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. (NUCC)	Does not provide healthcare
Day Care Providers (Developmentally Disabled Daycare)	**Day Training, Developmentally Disabled Services -** These agencies are authorized to provide day habilitation services to developmentally disabled individuals who live in their homes. The function of day habilitation is to assist an individual to acquire and maintain those life skills that enable the individual to cope more effectively with the demands of independent living. Also to raise the level of the individual's physical, mental, social, and vocational functioning. (NUCC) See also adult daycare provider.	"Developmentally disabled day care" means a service that provides planned care supervision and activities, personal care, activities of daily living skills training and habilitation services in a group setting during a portion of a continuous twenty-four hour period. "Activities of daily living" means ambulating, communicating, bathing, toileting, grooming, feeding and homemaking.
Day Training, Developmentally Disabled Services	These agencies are authorized to provide day habilitation services to developmentally disabled individuals who live in their homes. The function of day habilitation is to assist an individual to acquire and maintain those life skills that enable the individual to cope more effectively with the demands of independent living. Also to raise the level of the individual's physical, mental, social, and vocational functioning. (NUCC)	CMS specifies that habilitation is not a healthcare service
Driver	A person employed to operate a motor vehicle as a carrier of persons or property. (NUCC)	Not a healthcare provider and not providing healthcare.
Emergency Response System Companies (Alarm Companies)	Response system triggered by patient or machine indication of an emergency which may require medical attention.	A company that makes or installs the system is not providing healthcare so is not eligible for an NPI.
Environmental Modifications	**Contractor:** A person who contracts to supply certain materials or do certain work for a stipulated sum; esp., one whose business is	Environmental providers remodel homes [widen doorways for

Atypical Provider Type	Definition	Comments
Provider [Environmental Accessibility Providers, Building Contractors, Home Modifications]	contracting work in any of the building trades. For purposes of the taxonomy, a person who contracts to complete home repairs or modifications to accommodate a health condition (e.g. wheelchair ramp, kitchen counter lowering). (NUCC)	wheelchairs, install grab bars in bathroom, etc.] when it is a cost effective alternative to nursing facility placement. CMS has specified that building contractors, carpenters, etc. are not providing healthcare and are not eligible for an NPI.
Financial Administration Entity	Waiver service. Facilitates the employment of service workers by the waiver participant and the management of the self-determination budget. FA is available only to participants who self-direct services. The use of FA is mandatory whenever the participant is the employer of record for one or more service workers. The FA acts in the place of a home health agency in respect to the employment of the service workers.	Not providing healthcare – acting as a fiscal agent or contract employment agency
Foster Homes for Children	Residential setting in a family home in which the care, physical custody and supervision of the child are the responsibility, under a twenty-four hour care model, of the licensee who serves as the foster parent of the child in the home setting and who, in that capacity, is not an employee of the division or of a service provider and the home provides the following services for a group of siblings or up to three children: (a) Room and board. (b) Appropriate personal care. (c) Appropriate supervision.	Not providing healthcare (see Adult Foster Care)
Funeral Director	A person, usually an embalmer, whose business is to arrange for the burial or cremation of the dead and to assist at the funeral rites (NUCC)	Not a healthcare provider – not eligible for an NPI.
Graphics Designer	The practice or profession of designing print or electronic forms of visual information, as for an advertisement, publication, or website. (from American Heritage Dictionary)	Not a healthcare provider – not eligible for an NPI.
Habilitation Provider (Daily living skills)/ Residential Habilitation providers	**Day Training/Habilitation Specialist -** Individuals experienced or trained in working with developmentally disabled individuals who need assistance in acquiring and maintaining life skills that enable them to cope more effectively with the demands of independent living. (NUCC)	CMS specifies that habilitation is not healthcare. In Medicaid waiver services, habilitation services include prevocational, educational and supported employment services. The services are not healthcare services so a habilitation provider would not be eligible for an NPI. Habilitation services are provided to people with disabilities to

Atypical Provider Type	Definition	Comments
		develop the skills necessary to live and work in the community at their highest level of independence.
Home Delivered meals	Home-delivered meals are those services or activities designed to prepare and deliver one or more meals a day to an individual's residence in order to prevent institutionalization, malnutrition, and feelings of isolation. Component services or activities may include the cost of personnel, equipment, and food; assessment of nutritional and dietary needs; nutritional education and counseling; socialization services; and information and referral. (NUCC)	Home delivered meals, which means a service that provides for a nutritious meal containing at least one-third of the recommended dietary allowance for an individual and which is delivered to the member's residence.
Homemaker	An individual who provides general household activities such as meal preparation, laundry, and light housekeeping, when the individual regularly responsible for these activities is temporarily absent or unable to provide for himself. Homemakers must meet the state defined training standards. (NUCC)	Not a healthcare provider – not eligible for an NPI.
(Language) Interpreters	A person who translates oral communication between two or more people. This includes translating from one language to another or interpreting sign language	CMS has said that language interpreters are not health care providers and thus are not eligible for an NPI
Lodging (hotel)	A public or privately owned facility providing overnight lodging to individuals traveling long distances or receiving prolonged outpatient medical services away from home. (NUCC)	Not a healthcare provider and not providing healthcare
Medical Records Providers	**Technician, Health Information -** Preferred term for an Accredited Record Technician who is an individual with an associate's degree from an accredited college or independent study program that is skilled in analyzing health information and in examination of medical records for accuracy, reporting of patient data for reimbursement, and creation of disease registries for researchers. (NUCC)	This is an administrative service, not healthcare that is provided, so not eligible for an NPI
Non-Emergency Transportation Providers	**Taxi -** A land commercial vehicle used for the transporting of persons in non-emergency situations. The vehicle meets local, county or state regulations set forth by the jurisdictions where it is located. (NUCC) **Bus -** A public or private organization or business licensed to provide bus services. **Non-emergency Medical Transport (VAN) -** A land vehicle with a capacity to meet special height, clearance, access, and seating, for the conveyance of persons in non-emergency situations. The vehicle may or may not be required to meet local county or state regulations. **Private Vehicle -** An individual paid to provide non-emergency transportation using their privately owned/leased vehicle. **Train -** An organization or business licensed to provide passenger	Transportation to and from medically necessary services. Could be taxi companies. Individual providers must have proof of insurance. Companies must ensure that employees are licensed to drive, have current insurance. Other types of transportation include boats, hovercraft, ferries, airlines, charter planes, helicopters, etc.

Atypical Provider Type	Definition	Comments
	train service, including light rail, subway, and traditional services. **Transportation Broker -** A public or private organization or business contracted to arrange non-emergency medical transportation services, including appropriate ancillary services, e.g., lodging. (NUCC)	
Organ Procurement Organization	A federally designated organization that works with hospital personnel in retrieval of organs for transplantation. The federal government designates an OPO's service area and the hospitals with which an OPO is to establish working relationships. (NUCC)	Does not meet the definition of health care provider found at 45 CFR 160.103.
Spiritual Counselor or Care Provider	**(various web info) Spiritual counseling** is to assist you in finding God in the midst of life events and prayerfully support you during life's changes. Spiritual counseling is designed to inspire and awaken you to the possibilities of spiritual growth in the midst of life events. Spiritual counselors joyously give you unconditional love and empower you to connect with your own divine guidance. You may speak with us about relationships, prosperity, health, substance abuse, family or career issues, spiritual growth or anything of concern to you. It is our aim to help you focus on the solution, not the problem, and to see the solution with the eyes of Christ as you build your conscious awareness of God's presence, power, and activity in your life. Some identify themselves as psychics, faith healers, Christian counselors, life coaches, channels, ministers, soul advisors, and more.	A spiritual counselor does not appear to be a healthcare provider or an entity providing healthcare – would be atypical.
Peer Support Specialist	(From Peer-to-Peer Resource Center): A Peer Specialist is a person with a mental illness who has been trained to help her/his peers – other people with mental illnesses - to identify and achieve specific life goals. The Peer Specialist cultivates the ability of those they assist to make informed, independent choices and set goals, and to gain information and support from the community to achieve those goals. A Peer Specialist promotes self-determination, personal responsibility and empowerment inherent in self-directed recovery, and assists people with mental illnesses in regaining control over their own lives and over their own recovery process. As someone who experiences a mental illness themselves, the Peer Specialist models competency in recovery and maintaining ongoing wellness. Peer Specialists work for pay in either the public or private sectors of health care and in outpatient, inpatient, and agency settings.	Not a healthcare provider and not providing a health care service
Personal Care Attendants/ Personal Care Providers	An individual who provides assistance with eating, bathing, dressing, personal hygiene, activities of daily living as specified in the plan of care. Services which are incidental to the care furnished or essential to the health and welfare of the individual may also be provided.	CMS has identified personal care as a non-healthcare service

Atypical Provider Type	Definition	Comments
	Personal care providers must meet state defined training and certification standards. (NUCC)	
Personal Care Provider Organizations	(From MN): These are agencies that provide personal care services (activities of daily living like bathing, assistance with eating, toileting, dressing etc.) They do not have Medicare certification like a Home Health Agency.	No healthcare is provided.
Point of Service	This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the networks for an additional cost.	This would be considered a product – not a healthcare provider and not a healthcare service.
Polygraph examiner (licensed)	Polygraph examiners detect deception, verify truthfulness or provide a diagnostic opinion of either, through the use of an instrument or mechanical device.	A polygraph exam may be required by courts and child welfare agencies related to sex offenders. A polygrapher is not providing healthcare so is not eligible for an NPI
Preferred Provider Organization	A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO, the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level. (NUCC)	A **PPO** is an arrangement whereby a third party payer contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients. This would be considered a product, insurance plan or financial arrangement, not a healthcare provider.
Pre-maternal Homes	Pregnant women who live in the rural villages will be brought to urban areas 30 days before their due date. They stay in what is similar to a hostel or residential facility. Congregate meals, have room mates, may share a bathroom. They receive education on taking care of their baby. The purpose of these homes is to ensure that the mom-to-be is not without medical care when it is time to deliver.	The homes do not provide healthcare so are not eligible for an NPI. **Lodging -** A public or privately owned facility providing overnight lodging to individuals traveling long distances or receiving prolonged outpatient medical services away from home. (NUCC)
Registered Records Administrator	No definition by NUCC yet (from Univ of CA Irvine): **Medical Record Administrators** plan, direct and/or supervise the acquisition, analysis, storage and retrieval of medical and related information in a campus medical facility; and perform other related duties as required. Incumbents typically	Not providing healthcare.

Atypical Provider Type	Definition	Comments
	design, initiate, and coordinate methods for collecting, analyzing, storing, retrieving and reporting patient medical information and statistics in accordance with the requirements of federal, state and local laws, the standards of accrediting and regulatory agencies, the data needs of physicians, researchers, students and administrators, and information requirements of patients, attorneys, insurance firms, and governmental agencies; plan and coordinate the development of medical information systems to insure effective maintenance and retrieval medical records; inspect records to insure completeness and internal consistency in quality control and data substantiating diagnosis and treatment; assist clinical staff in establishing criteria for the evaluation of patient care; maintain confidentiality of patient records in accordance with established legal requirements; maintain liaison with clinical and other users of medical records; assist clinical staff in research utilizing medical records; assist in defining and maintaining standards for medical record keeping; and may supervise other professional, technical and/or clerical personnel. Must have certification as a Registered Record Administrator by the American Medical Record Association or eligibility for examination for accreditation.	
School Based Transportation	From Michigan Medicaid School Based policy: Special education transportation services include transport to and from the student's pick-up and drop-off site where school based services are provided. It includes no more than one round-trip on a date of service. The need for special education transportation must be specified in the student's IEP/IFSP treatment plan. Medicaid may reimburse for special education transportation when a student receives a Medicaid-covered service on the same day. Medicaid does not reimburse for transportation provided in a regular or general education school bus. Also, there is no additional payment for an attendant.	**Bus -** A public or private organization or business licensed to provide bus services. (NUCC)
School Counselor	(From ASCA): The **professional school counselor** is a certified/licensed educator trained in school counseling with unique qualifications and skills to address all students' academic, personal/social and career development needs. Professional school counselors implement a comprehensive school counseling program that promotes and enhances student achievement. Professional school counselors are employed in elementary, middle/junior high and high schools and in district supervisory, counselor education and post-secondary settings. Their work is differentiated by attention to developmental stages of student growth, including the needs, tasks and student interests related to those stages. Professional school counselors have a master's degree or higher in school counseling or the substantial equivalent, meet the state certification/licensure standards and abide by the laws of the states in which they are	Not healthcare providers and do not provide healthcare

Atypical Provider Type	Definition	Comments
	employed.	
Specialist/Technologist, Health Information	An individual with a high school diploma, on-the job experience and coding education from seminars or college classes who passes a national certification examination in either inpatient and outpatient facility services coding, or physician services coding.	Not a healthcare provider and does not provide healthcare
State School for Deaf and Blind	Schools for the Deaf and Blind is a statewide agency providing educational services to visually impaired students and youth. Technical Assistance to Schools (TAS) works with IEP teams in school districts throughout the state to provide comprehensive assessments to support effective educational programming for students who have sensory impairments, including those with multiple disabilities. Support is also offered through consultation and training for teachers, school personnel and families to address the specialized needs of these students.	If the school provides school-based health services and bills Medicaid for the services, usually the LEA (Local Education Agency) or Intermediate school district is the designated biller and pay-to provider. See discussion under School Systems. Educational services are not healthcare in this context so the school for the Deaf & Blind would not be eligible for an NPI.
Supervisory Care Home	Provide room, board, and general supervision to multiple people.	Sounds like a custodial care facility – see definition.
Supported Employment Services	Supported employment is paid employment which: • Is for persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting; • Is conducted in a variety of settings, particularly worksites in which persons without disabilities are employed; and • Is supported by any activity needed to sustain paid work by persons with disabilities, including supervision, training and transportation. (State Medicaid Manual 4442.3)	Not a healthcare service. The provider of this service likely is not a healthcare provider and would not be eligible for an NPI.
Supported Living Providers Individual	Supported living services assist people with disabilities to live in their own home or apartment with the support of trained staff assistance. Supported Living Services include: assistance with securing and maintaining housing, housekeeping and meal preparation, personal care, money management, hiring, training, scheduling and supervising direct support staff and 24 hour emergency response services.	These services are covered under Medicaid Waiver programs. These are not healthcare services.
Supported Living Providers Institution	See services provided above. The institutional setting would be for people who cannot live totally by themselves, or are aged or disabled, and need support in meals, laundry, chore service, personal care.	This is not healthcare provider.
Supports Brokerage Providers	From CMS Independence Plus Waiver template: Case Management/Supports Brokerage: Service/function that assists participating families and individuals to make informed decisions about what will work best for them, are consistent with their needs and reflect their individual circumstances.	Similar to non-medical case management activities. Not providing health care so not eligible for NPI.

Atypical Provider Type	Definition	Comments
	Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem solving. The service/function provides sufficient information to assure that participants and their families understand the responsibilities involved with self-direction and assist in the development of an effective back-up and emergency plan. States may elect to fulfill the requirement of this service/function using a self-directed case manager or creating a distinct service. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. The services/functions included in Supports Brokerage are mandatory requirements of the template. From Louisiana Waiver: Supports Brokerage is provided by targeted case managers and includes the following: • Educates the family about the service planning process • Elicits information from the individual or family regarding their preferences, goals and service needs 1 • Assists with the identification of direct supports, community, public and private resources • Monitors consumer satisfaction and service delivery • Initiates and facilitates planning meetings From Kansas Waiver application: Supports Brokerage: Services include assistance in enrolling, accessing other systems, developing the Plan for Independence and the Individualized Budget, managing personal attendants, documenting the need for assistive services, planning for and documenting the use of excess funds and locating and maintaining services. From New Hampshire Independence Plus Waiver: Supports Brokerage is called Family Support/Service Coordination. It is a waiver services, and includes the following: • Coordinating, facilitating and monitoring services provided under the waiver; • Assessing and reassessing service needs; • Assistance with recruiting, screening, hiring, and training in-home support providers; • Identifying, providing information regarding and assisting families to access community resources and supports;	

Atypical Provider Type	Definition	Comments
	• Development, review, and modification of service agreements; • Providing counseling and support; • Skills and advocacy training for the child/individual or representative; • Monitoring consumer satisfaction; • Initiating, collaborating and facilitating the development of a transition plan at the age of 16, to access adult supports, services, and community resources when the child/individual turns age 21; and • Creating and maintaining work registries.	
Technician, Health Information	Preferred term for an Accredited Record Technician who is an individual with an associate's degree from an accredited college or independent study program who is skilled in analyzing health information and in examination of medical records for accuracy, reporting of patient data for reimbursement, and creation of disease registries for researchers. (NUCC)	Appears to be administrative and not a provider of healthcare No definition for Assistant Record Technician yet.
Vehicle Accessibility Modifications provider	**(Contractor) Vehicle Modifications -** A contractor who makes modifications to private vehicles to accommodate a health condition. (NUCC)	Not a healthcare provider – not eligible for an NPI.
Veterinarian	A doctor of veterinary medicine trained and authorized to practice veterinarian medicine and surgery. (NUCC)	Not a healthcare provider and does not provide healthcare to individuals – not eligible for an NPI.

MODULE 3 – REPORTS

Purpose

This module introduces participants to the Encounter Data Front-End System (EDFES) acknowledgment reports and provides insight on the appropriate use of encounter data acknowledgement reports to manage data submission and error resolution processes.

Learning Objectives

At the completion of this module, participants will be able to:

- Interpret EDFES acknowledgement reports.
- Describe the Encounter Data System (EDS) error codes.
- Identify Common Edits and Enhancement Modules (CEM) edits applied within EDS.

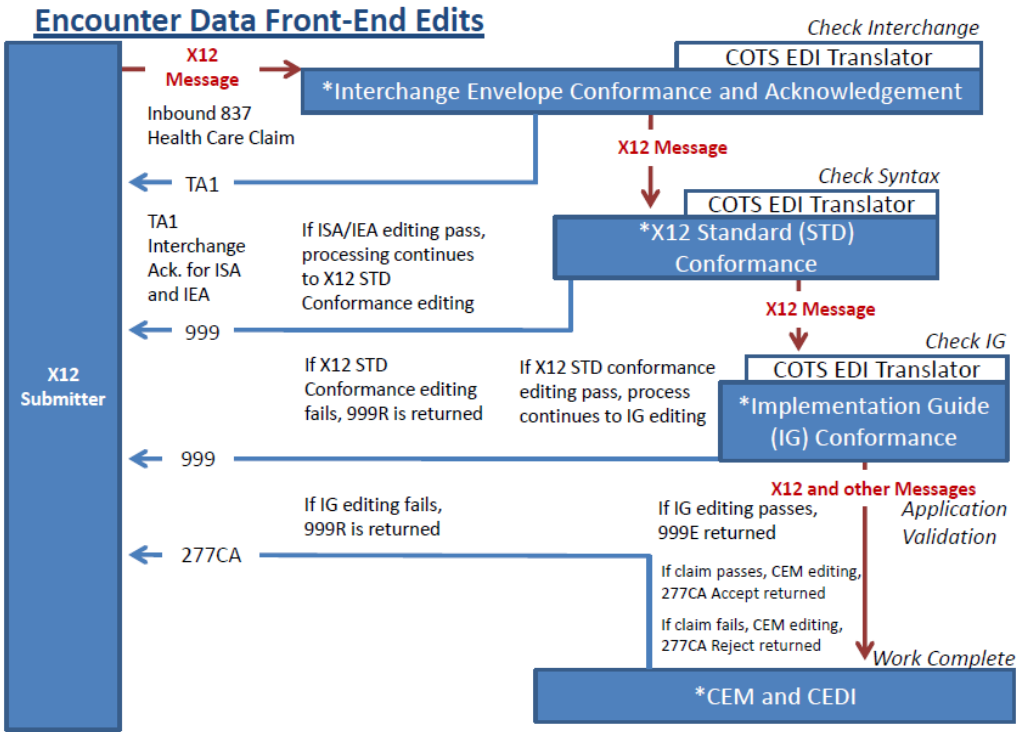
ICON KEY	
Definition	
Example	
Reminder	
Resource	

3.1 Data Flow and Reporting

After Medicare Advantage Organizations (MAOs) and other entities submit data, the EDFES performs format and integrity checks on the file at the Electronic Data Interchange (EDI) translator and CEM levels. The EDI translator will perform all X12 syntax edits and CMS selected HIPAA Implementation Guide (IG) edits, and output the TA1 and 999 acknowledgement reports. The CEM software will perform Medicare and CMS selected IG edits. An internal claim control number (ICN) will be assigned for accepted encounters. A 277CA will be generated for each accepted or rejected file and the flat file containing all accepted encounters will be forwarded to the Encounter Data Processing System (EDPS).

Figure 3A illustrates the flow of data for edit processing.

Figure 3A – Encounter Data Front-End Edits



3.2 Reports Naming Convention

In order for MAOs and other entities to receive the TA1, 999, and 277CA, one (1) of three (3) approved connectivity application methods must be used. The EDFES incorporates a unique file naming convention for 837-I and 837-P (production and test) acknowledgement reports. Based on the connectivity method, MAOs and other entities will receive the acknowledgement reports as flat files directly to the EDS mailbox. Flat files can be retrieved from MAO's and other entities' mailbox for 14 days. The file name ensures that the specific reports are appropriately distributed to each secure, unique mailbox. Table 3A provides the file naming conventions by connectivity method.

TABLE 3A – FILE NAMING CONVENTIONS BY CONNECTIVITY METHOD

CONNECTIVITY METHOD	TESTING NAMING CONVENTION	PRODUCTION NAMING CONVENTION
GENTRAN	GUID.RACF.EDS.FREQ.CCCCC.FUTURE.T	GUID.RACF.EDS.FREQ.CCCCC.FUTURE.P
NDM	MAB.PROD.NDM.EDST.TEST.ENXXXXX (+1)	MAB.PROD.NDM.EDST.PROD.ENXXXXX(+1)
FTP	User Defined	User Defined

3.3 TA1 Acknowledgement Report

As the interchange envelope enters the EDFES, the EDI translator performs TA1 validation of the ISA/IEA, which is the X12 interchange. The TA1 validates the interchange stage at the X12 interchange level and reviews the ISA/IEA interchange and their consistency with the data contained. Errors found in this stage will cause the entire X12 interchange to be rejected with no further processing.

MAOs and other entities will receive a TA1 interchange report acknowledging the syntactical incorrectness of an X12 interchange header ISA and trailer IEA, and the envelope's structure. Encompassed in the TA1 is the interchange control number, interchange date and time, interchange acknowledgement code, and interchange note code. The interchange control number, date, and time are identical to those that were populated on the original 837-I or 837-P ISA line, which allows for MAOs and other entities to associate the TA1 with a specific file previously submitted.

Within the TA1 segment, MAOs and other entities will be able to determine if the interchange was rejected by examining the interchange acknowledgement code (TA104) and the interchange note code (TA105). The interchange acknowledgement code stipulates whether the interchange (ISA/IEA) rejected due to syntactical errors. An "R" will be the value in the TA104 data element if the interchange was rejected due to errors. The interchange note code is a numeric code that notifies MAOs and other entities of the specific error. The TA1 interchange acknowledgment report is generated and returned within 24 hours after submitting the interchange if a fatal error occurs. If a TA1 interchange control structure error is identified, MAOs and other entities must correct the error and resubmit the interchange file.

- Refer to Table 3B below, TA104 (#22) and TA105 (#23) data elements, which provides the interchange acknowledgement code and interchange note code positions on the TA1 segment. Table 3C provides a complete list of interchange note codes that MAOs may receive.

Example: Apple Health Plan received a TA1 acknowledgement indicating the interchange was rejected due to an Invalid Interchange ID for the Sender. The TA104 data element indicates the interchange was rejected, as shown by an "R." The TA105 data element indicates an interchange note code of "006," which means the interchange was rejected due to an invalid interchange sender ID.

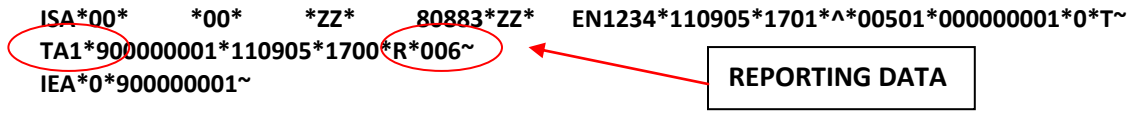


TABLE 3B – TA1 INTERPRETATION

REPORT LINE	REPORT LINE DESCRIPTION
ISA*00* *00* *ZZ*80883*ZZ*ENH1234* (1) (2) (3) (4) (5) (6) (7) (8) (9) 110905*1701*^*00501*000000001*0*T*:~ (10) (11) (12) (13) (14) (15)(16)(17)	**(1) ISA** – SEGMENT NAME - Interchange Control Header **(2) ISA01** – Authorization Information Qualifier **(3) ISA02** – Authorization Information (Not populated in this example) **(4) ISA03** - Security Information Qualifier (No Security Information Present) **(5) ISA04** – Security Information **(6) ISA05** – Interchange ID Qualifier **(7) ISA06** – Interchange Sender ID Interchange ID Qualifier (Mutually Defined) **(8) ISA07** – Interchange ID Qualifier **(9) ISA08** – Interchange Receiver ID **(10) ISA09** – Interchange Date **(11) ISA10** – Interchange Time **(12) ISA11** – Repetition Separator **(13) ISA12** – Internal Control Version Number **(14) ISA13** – Internal Control Number **(15) ISA14** – Acknowledgement Requested **(16) ISA15** – Usage Indicator **(17) ISA16** – Component Element Separator
TA1*900000001*110905*1700*R*006~ (18) (19) (20) (21) (22) (23)	**(18) TA1** – SEGMENT NAME - Interchange Acknowledgment **(19) TA01** - Interchange Control Number **(20) TA02** - Interchange Date **(21) TA103** – Interchange Time **(22) TA104** – Interchange Acknowledgement Code (R=Reject) **(23) TA105**– Interchange Note Code (See Table 3C for a complete list of TA1 error codes)

TABLE 3B – TA1 INTERPRETATION (CONTINUED)

REPORT LINE	REPORT LINE DESCRIPTION
IEA*0*900000001~ **(24) (25) (26)**	**(24) IEA** – SEGMENT NAME - Interchange Control Trailer **(25) IEA01** – Number of Included Functional Groups **(26) IEA02** – Interchange Control Number

Table 3C provides a complete list of interchange note codes that an MAO or other entity may receive on the TA1 acknowledgement report.

TABLE 3C – TA1 INTERCHANGE NOTE CODES

ERROR CODE	ERROR CODE DESCRIPTION
000	No Error
001	The Interchange Control Number in the header and trailer do not match
002	This standard as noted in the Control Standards Identifier is not supported
003	This version of controls is not supported
004	The segment terminator is invalid
005	Invalid Interchange ID Qualifier for sender
006	Invalid Interchange sender ID
007	Invalid Interchange ID Qualifier for receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier value
011	Invalid Authorization Information value
012	Invalid Security Information Qualifier value
013	Invalid Security Information value
014	Invalid Interchange Date value
015	Invalid Interchange Time value
016	Invalid Interchange Standards Identifier value
017	Invalid Interchange Version ID value
018	Invalid Interchange Control Number
019	Invalid Acknowledgement Requested value
020	Invalid Test Indicator value
021	Invalid Number of Included Group value
022	Invalid control structure
023	Improper (premature) end-of-file (transmission)
024	Invalid Interchange Content
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator

TABLE 3C – TA1 INTERCHANGE NOTE CODES (CONTINUED)

ERROR CODE	ERROR CODE DESCRIPTION
027	Invalid Component Element Separator
028	Invalid delivery date in Deferred Delivery Request
029	Invalid delivery time in Deferred Delivery Request
030	Invalid delivery time Code in Deferred Delivery Request
031	Invalid grade of service code

When MAOs and other entities receive a TA1 report indicating there was an error, this may be a result of developing the interchange inconsistent with the CMS edit spreadsheet. CMS provides MAOs and other entities an 837-I and 837-P edits spreadsheet, which identifies edits resulting in errors. Table 3D provides examples of TA1 level edits.

CMS Edits Spreadsheet
http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

TABLE 3D – TA1 LEVEL EDIT EXAMPLES

ELEMENT	ELEMENT DESCRIPTION	INTERCHANGE NOTE CODE	INTERCHANGE NOTE CODE DESCRIPTION
ISA01	Identification Code Qualifier	010	Invalid Authorization Information Qualifier Value
ISA02	Authorization Information	011	Invalid Authorization Information Value
ISA03	Security Information Qualifier	012	Invalid Security Information Qualifier Value
ISA04	Security Information	013	Invalid Security Information Value
ISA05	Interchange ID Qualifier	005	Invalid Interchange ID Qualifier for Sender
ISA06	Interchange ID	006	Invalid Interchange ID for Sender

3.4 999 Acknowledgement Report

After the interchange passes the TA1 edits, the next stage of editing is to apply Implementation Guide (IG) edits and verify the syntactical correctness of the functional group(s) (GS/GE). Functional groups allow for like data to be organized within an interchange; therefore, more than one (1) functional group with multiple claims within the functional group can be populated in a file. The 999 acknowledgement

report provides information on the validation of the GS/GE functional group(s) and their consistency with the data contained. The 999 report provides MAOs and other entities information on whether the functional group(s) were accepted or rejected.

If a file has multiple GS/GE segments and errors occurred at any point within one of the syntactical and IG edit validations, that GS/GE segment will be rejected and processing will continue to the next GS/GE segment. For instance, if a file is submitted with three (3) functional groups and the second functional group encounters errors, the first functional group will be accepted the second functional group will be rejected and processing will continue to the third functional group.

The 999 transaction set is designed to report on adherence to IG level edits and CMS standard syntax errors as depicted in the CMS edit spreadsheet. Three (3) possible acknowledgement values are:

- "A" – Accepted
- "R" – Rejected
- "E" – Accepted with non-syntactical errors

When viewing the 999 report, MAOs and other entities should navigate to the IK5 and AK9 segments. If an "A" is displayed in the IK5 and AK9 segments, the claim file is accepted and will continue processing. If an "R" is displayed in the IK5 and AK9 segments, an IK3 and an IK4 segments will be displayed. These segments indicate what loops and segments contain the error that needs correcting so the interchange can be resubmitted. The third element in the IK3 segment tells the loop that contains the error. The first element in the IK3 and IK4 indicate the segment and element that contain the error. The third element in the IK4 segment indicates the reason code for the error.

3.4.1 999A Acknowledgement Report

If an "A" value is populated in data element IK501 and AK901, a 999A level acknowledgement report will be generated to notify MAOs and other entities that the functional group(s) were accepted and will be forwarded for further processing.

Refer to Table 3E below, IK501 (#23) and AK901 (#25), which provides notification of an acceptance of the functional group(s).

Example: The following is an example of the 999A acknowledgement report showing an acceptance of the interchange file and contains one (1) GS/GE; however, there may be multiple GS/GE functional groups within an interchange. Table 3E provides interpretation for the 999A example provided.

**ISA*00* *00* *ZZ* 80881*ZZ* ENH1234*100831*1425*^*
00501 *243013828*0*T:~
GS*FA*80881*ENH1234*20100831*1425*243013832*X*005010X231~
ST*999*0001*005010X231~
AKI*HC*1111*005010X223A2~
AK2*837*111111111*005010X223A2~
IK5*A~
AK9*A*1*1*1~
SE*6*0001~
GE*1*243013832~
IEA*1*243013828~**

TABLE 3E – 999A INTERPRETATION

REPORT LINE	REPORT LINE DESCRIPTION
ISA*00*00*ZZ*80881*ZZ*ENH1234*100831*1425*00501*243013828*0*T~	Refer to Table 3B for the ISA interpretation.
GS*FA*80881*ENH1234*20100831*1425*243013832*X* **(1) (2) (3) (4) (5) (6) (7) (8)** **005010X231~** **(9)**	**(1) GS -** SEGMENT NAME - Functional Group Header **(2) GS01** – Functional Identifier Code **(3) GS02** – Application Sender's Code **(4) GS03** – Application Receiver's Code **(5) GS04** – Date (CCYYMMDD) **(6) GS05** – Time (HHMM) **(7) GS06** – Group Control Number **(8) GS07**– Responsible Agency Code **(9) GS08** – Implementation Convention Reference
ST*999*0001*005010X231~ **(10) (11) (12) (13)**	**(10) ST** – SEGMENT NAME - Transaction Set Header **(11) ST01** – Implementation Acknowledgement **(12) ST02** – Transaction Set Control Number (must be identical to SE02) **(13) ST03**– Implementation Convention Reference (same as GS08)
AKI*HC*1111*005010X223A2~ **(14) (15) (16) (17)**	**(14) AKI** – SEGMENT NAME - Functional Group Response Header **(15) AKI01** – Functional Identifier Code **(16) AKI02** – Group Control Number **(17) AKI03** – Implementation Convention Reference

TABLE 3E – 999A INTERPRETATION (CONTINUED)

REPORT LINE	REPORT LINE DESCRIPTION
AK2*837*111111111*005010X223A2~ **(18) (19) (20) (21)**	**(18) AK2** – SEGMENT NAME - Transaction Set Response Header **(19) AK201** – Transaction Set Identifier Code **(20) AK202** – Transaction Set Control Number **(21) AK203** – Implementation Convention Reference
IK5*A~ **(22) (23)**	**(22) IK5** – SEGMENT NAME - Transaction Set Response Trailer **(23) IK501** – Transaction Set Acknowledgement Code (accept)
AK9*A*1*1*1~ **(24) (25)(26)(27)(28)**	**(24) AK9** – SEGMENT NAME - Functional Group Response Trailer **(25) AK901** – Functional Group Acknowledgement Code (accept) **(26) AK902** – Number of Transaction Sets Included **(27) AK903** – Number of Received Transaction Sets **(28) AK904** – Number of Accepted Transaction Sets
SE*6*0001~ **(29) (30)(31)**	**(29) SE** – SEGMENT NAME - Transaction Set Trailer **(30) SE01** – Number of Included Segments **(31) SE02** – Transaction Set Control Number (must be identical to ST02)
GE*1*243013832~ **(32) (33) (34)**	**(32) GE** – SEGMENT NAME - Functional Group Trailer **(33) GE01** – Number of Transaction Sets Included **(34) GE02** – Group Control Number (must be identical to GS06)
IEA*1*243013828~ **(35) (36) (37)**	**(35) IEA** – SEGMENT NAME - Interchange Control Trailer **(36) IEA01** – Number of Included Functional Groups **(37) IEA02** – Interchange Control Number (must be identical to ISA13)

3.4.2 999R Acknowledgement Report

If an "R" value is populated in data element IK501 and AK901, a 999R level acknowledgement report will be generated to notify MAOs and other entities that the functional group(s) rejected and will not be forwarded for further processing. Although the 999 validates the functional group level, it also validates the ST-SE formatting. The 999R will reflect errors encountered at the functional group level (GS-GE). Errors in this stage will cause the entire X12 functional group (GS/GE) to be rejected with no further processing. The 999R is designed specifically to notify MAOs and other entities of the error location and the appropriate corrective steps to take to correct the errors. When a 999R is received, MAOs and other entities must correct and resubmit the entire corrected GS/GE functional group as part of their next interchange file.

The pivotal components of the 999R acknowledgement report are the IK5 and AK9 lines. These lines serve the same function as in the 999E report, but an "R" will be placed in the IK5 and AK9 lines, which notifies the MAO and other entities that the claim encountered a fatal error; therefore, the whole interchange file must be corrected and resubmitted.

3.4.2.1 Error Codes for 999R Acknowledgement Report

As mentioned for the 999E reports, errors are reported also in 999R in IK3, IK4, IK5, and AK9 segments. Table 3F provides the IK5 Implementation Transaction Set Syntax Error Codes for 999R acknowledgement reports. Table 3G provides AK9 Functional Set Syntax Error Codes for 999R.

TABLE 3F – IK5 IMPLEMENTATION TRANSACTION SET SYNTAX ERROR CODES

ERROR CODE	ERROR CODE DESCRIPTION
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
18	Transaction Set not in Functional Group
19	Invalid Transaction Set Implementation Convention Reference
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment

TABLE 3F – IK5 IMPLEMENTATION TRANSACTION SET SYNTAX ERROR CODES (CONTINUED)

ERROR CODE	ERROR CODE DESCRIPTION
27	S4S Security Start Segment Missing for S4E Security End Segment
I6	Implementation Convention Not Supported

Table 3G provides the Functional Group Syntax Error Codes that are located on the AK9 segment.

TABLE 3G – AK9 FUNCTIONAL GROUP SYNTAX ERROR CODES

ERROR CODE	ERROR CODE DESCRIPTION
1	Functional Group Not Supported
2	Functional Group Version Not Supported
3	Functional Group Trailer Missing
4	Group Control Number in the Functional Group Header and Trailer Do Not Agree
5	Number of Included Transaction Sets Does not Match Actual Count
6	Group Control Number Violates Syntax
10	Authentication Key Name Unknown
11	Encryption Key Name Unknown
12	Requested Service (Authentication or Encryption) Not Available
13	Unknown Security Recipient
14	Unknown Security Originator
15	Syntax Error in Decrypted Text
16	Security Not Supported
17	Incorrect Message Length (Encryption Only)
18	Message Authentication Code Failed
19	Functional Group Control Number Not Unique Within Interchange
23	S3E Security End Segment Missing for S3S Security Start Segment
24	S3S Security Start Segment Missing for S3E Security End Segment
25	S4E Security End Segment Missing for S4S Security Start Segment
26	S4S Security Start Segment Missing for S4E Security End Segment

When MAOs and other entities receive a 999 report indicating there was an error, this may be a result of developing the file inconsistent with the CMS edit spreadsheet. CMS provides MAOs and other entities an 837-I and 837-P edits spreadsheet, which identifies edits resulting in errors. Table 3H provides examples of 999R level edits.

CMS Edits Spreadsheet
http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

TABLE 3H – 999R LEVEL EDITS

LOOP	ELEMENT	ELEMENT DESCRIPTION	IK5/AK9	IMPLEMENTATION/ FUNCTIONAL GROUP SYNTAX CODE	IMPLEMENTATION/ FUNCTIONAL GROUP SYNTAX CODE DESCRIPTION
1000A	ST01	Transaction Set Header	IK5	6	Missing or Invalid Transaction Set Identifier
2010AA	ST02	Transaction Set Control Number	IK5	7	Missing or Invalid Transaction Set Control Number
2010AB	GS02	Application Sender Code	AK9	14	Unknown Security Originator
2010BA	GS03	Application Receiver Code	AK9	13	Unknown Security Recipient

Example

Trinity Health Plan submitted a file and received a 999R indicating the functional group was rejected. The 999R report reflects that an error was encountered in Loop ID-2300, segment CLM, data element CLM01 (Patient Control Number, WPC data element location 1028) was not populated.

ISA*00* *00* *ZZ*ENH1234 *ZZ*80881 *100429 *1415*^* 00501* 119003967*0*T~
GS*FA*80881*ENH1234*20100429*1415*11903970*X*005010231~
ST*999*0001*005010X231~
AKI*HC*7597*005010X223A2~
AK2*837*000000001*005010X223A2~
IK3*CLM*20*2300*8~
IK4*1*1028*1~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*119003970~
IEA*1*119003970~

3.4.3 999E Acknowledgement Report

If an "E" value is populated in data element IK501 and AK901, a 999E level acknowledgement report will be generated to notify MAOs and other entities that the functional group(s) were accepted with non-syntactical errors and will be forwarded for further processing. Although the 999 validates the functional group level, it also validates the ST-SE formatting.

The 999E is designed to reflect that the translator recognized an error, but the error is not significant enough to cause the whole file to reject. Rather, the error code will be transmitted to the CEM, and CEM level edits will then determine if the claim will be accepted or rejected.

CMS has identified certain edits to be processed as "Accept with Errors." If these are the only edits encountered in translator processing, the IK3, IK4, IK5 and AK9 segments will be populated with specific information to notify the MAOs and other entities of the data elements in error (IK3), the reason for the error (IK4), and that the claim was accepted with errors (IK5 and AK9).

- Refer to Table 3I below, IK3 (#1), IK4 (#6), IK5 and AK9, which provides notification of an acceptance with errors of the file, the original data elements in error, and the reason why the data elements were in error.

Example: Mercy Health Plan submits an interchange file to the EDS and receives a 999E report indicating the transactions were accepted with errors. Mercy Health Plan populated the 837-I with NM107 data element (Name Suffix, WPC data element location 1039), with JUNIOR. The 999E report notifies Mercy Health Plan that there was a data element in error, specifically that there was an invalid character in data element NM107.

**ISA*00* *00* *ZZ* 80881*ZZ* ENH1234*100625*1637*^*
00501*176009036*0*T:~
GS*FA*80881*ENH1234*20100625*1637*176009039*X*005010X231~
ST*999*0001*005010X231~
AK1*HC*5134*005010X223A2~
AK2*837*000000001*005010223A2~
IK3*NM1*30*2310*8~
IK4*7*1039*6*JUNIOR~
IK5*E*5~
AK9*E*1*1*1~
SE*9*0001~
GE*1*176009039~
IEA*1*176009036~**

TABLE 3I – 999E INTERPRETATION

REPORT LINE	REPORT LINE DESCRIPTION
ISA*00*00*ZZ*80881*ZZ*ENH1234*100625*137*^*00501 *176009036*0*T:~	Refer to Table 3B for the ISA interpretation
GS*FA*80881*ENH1234*20100625*1637*176009039*X*0 05010X231~	Refer to Table 3E for the GS interpretation

TABLE 3I – 999E INTERPRETATION (CONTINUED)

REPORT LINE	REPORT LINE DESCRIPTION
ST*999*0001*005010X231~	Refer to Table 3E for the ST interpretation
AK1*HC*5134*005010X223A2~	Refer to Table 3E for the AK1 interpretation
AK2*837*000000001*005010X223A2~	Refer to Table 3E for the AK2 interpretation.
IK3*NM1*30*2310*8~ **(1) (2) (3) (4) (5)**	**(1) IK3 –** SEGMENT NAME - Error Identification **(2) IK301 –** Segment Id Code **(3) IK302 –** Segment Position in Transaction Set **(4) IK303 –** Loop Identifier Code **(5) IK304 –** Implementation Segment Syntax Error Code
IK4*7*1039*6*JUNIOR~ **(6) (7) (8) (9) (10)**	**(6) IK4 –**SEGMENT NAME - Implementation Data Element Note **(7) IK401 –** Position in Segment **(8) IK402** – Data Element Reference Number **(9) IK403** – Implementation Data Element Syntax Error Code **(10) IK404** – Copy of Bad Data Element
IK5*E*5~	Refer to Table 3E for the IK5 interpretation
AK9*E*1*1*1~	Refer to Table 3E for the AK9 interpretation
SE*9*0001~	Refer to Table 3E for the SE interpretation.
GE*1*176009039~	Refer to Table 3E for the GE interpretation
IEA*1*176009036~	Refer to Table 3B for the IEA interpretation

3.4.3.1 Error Codes for 999E Acknowledgement Report

Even though the file will be forwarded for processing through the CEM, the error codes provided in the IK3 and IK4 lines will provide MAOs and other entities information if subsequent errors may be encountered during further processing. Table 3J provides IK3 implementation data element syntax error codes. Table 3K provides IK4 implementation data element syntax errors codes.

TABLE 3J – IK3 IMPLEMENTATION SEGMENT SYNTAX ERROR CODES

ERROR CODE	ERROR CODE DESCRIPTION
1	Unrecognized Segment ID
2	Unexpected Segment
3	Required Segment Missing
4	Loop Occurs over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors
I4	Implementation “Not Used” Segment Present
I6	Implementation Dependent Segment Missing
I7	Implementation Loop Occurs Under Minimum Times
I8	Implementation Segment Below Minimum Use
I9	Implementation Dependent “Not Used” Segment Present

TABLE 3K – IK4 IMPLEMENTATION DATA ELEMENT SYNTAX ERROR CODES

ERROR CODE	ERROR CODE DESCRIPTION
1	Required Data Element Missing
2	Conditional Required Data Element Missing
3	Too Many Data Elements
4	Data Element Too Short
5	Data Element Too Long
6	Invalid Character in Data Element
7	Invalid Code Value
8	Invalid Date
9	Invalid Time
10	Exclusion Condition Violated
12	Too Many Repetitions
13	Too Many Components
I10	Implementation “Not Used” Data Element Present
I11	Implementation Too Few Repetitions
I12	Implementation Pattern Match Failure
I13	Implementation Dependent “Not Used” Data Element Present
I6	Code Value Not Used in Implementation
I9	Implementation Dependent Data Element Missing

When MAOs and other entities receive a 999 report indicating there was an error, this may be a result of developing the file inconsistent with the CMS edit spreadsheet. CMS provides MAOs and other entities

an 837-I and 837-P edits spreadsheet, which identifies edits resulting in errors. Table 3L provides examples of 999E level edits.

CMS Edits Spreadsheet
http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

TABLE 3L – 999E LEVEL EDITS

LOOP	ELEMENT	ELEMENT DESCRIPTION	DATA ELEMENT SYNTAX ERROR CODE	DATA ELEMENT SYNTAX ERROR CODE DESCRIPTION
1000A	NM106	Name Prefix	I10	Implementation "Not Used" Element Present
2010AA	N301	Address	5	Data Element Too Long
2010AB	N301	Address	6	Invalid Character in Data Element
2010BA	N401	City, State, Zip Code	4	Data Element Too Short

3.5 277CA Acknowledgement Report

After the file is accepted at the interchange and functional group levels, the third level of editing occurs at the transaction set level within the CEM in order to create the Claim Acknowledgement Transaction (277CA) report. The CEM checks the validity of the values within the data elements. For instance, data element N403 must be a valid nine (9) digit zip code. If a non-existent zip code is populated, the CEM will reject the encounter.

- The 999 edit will verify that there were nine (9) digits populated, however, it would not check to ensure that the zip code is an existing zip code.

The 277CA is used to return a reply of "accepted" or "rejected" at the claim level of the encounter. Acceptance at this level is based on the WPC and the CMS edits spreadsheet, and will apply to individual encounters within an ST-SE transaction. The 277CA is an unsolicited acknowledgement report from CMS to MAOs and other entities, and will be returned within 24 hours of file submission. For those encounters not accepted, the 277CA will detail additional actions required of MAOs and other entities in order to correct and resubmit those encounters.

It is important to read the entire 277CA, as the report appearance may vary depending on if there were rejected encounters and the number of functional groups of encounters sent. If an MAO or other entity receives a 277CA indicating an encounter was rejected, the MAO or other entity must resubmit the encounter until the 277CA indicates no errors were found.

If an encounter is accepted, the 277CA will provide the ICN assigned to that encounter. The ICN segment for the accepted encounter will be located in REF segment, REF01=IK and REF02=ICN. The ICN is a unique 13-digit number.

If an encounter is rejected, the 277CA will provide edit information in the STC segment. The STC03 data element will indicate whether the encounter was accepted or rejected. If the STC03 is populated with a value of "WQ," the claim was accepted. If the STC03 data element is populated with a value of "U," the encounter is rejected and the STC01 data element will list the acknowledgement code. Table 3M provides a complete listing of the Claim Status Category Code (CSCC), also referred to as the acknowledgement code.

TABLE 3M – 277CA CLAIM/ENCOUNTER STATUS CATEGORY CODES

ERROR CODE	ERROR CODE DESCRIPTION
A1	Acknowledgement/Receipt – The claim/encounter has been received.
A2	Acknowledgement/Acceptance – The claim/encounter has been accepted.
A3	Acknowledgement/Returned as unprocessable claim – The claim/encounter has been rejected. **The claim must be resubmitted.**
A4	Acknowledgement/Not Found – The claim/encounter cannot be found
A6	Acknowledgement/Rejected for Missing Information – The claim/encounter is missing the information specified in the Status details and has been rejected
A7	Acknowledgement/Rejected for Invalid Information – The claim/encounter has invalid information as specified in the Status details and has been rejected.
A8	Acknowledgement/Rejected for relational field in error.

Following the acknowledgement code in STC01, is the claim status code (CSC) in STC02. This code provides more specific information about the error. Table 3N provides examples of CSC codes. A complete list of the CSC codes is located on the WPC website at: http://www.wpc-edi.com/content/view/711/401/.

TABLE 3N – CLAIM STATUS CODES

CODE	DESCRIPTION
19	Entity acknowledges receipt of claim/encounter
20	Accepted for Processing
23	Returned to Entity
164	Entity's contract/member number. Note: This code requires use of an Entity Code.
178	Submitted Charges
183	Purchase Price for Durable Medical Equipment
218	NDC Number
228	Type of Bill
229	Hospital Admission Source

TABLE 3N – CLAIM STATUS CODES (CONTINUED)

CODE	DESCRIPTION
231	Hospital Admission Type
232	Admitting Diagnosis
234	Patient Discharge Status
249	Place of Service
254	Principal Diagnosis Code
255	Diagnosis Code
256	DRG Code
286	Payer Paid Information
306	Detailed Description of Service
400	Claim is out of balance
402	Amount must be greater than zero. Note: At least one other status code is required to identify which amount element is in error.
453	Procedure Code Modifier(s) for Service(s) Rendered
455	Revenue code for services rendered.
460	NUBC Condition Code(s)
461	NUBC Occurrence Code(s) and Date(s)
463	NUBC Value Code(s) and/or Amount(s)
465	Principal Procedure Code for Service(s) Rendered
477	Diagnosis code pointer is missing or invalid
490	Other Procedure Code for Service(s) Rendered
504	Entity's Last Name
507	HCPCS
511	Invalid Character
512	Invalid Length for Receiver's Application System
513	HIPPS Rate Code for services Rendered
534	Claim ESRD Payment Amount
535	Claim Frequency Code
562	Entity's National Provider Identifier (NPI).
574	HCPCS Payable Amount Home Health
583	Line Item Charge Amount
596	Non-covered Charge Amount
598	Non-payable Professional Component Billed Amount
617	Postage Claimed Amount
643	Service Line Paid Amount
672	Other Payer's payment information is out of balance
673	Patient Reason for Visit

TABLE 3N – CLAIM STATUS CODES (CONTINUED)

CODE	DESCRIPTION
693	Amount must be greater than or equal to zero. Note: At least one other status code is required to identify which amount element is in error.
708	Repriced Approved Revenue Code
710	Line Adjudication Information. Note: At least one other status code is required to identify the data element in error.

- Refer to Table 3O below for the 277CA interpretation.

Example

Apple Health Plan submitted an interchange file with one (1) encounter, which was rejected at the CEM level for an invalid total charge. A 277CA was returned to the Apple Health Plan indicating the encounter was rejected for invalid information and that the encounter was returned to the MAO and other entities.

ST*277*0001*005010X214~
BHT*0085*08*277X21400001*20110805*1635*TH~
HL*120*1~**
NM1*PR*2*EDSCMS***46*80881~**
TRN*1*200102051635S00001ABCDEF~
DTP*050*D8*20110805~
DTP*009*D8*20110805~
HL*2*1*21*1~
NM1*41*2*ABC MAO***46*ENH1234~**
TRN*2*2002020542857~
STC*A7:23*20110805*U*1000~
QTY*AA*3~
AMT*YY*1000.00
HL*3*2*19*0~
NM1*85*2*SMITH CLINIC***FI*123456789~**
TRN*1*SMITH789~
STC*A7:511:85U*1000.00*****A7:504**
QTY*QC*3
AMT*YY*1000.00
SE*22*0001~

TABLE 3O – 277CA INTERPRETATION

ST*277*0001*005010X214~ **(1) (2) (3) (4)**	**(1) ST** – Transaction Set Header **(2) ST01** – Health Care Claim Acknowledgment **(3) ST02** – Transaction Set Control Number **(4) ST03** – Implementation Convention Reference
BHT*0085*08*277X2140001*20110805*1635*TH~ **(5) (6) (7) (8) (9) (10) (11)**	**(5) BHT** – Beginning of Hierarchical Transaction **(6) BHT01** – Hierarchical Structure Code • Information Source • Information Receiver • Provider of Service • Patient **(7) BHT02** – Transaction Set Purpose Code (Status) **(8) BHT03** – Inventory File Number **(9) BHT04** – Transaction Set Creation Date **(10) BHT05** – Transaction Set Creation Time **(11) BHT06** – Transaction Type Code (Receipt Acknowledgement Advice)
HL*120*1~** **(12)(13)(14)(15)**	**(12) HL** – Information Source Level **(13) HL01** – Hierarchical ID Number **(14) HL02** – Hierarchical Level Code (Information Source) **(15) HL03** - Subordinate Levels exist
NM1*PR*2*EDSCMS***PI*80881~** **(16) (17)(18)(19) (20) (21)**	**(16) NM1** – Information Source Name **(17) NM101** – Entity Identifier Code (Payer) **(18) NM102** – Entity Type Qualifier **(19) NM103** – Information Source Name **(20) NM108** – Payer Identifier **(21) NM109** – Payer ID
TRN*1*200102051635S00001ABCDEF~ **(22)(23) (24)**	**(22) TRN** – Transmission Report Control Identifier **(23) TRN01** – Current Transaction Trace Numbers **(24) TRN02** – Information Source Application Trace Identifier
DTP*050*D8*20110805~ **(25) (26) (27) (28)**	**(25) DTP** – Information Source Receipt Date **(26) DTP01** – Received Qualifier **(27) DTP02** – Date Format Qualifier **(28) DTP03** – Information Source Receipt Date
DTP*009*D8*20110805~ **(29) (30) (31) (32)**	**(29) DTP** – Information Source Process Date **(30) DTP01** – Process Qualifier **(31) DTP02** – Date Format Qualifier **(32) DTP03** – Information Source Process Date
HL*2*1*21*1~ **(33) (34) (35) (36) (37)**	**(33) HL** – Information Receiver Level **(34) HL01** – Hierarchical ID Number **(35) HL02** – Sequential Increase **(36) HL03** – Hierarchical Level Code (Information Receiver) **(37) HL04** – Subordinate Level exists

NM1*41*2*ABC MAO***46*ENH1234~** **(38) (39) (40) (41) (42) (43)**	**(38) NM1** – Information Receiver Name **(39) NM101** – Entity Identifier Code (Submitter) **(40) NM102** – Entity Type Qualifier **(41) NM103** – Information Source Name **(42) NM108** – Submitter Identification Qualifier **(43) NM109** – Submitter ID
TRN*2*2002020542857~ **(44) (45) (46)**	**(44) TRN** – Information Receiver Application Trace ID **(45) TRN01** – Referenced Transaction Trace Numbers **(46) TRN02** – Claim Transaction Batch Number
STC*A7:23*20110805*U*1000~ **(47) (48)(49) (50) (51) (52)**	**(47) STC** – Information Receiver Status Information **(48) STC01** – Acknowledgement/Rejected for Invalid Information **(49) STC01-1** – CSCC Code **(50) STC02**– Status Information Effective Date **(51) STC03** – Reject **(52) STC04**– Total Submitted Charges for Units Work
QTY*AA*3~ **(53) (54) (55)**	**(53) QTY** – Total Rejected Quantity **(54) QTY01** – Unacknowledged Quantity **(55) QTY02**– Total Rejected Quantity
AMT*YY*1000.00 **(56) (57) (58)**	**(56) AMT** – Total Rejected Amount **(57) AMT01** – Returned Qualifier **(58) AMT02** – Total Rejected Amount
HL*3*2*19*0~ **(59)(60) (61) (62) (63)**	**(59) HL** – Billing Provider of Service Level Segment ID **(60) HL01** – Hierarchical ID Number **(61) HL02** – Sequential Increase **(62) HL03** – Provider of Service Qualifier **(63) HL04** – Subordinate levels do not exist
NM1*85*2*SMITH CLINIC***XX*1234567890~** **(64) (65) (66) (67) (68) (69)**	**(64) NM1** – Billing Provider Name Segment ID **(65) NM101** – Billing Provider Qualifier **(66) NM102** – Non Person Qualifier **(67) NM103** – Billing Provider Name **(68) NM108** – NPI Qualifier **(69) NM109** – NPI
TRN*1*SMITH789~ **(70) (71) (72)**	**(70) TRN** – Provider of Service Information Trace ID Segment ID **(71) TRN01** – Current Transaction Trace Numbers **(72) TRN02** – Provider of Service Information Trace ID
STC*A7:511:85U*1000*****A7:504** **(73) (74) (75)(76) (77) (78) (79)(80)**	**(73) STC** – Billing Provider Status Information Segment ID **(74) STC01** – Health Care Claim Status Category Code **(75) STC01-1** – Health Care Claim Status Code **(76) STC03** – Billing Provider Qualifier **(77) STC04** – Reject **(78) STC05** – Total Submitted Charges for Unit Work **(79) STC06** – Acknowledged/Rejected for Invalid Information **(80) STC07** – Entity's Last Name

QTY*QC*3 **(81) (82)(83)**	**(81) QTY** – Total Rejected Quantity Segment ID **(82) QTY01** – Quantity Disapproved Qualifier **(83) QTY02** – Total Rejected Quantity
AMT*YY*1000.00 **(84) (85) (86)**	**(84) AMT** – Total Rejected Amount Segment ID **(85) AMT01** – Returned Qualifier **(86) AMT02** – Total Rejected Amount
SE*22*0001~ **(87) (88) (89)**	**(87) SE** – Transaction Set Trailer **(88) SE01** – Transaction Segment Count **(89) SE02** – Transaction Set Control Number

Example

Mercy Health Plan submitted an interchange file containing 14 encounters. Twelve encounters were accepted and two (2) were rejected. The last two (2) STC segments indicate the rejected encounters. Note: ICNs are not provided for rejected encounters.

ISA*0000**ZZ*PPPPP*ZZ*SSSSSS*091006*1250*`*00501*000000001*1*P*>~**
GS*HN*SSSSSS*PPPPP*20091006*1250*1234*X*005010X214~
ST*277*999000002*005010X214~
BHT*0085*08*BATCH0001*20091006*1250*TH~
HL*120*1~**
NM1*PR*2*EDSCMS***PI*PPPPP~**
TRN*1*0001~
DTP*050*D8*20091006~
DTP*009*D8*20091006~
HL*2*1*21*1~
NM1*41*2*MASTERS CLINIC***XX*NNNNNNNNNN~**
TRN*2*000003~
STC*A1>19*20091006*WQ*6488~
REF*1K*ICN~
QTY*90*12~
QTY*AA*2~
AMT*YU*4588~
AMT*YY*1900~
HL*3*2*19*1~
NM1*85*2*MASTERS CLINIC***XX*NNNNNNNNNN~**
HL*4*3*PT~
NM1*QC*1*PUBLIC*JOHN*Q*MI*111111111F~**
TRN*2*1234-1~
STC*A2>20*20091006*WQ*950~
REF*1K*ICN~
DTP*472*D8*20090828~
HL*5*3*PT~

NM1*QC*1*PUBLIC*JOHN*Q***MI*111111111F~
TRN*2*1234-2~
STC*A2>20*20091006*WQ*950~
REF*1K*ICN~
DTP*472*D8*20090828~
HL*5*3*PT~
NM1*IL*1*PUBLIC*JOHN*Q***MI*111111111F~
TRN*2*1234-3~
STC*A2>20*20091006*WQ*950~
REF*1K*ICN~
DTP*472*D8*20090828~
HL*6*3*PT~
NM1*QC*1*TEST*PART*B**JR.*MI*111111111F~
TRN*2*PAS2420Fx.NM103.0001~
STC*A2>20*20091006*WQ*98.50~
REF*1K*ICN~
DTP*472*D8*20090701~
TRN*2*PAS2420Fx.NM104.0001~
STC*A2>20*20091006*WQ*98.50~
REF*1K*ICN~
DTP*472*D8*20090701~
TRN*2*PAS2420Fx.NM104.0002~
STC*A2>20*20091006*WQ*98.50~
REF*1K*ICN~
DTP*472*D8*20090701~
TRN*2*PAS2420Fx.NM105.0001~
STC*A2>20*20091006*WQ*98.50~
REF*1K*ICN~
DTP*472*D8*20090701~
TRN*2*PAS2420Fx.NM105.0002~
STC*A2>20*20091006*WQ*98.50~
REF*1K*ICN~
DTP*472*D8*20090701~
TRN*2*PAS2420Fx.NM107.0001~
STC*A2>20*20091006*WQ*98.50~
REF*1K*ICN~
DTP*472*D8*20090701~
TRN*2*PAS2420Fx.NM107.0002~
STC*A2>20*20091006*WQ*98.50~
REF*1K*ICN~
DTP*472*D8*20090701~
HL*7*3*PT~
NM1*QC*1*PUBLIC*JOHN*Q***MI*111111111F~

TRN*2*1234-4~
STC*A2>20*20091006*WQ*950~
REF*1K*ICN~
DTP*472*D8*20090828~
HL*8*3*PT~
NM1*QC*1*PUBLIC*JOHN*Q*MI*111111111F~**
TRN*2*1234-5~
STC*A7>504>DN*20091006*U*950****A7>512~**
DTP*472*D8*20090828~
HL*9*3*PT~
NM1*QC*1*PUBLIC*JOHN*Q*MI*111111111F~**
TRN*2*1234-6~
STC*A7>504>PR*20091006*U*950****A7>511~**
DTP*472*D8*20090828~
SE*84*999000001~
GE*1*1234~
IEA*1*000000001~

3.6 CEM Level Edits

After the interchange file passes the translator, the CEM level edits are applied. There are over 300 of the 837-I and over 300 or the 837-P edits. Of those, the Companion Guide will indicate all CEM level edits that will produce encounter level rejects. Listed in Table 3P are examples of Institutional edits that will be applied to EDS encounters. Encounters failing the edits will be rejected.

TABLE 3P – INSTITUTIONAL EDITS

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2010AA	NM108	Identification Code Qualifier	A8	
2010AA	NM108	Identification Code Qualifier	A6	

TABLE 3P – INSTITUTIONAL EDITS (CONTINUED)

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2010AA	NM109	National Provider Identifier	A7	562
2010AA	NM109	National Provider Identifier	A7	562
2010AA	NM109	National Provider Identifier	A8	562
2010BA	NM108	Identification Code Qualifier	A8	
2010BA	NM108	Identification Code Qualifier	A6	
2010BA	NM109	HICN	A7	164
2300	CLM02	Amount Field	A7	400, 178
2300	CLM02	Amount Field	A7	400, 672
2300	CLM05-1	TOB	A7	228
2300	CLM05-3	TOB	A7	228
2300	CL101	Admission Type Code	A7	231
2300	CL102	Admission Source Code	A7	229
2300	CL103	Patient Status Code	A7	234
2300	HI01-2	Principal Diagnosis	A7	254
2300	HI01-2	Admitting Diagnosis Code	A7	232
2300	HI01-2	Patient Reason For Visit	A7	673
2300	HI02-2	Patient Reason For Visit	A7	673
2300	HI03-2	Patient Reason For Visit	A7	673
2300	HI01-2	DRG Code	A7	256
2300	HI01-2	Diagnosis Code	A7	255
2300	HI02-2 – HI12-2	Diagnosis Code	A7	255
2300	HI01-2	Principal Procedure Code	A7	465
2300	HI01-2	Procedure Code	A7	490
2300	HI02-2-HI12-2	Procedure Code	A7	490
2300	HI01-2-HI12-2	Occurrence Span Code	A7	462
2300	HI01-2-HI12-2	Occurrence Code	A7	461
2300	HI01-2 – HI12-2	Value Code	A7	463
2300	HI01-2 – HI12-2	Condition Code	A7	460
2310A	NM108	Identification Code Qualifier	A8	

TABLE 3P – INSTITUTIONAL EDITS (CONTINUED)

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2310A	NM108	Identification Code Qualifier	A6	
2310A	NM109	National Provider Identifier	A7	562
2310A	NM109	National Provider Identifier	A7	562
2310B	NM108	Identification Code Qualifier	A8	
2310B	NM108	Identification Code Qualifier	A6	
2310B	NM109	National Provider Identifier	A7	562
2310B	NM109	National Provider Identifier	A7	562
2310C	NM108	Identification Code Qualifier	A8	
2310C	NM108	Identification Code Qualifier	A6	
2310C	NM109	National Provider Identifier	A7	562
2310D	NM108	Identification Code Qualifier	A8	
2310D	NM108	Identification Code Qualifier	A6	
2310D	NM109	National Provider Identifier	A7	562
2310E	NM108	Identification Code Qualifier	A8	
2310E	NM108	Identification Code Qualifier	A6	
2310E	NM109	National Provider Identifier	A7	562
2310F	NM108	Identification Code Qualifier	A8	
2310F	NM108	Identification Code Qualifier	A6	
2310F	NM109	National Provider Identifier	A7	562
2320	AMT	Amount Field	A6	286
2320	AMT02	Amount Field	A7	672, 286
2320	AMT02	Amount Field	A7	596
2400	SV201	Revenue Code	A7	455
2400	SV202-2	HCPCS	A7	507
2400	SV202-3	Procedure Modifier	A7	453
2400	SV202-4	Procedure Modifier	A7	453
2400	SV202-5	Procedure Modifier	A7	453
2400	SV202-6	Procedure Modifier	A7	453
2400	SV203	Amount Field	A7	400, 583, 643
2400	HCP08	Product/Service ID	A7	708
2400	HCP10	HCPCS	A7	507
2420A	NM108	Identification Code Qualifier	A8	
2420A	NM108	Identification Code Qualifier	A6	

TABLE 3P – INSTITUTIONAL EDITS (CONTINUED)

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2420A	NM109	National Provider Identifier	A7	562
2420B	NM108	Identification Code Qualifier	A8	
2420B	NM108	Identification Code Qualifier	A6	
2420B	NM109	National Provider Identifier	A7	562
2420C	NM108	Identification Code Qualifier	A8	
2420C	NM108	Identification Code Qualifier	A6	
2420C	NM109	National Provider Identifier	A7	562
2420D	NM108	Identification Code Qualifier	A7	
2420D	NM108	Identification Code Qualifier	A7	
2420D	NM109	National Provider Identifier	A7	562
2430	SVD03-2	HCPCS	A7	507, 710
2430	SVD03-2	Rate Code	A7	513, 710
2430	SVD03-3	Procedure Modifier	A7	453, 710
2430	SVD03-4	Procedure Modifier	A7	453, 710
2430	SVD03-5	Procedure Modifier	A7	453, 710
2430	SVD03-6	Procedure Modifier	A7	453, 710

Listed in Table 3Q are examples of Professional edits that will be applied to EDS encounters. MAOs and other entities should use the CEM edits and understand that a soft (informational) edit will be applied to all edits not included in these tables and the Companion Guide. As CEM testing and progresses, changes to the editing logic may occur. MAOs and other entities will be informed through updated Companion Guides as edit logic is finalized.

TABLE 3Q – PROFESSIONAL EDITS

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2010AA	NM108	Identification Code Qualifier	A8	
2010AA	NM108	Identification Code Qualifier	A6	
2010AA	NM109	National Provider Identifier	A7	562
2010AA	CLM02	Amount Field	A7	178

TABLE 3Q – PROFESSIONAL EDITS (CONTINUED)

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2010BA	NM108	Identification Code Qualifier	A8	
2010BA	NM108	Identification Code Qualifier	A6	
2010BA	NM109	HICN	A7	164
2300	CLM02	Amount Field	A7	400, 672
2300	CLM05-1	Place of Service Code	A7	249
2300	CLM05-3	Place of Service Code	A7	535
2300	AMT02	Amount Field	A7	693, 183
2300	REF02	National Provider Identifier	A7	562
2300	REF02	National Provider Identifier	A7	562
2300	HI01-2	Primary Diagnosis Code	A7	254
2300	HI02-2 – HI12-2	Diagnosis Code	A7	255
2300	HI01-2	Principal Procedure Code	A7	465
2300	HI01-2 – HI12-2	Condition Code	A7	460
2310A	NM108	Identification Code Qualifier	A8	
2310A	NM108	Identification Code Qualifier	A6	
2310A	NM109	National Provider Identifier	A7	562
2310B	NM108	Identification Code Qualifier	A8	
2310B	NM108	Identification Code Qualifier	A6	
2310B	NM109	National Provider Identifier	A7	562
2310C	NM108	Identification Code Qualifier	A8	
2310C	NM108	Identification Code Qualifier	A6	

TABLE 3Q – PROFESSIONAL EDITS (CONTINUED)

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2310C	NM109	National Provider Identifier	A7	562
2310C	NM109	National Provider Identifier	A7	562
2310D	NM108	Identification Code Qualifier	A8	
2310D	NM108	Identification Code Qualifier	A6	
2310D	NM109	National Provider Identifier	A7	562
2320	AMT	Amount Field	A6	286
2320	AMT02	Amount Field	A7	693, 183, 286
2320	AMT02	Amount Field	A7	672, 286
2320	AMT02	Amount Field	A7	596
2320	AMT02	Amount Field	A7	693, 596
2320	MOA02	Amount Field	A7	693, 574
2320	MOA08	Amount Field	A7	693, 534
2320	MOA09	Amount Field	A7	693, 598
2400	SV101-2	HCPCS Code	A7	507
2400	SV101-2	HCPCS Code	A7	507
2400	SV101-3	Procedure Modifier	A7	453
2400	SV101-3	Procedure Modifier	A7	453
2400	SV101-4	Procedure Modifier	A7	453
2400	SV101-5	Procedure Modifier	A7	453
2400	SV101-6	Procedure Modifier	A7	453
2400	SV101-7	Procedure Modifier	A8	306
2400	SV102	Amount Field	A7	400, 583, 643
2400	SV105	Place of Service Code	A7	249
2400	SV107-1	Diagnosis Code Pointer	A3	477
2400	SV107-1	Diagnosis Code Pointer	A7	477
2400	SV107-2	Diagnosis Code Pointer	A3	477
2400	SV107-2	Diagnosis Code Pointer	A7	477
2400	SV107-3	Diagnosis Code Pointer	A3	477
2400	SV107-3	Diagnosis Code Pointer	A7	477

TABLE 3Q – PROFESSIONAL EDITS (CONTINUED)

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2400	SV107-4	Diagnosis Code Pointer	A3	477
2400	SV107-4	Diagnosis Code Pointer	A7	477
2400	AMT02	Amount Field	A7	402, 617
2400	NTE	Line Note	A7	586
2400	HCP10	HCPCS	A7	507
2400	LIN03	HCPCS	A8	218, 507
2400	LIN03	HCPCS	A8	218, 507
2420A	NM108	Identification Code Qualifier	A8	
2420A	NM108	Identification Code Qualifier	A6	
2420A	NM109	National Provider Identifier	A7	562
2420B	NM108	Identification Code Qualifier	A8	
2420B	NM108	Identification Code Qualifier	A6	
2420B	NM109	National Provider Identifier	A7	562
2420C	NM108	Identification Code Qualifier	A8	
2420C	NM108	Identification Code Qualifier	A6	
2420C	NM109	National Provider Identifier	A7	562
2420D	NM108	Identification Code Qualifier	A8	
2420D	NM108	Identification Code Qualifier	A6	
2420D	NM109	National Provider Identifier	A7	562
2420E	NM108	Identification Code Qualifier	A8	
2420E	NM108	Identification Code Qualifier	A6	
2420E	NM109	National Provider Identifier	A7	562

TABLE 3Q – PROFESSIONAL EDITS (CONTINUED)

LOOP	ELEMENT	ELEMENT DESCRIPTION	CLAIM STATUS CATEGORY CODE	CLAIM STATUS CODE
2420F	NM108	Identification Code Qualifier	A8	
2420F	NM108	Identification Code Qualifier	A6	
2420F	NM109	National Provider Identifier	A7	562
2430	SVD03-2	HCPCS	A7	507
2430	SVD03-2	HCPCS	A7	507
2430	SVD03-3	Procedure Modifier	A7	453
2430	SVD03-4	Procedure Modifier	A7	453
2430	SVD03-5	Procedure Modifier	A7	453
2430	SVD03-6	Procedure Modifier	A7	453

- The editing logic provided in Tables 3P and 3Q are provided as examples. As testing progresses, editing logic may change.

3.7 Summary

During this module, the purpose of the TA1, 999A, 999E, 999R, and 277CA acknowledgement reports were identified. Participants were provided guidance on the interpretation of the acknowledgement reports and the associated error codes. Participants were also provided CEM level edits that will be applied to all files that pass translator level edits.

MODULE 4 – COMPLIANCE

Purpose

This module will delineate the encounter data compliance standards, describe preliminary enforcement of compliance benchmarks, and discuss methods Medicare Advantage Organizations (MAOs) and other entities can use to ensure compliance measures are achieved.

In accordance with contract stipulations and federal legislation, all MAOs and other entities, identified by CMS as Medicare Advantage (MA) Plans, Medicare Advantage Prescription Drug (MA-PD) Plans, Cost Plans (including both §1876 Cost HMOs/CMPs and §1833 HCPPs), and Programs for All-Inclusive Care for the Elderly (PACE) organizations, are required to adhere to compliance standards for encounter data submissions. The MAO or other entity must submit encounter data based on its best knowledge, information, and belief, as of the date of submission, that all information submitted to CMS is accurate, complete, and truthful. The MAO or other entity must also acknowledge that misrepresentations to CMS regarding the accuracy of such information may result in Federal civil action and/or criminal prosecution. MAOs and other entities must also ensure compliance with standards for duplicate claims submissions and the Health Insurance Portability and Accountability Act (HIPAA) regulations. Non-compliance with these requirements may adversely affect the ability of CMS to accurately measure MA program cost and enrollee utilization patterns, in addition to limiting its ability to support accurate recalibration of the risk adjustment models that determine payment. Failure to adhere to compliance standards may result in Federal civil action and/or criminal prosecution of the MAO, other entities, or their agents.

Learning Objectives

At the completion of this module, participants will be able to:

- Describe HIPAA standards as they relate to encounter data.
- Identify the encounter data compliance standards.
- Understand the enforcement of encounter data compliance measures.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

4.1 HIPAA Standards

The 1996 HIPAA Standards include provisions related to insurance, privacy, security, transactions, and code sets. The Administrative Simplification provisions of HIPAA require that the Department of Health and Human Services (DHHS) adopt national standards for electronic health care transactions as well as national identifiers for providers, health plans, and employers. Generally, HIPAA was implemented to:

- Improve portability and continuity of health insurance coverage;
- Combat waste, fraud, and abuse in health insurance and health care delivery;
- Improve access to long-term care services and coverage; and
- Simplify the administration of health insurance.

Administrative Simplification Compliance Act (ASCA) and the Affordable Care Act (ACA)
The ASCA builds upon HIPAA provisions and requires submitters to adopt operating rules for each of the HIPAA transactions. ASCA enhances HIPAA requirements by establishing:

- Operating rules for HIPAA transactions;
- Standards for electronic health care transactions;
- Unique National Provider Identifiers (NPIs); and
- Standard formats for electronic claims and claims related transactions.

Additionally, ACA requires that submitters certify their compliance with HIPAA and ASCA standards and provides penalties for non-compliance.

Encounter Data HIPAA, ASCA, and ACA Compliance
For encounter data, compliance with HIPAA, ACA, and ASCA requires that data be submitted in the ANSI version 5010 of the X12 standard, that all required data elements specific to the collection of encounter data be populated on the 5010, and that a valid NPI be used to certify the source of all provider and supplier information.

HIPAA Overview
https://www.cms.gov/HIPAAGenInfo/01_Overview.asp#TopOfPage

4.1.1 5010 Standard Format

HIPAA regulations mandate that all health care claims be submitted electronically using the ANSI X12 V5010 form by January 1, 2012. Accordingly, submissions to the EDS must also meet these compliance standards by the designated implementation date. To send encounter data, submitters must ensure that data is in the appropriate HIPAA compliant standard Health Care Claims transaction for professional data (currently using implementation guide ASC X12N 837/005010X222 with Errata for ASC X12N 837/005010X222A1) and institutional data (currently using implementation guide ASC X12N 837/005010X223 with Errata for ASC X12N 837/005010X223A2) as defined in the Washington Publishing Company (WPC) Technical Report 5010 X12.

Washington Publishing Company 5010 Resources
http://www.wpc-edi.com/

4.1.2 Format Compliance Standards

Based on the HIPAA, ASCA, and ACA regulations, and current risk adjustment methodologies, these compliance standards are required for encounter data submissions:

- Encounter data must be submitted in the ANSI version 5010 of the X12 standard format;
- All required data elements specific to the collection of encounter data must be populated on the ANSI version 5010 of the X12 standard; and
- A valid NPI must be included on encounter data submissions to certify the source of all provider and supplier information.

4.1.3 Enforcement of Format Standards

Failure to comply with HIPAA, ASCA, and ACA standards may result in encounter data submissions being rejected and returned to the submitter for correction. In addition, for those who do not submit encounter data on the 5010 format, risk adjustment payment will be adversely affected beyond the 2012 data collection year.

4.2 Compliance Standards

CMS is developing an analysis tool that will evaluate submitter compliance with submission standards. This tool will permit CMS to track non-compliance to the specific contract ID in order to determine consistently subpar encounter data submitters that do not meet the established compliance benchmarks. MAOs and other entities will be notified of non-compliance.

MAOs and other entities are required to submit all data that is collected. CMS will monitor the collected encounter data and develop reports to communicate compliance standards in these areas:

- Timeliness of submission.
- Quantity (volume) of submission.
- Quality of submission.
- Accuracy of submission

4.3 Timeliness of Submission

The timely submission of claims ensures that data are evaluated, processed accurately, and stored so that they are available for accurate payment calculations and risk adjustment payment model recalibration. CMS has established timeliness compliance standards for the following types of data:

- Submission of adjudicated claims data.
- Submission of chart review data.
- Submission prior to the last day of required reporting period.

13 Month Timely Filing
The 13-month timely filing rule benefits MAOs and other entities by allowing an extra month beyond the FFS timely filing limit – which now require submission within 12 months of the date of service – see section 6404 of the ACA. This allows more time for receiving and processing more accurate encounter data prior to transmitting to CMS.

Chart Review Timely Filing
Understanding that chart reviews can take longer than standard claims adjudication processes, CMS retained the current risk adjustment deadlines for submitting chart review data. This is a variable timeframe, but can be up to 25 months after the date of service, depending on the date the chart review data is submitted in relation to the beginning of the data collection period. This will provide MAOs and other entities time to conduct medical review and aligns with the current data submission deadlines for RAPS processing.

Prior to the Last Day of Required Reporting Period Submissions
CMS encourages plans to stagger submissions in order to reduce the number of large file submissions on the last day of the required reporting period.

4.3.1 Frequency of Claim Submissions

Additionally, MAOs and other entities will be required to submit data at the frequency specified according to a tiered scale determined by the number of Medicare enrollees per contract. MAOs and other entities must adhere to the minimum frequency standards established by the tiered scale, but are encouraged to submit encounter data more frequently. CMS will track MAO and other entities' submission frequencies. More frequent submission will help the EDS maintain its systematic capabilities to process encounter data. CMS will provide reports on data submission results so that organizations can identify errors that require attention. Table 4A provides the minimum frequency standards for encounter data submission based on the number of Medicare beneficiaries enrolled per contract.

TABLE 4A — TIERED DATA SUBMISSION FREQUENCY

NUMBER OF MEDICARE ENROLLEES	MINIMUM SUBMISSION FREQUENCY
Greater than 100,000	Weekly
50,000 – 100,000	Bi-weekly
Less than 50,000	Monthly

- Table 4A identifies minimum frequency standards for submission. MAOs and other entities may submit data as often as daily and should not delay the submission of data for any reason.

4.3.2 Enforcement of Timeliness Standards

Failure to comply with timeliness standards may result in encounter data submissions being rejected and plan payments being affected by untimely data submissions. CMS will communicate additional measures to enforce timeliness compliance measures as needed.

4.4 Quantity of Submission

The specifications of the EDS require that the volume of encounters submitted to the system align with a number of metrics based on established Fee-For-Service (FFS) benchmarks. Specific metrics include but are not limited to submission rates, proportions of claims in particular service categories, and overall volume of submission.

4.4.1 Service Types

MAOs and other entities are responsible for collecting data for all types of services, both institutional and professional. The full scope of services, on which MAOs and other entities are required to submit encounter data are listed in Table 4B.

TABLE 4B — REQUIRED ENCOUNTER DATA TYPES OF SERVICE

• Ambulance • Federally Qualified Health Center • Clinical Laboratory • Community Mental Health • Home Health • Skilled Nursing Outpatient	• Critical Access Hospital Outpatient • Durable Medical Equipment (DME) • End-Stage Renal Disease • Ambulatory Surgical Centers • Vision • Outpatient Hospital	• Inpatient Hospital • Skilled Nursing Inpatient/Swing Bed • Inpatient Rehab • Long Term Care • Dental • Critical Access Hospital Inpatient/Swing Bed	• Outpatient Rehab • Physician/ Professional • Rural Health Clinic • Inpatient Psychiatric • Hospice

4.4.2 Enforcement of Quantity Standards

CMS will analyze trends in the volume of encounter data collected and will apply the benchmarks to determine compliance rates. Failure to comply with quantity standards may result in impacts to plan payments or a letter of non-compliance for quantity. Procedures for non-compliance will be developed,

which will feed into the CMS compliance framework. CMS will communicate additional measures to enforce quantity compliance as deemed necessary.

4.5 Quality of Submission

Quality standards allow CMS to measure the industry across calendar years to ensure that the EDS is capturing accurate and complete information. Adherence to quality standards requires that MAOs and other entities collect and submit all encounter data in the appropriate ANSI V5010 X12 format. The quality of encounter data submitted is evidenced by the number of errors returned to the submitter and the number of duplicates submitted per contract identification number (ID). This will be monitored and tracked by CMS.

Quality of submission will be based on the following metrics:

- Do not exceed an error rate of 5%
- Duplicate encounters.

4.5.1 Evaluating Error Rates

CMS is developing an analysis tool that evaluates the volume of errors received per submitter ID. This will then be tracked to the specific contract ID in order to determine the contract numbers that consistently submit data that does not meet the established quality standards. CMS will review the submitted files on a monthly basis to determine the volume of errors per submitter and contract. MAOs and other entities will be notified of non-compliance.

4.5.2 Duplicate Claim Standards

CMS will monitor duplicates on two (2) levels, the front-end and processing systems.

- Front-End Duplicates
- Processing System

Front-End Duplicates
At the front-end, the system is performing file level duplicate checks only. Each ISA – IEA interchange creates a unique hash total. If the same hash total is discovered in the EDFES from a subsequent ISA – IEA interchange, then this is considered a duplicate claim.

Processing System Duplicates
The Encounter Data Processing System (EDPS) duplicate check will apply to the claims level only. The claim will be returned to the submitter with an error message identifying a duplicate claim.

4.5.3 Accuracy of Submission

CMS will audit submitted encounters back to the MAO or other entity's claims system. Encounters must have the ability to be traced back to the original claim or verifiable electronic transaction or paper claim and be unmodified from the original claim. MAO and other entities' adjudication processes may be applied but no alteration of original claims will be accepted, especially in relation to HCPCS, Revenue codes, and diagnosis data.

4.5.4 Enforcement of Quality and Accuracy Standards

Failure to comply with quality and accuracy standards may result in encounter data submissions being rejected and plan payments being affected by untimely data submissions. CMS will communicate additional measures to enforce quality compliance measures as deemed necessary.

4.6 Summary

MAOs and other entities are contractually and legally obligated to comply with standards that govern the timelines, quantity, and quality of encounter data submissions. Additionally, encounter data submissions are subject to the HIPAA standards that apply to all health care transactions. Failure to comply with these standards can be detrimental to the capability of the EDS to accurately measure MA cost and utilization patterns and to recalibrate the risk adjustment payment model. Additionally, non-compliance may result in penalties to the MAO or other entity. MAOs and other entities must be proactive and diligent in adhering to compliance standards and adopting internal measures to reduce the likelihood of non-compliance.

MODULE 5 – TRANSITION TO THE ENCOUNTER DATA SYSTEM (EDS)

Purpose

The roll-out of the Encounter Data System (EDS), which occurs on January 3, 2012, will begin the transition for Medicare Advantage Organizations (MAOs) and other entities from submission of abbreviated claims data through the Risk Adjustment Processing System (RAPS) to submission of full encounter data through the EDS. CMS will use encounter data for determining the risk adjustment factors for payment, calibrating the risk adjustment model, calculating Medicare Disproportionate Share Hospital (DSH) percentages, Medicare coverage purposes, and quality review and improvement activities. To mitigate risk to plan payments during the transition from RAPS to EDS, the systems will run parallel until transition to the EDS is complete. The purpose of this module is to describe the implementation plan for transition from RAPS to EDS and CMS' expectations for submission and reconciliation of data throughout the transition process.

Learning Objectives

At the completion of this module, participants will be able to:

- Describe the implementation plan to run parallel systems for Risk Adjustment and Encounter Data.
- Identify the target roll out dates for phase-in of the EDS and phase out of RAPS.
- Understand the expectations for reconciliation of plan payments during the transition to EDS.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

5.1 Parallel Systems Processing of EDS and RAPS

Currently, calibration of the CMS-Hierarchical Condition Category (HCC) risk adjustment model is based on the Fee-For-Service (FFS) beneficiary population. Once encounter data collection is fully implemented, future calibration of the risk adjustment model will be based upon Medicare Advantage (MA) beneficiary utilization data instead of FFS beneficiary utilization data. The payment and risk score calculation methodology will not change and diagnosis data will continue to drive payment. However, once transition to EDS is complete, calculation of beneficiary risk scores will be based solely on encounter data submitted and stored through EDS. In support of successful transition to encounter data collection, RAPS and EDS will run parallel once the EDS rolls-out January 3, 2012. During this time, plans will submit data to both RAPS and EDS.

5.1.1 Purpose of Parallel Processing

The purpose of parallel systems processing is to mitigate the risk of a negative impact to risk adjustment payment methodology during the transition to EDS by:

1. Ensuring that EDS is functioning properly; and
2. Validating the accuracy and quality of the encounter data collected for accurate recalibration of the CMS-HCC risk adjustment models.

5.1.2 Target Timeline

Beginning January 3, 2012, EDS and RAPS will process in parallel for a minimum of one (1) year. The systems will continue to run in parallel until CMS validates that the encounter data collected is high quality data and yields accurate calculation of beneficiary risk scores. Submitters will continue to submit both RAPS data and encounter data until CMS validation of the EDS is complete. Upon successful validation of the EDS, the RAPS system will cease and all risk adjustment claims submissions and processing will occur through the EDS. MAOs and other entities will be notified prior to ceasing parallel systems processing and the complete shutdown of RAPS.

5.2 Phase-In of the EDS

Testing for the implementation and phase-in of encounter data collection will occur in two (2) phases: first, testing of the Encounter Data Front-End System (EDFES) and then, testing of the Encounter Data Processing System (EDPS). Upon completion of the testing phases, MAOs and other entities will submit encounter data to the EDS and RAPS for parallel systems processing.

5.2.1 Testing of the Institutional and Professional Encounter Data Processing and Pricing System

Target implementation dates for the phase-in of the EDS are illustrated in Table 5A. Beginning September 06, 2011, MAOs and other entities will begin testing of the EDFES for the Commercial Off-the Shelf (COTS) Electronic Data Interchange (EDI) Translator and the Encounter Data Common Edits and Enhancements Module (CEM) for both institutional and professional services.

Following the EDFES testing phase, which ends on October 04, 2011, the EDPS end-to-end testing phase for both institutional and professional encounters will begin. End-to-end testing starts on October 31, 2011, and ends on November 30, 2011. MAOs and other entities must submit both an institutional (837-I) and a professional (837-P) end-to-end test file to the EDPS no later than November 30, 2011. Plan encounter data file submission certification will also occur during this period.

- Once acknowledgment is received from CMS indicating a submitted test file was successfully processed through the EDFES and the EDPS, the plan will be certified to submit encounter data as of January 3, 2012.

TABLE 5A – TARGET IMPLEMENTATION DATES FOR EDS

EDS IMPLEMENTATION TIMELINE		
START DATE	**END DATE**	**EVENT**
March 30, 2011	September 05, 2011	Test Case Preparation Period
September 06, 2011	October 04, 2011	Front-End Testing of the COTS EDI Translator and both the Encounter Data Institutional (837-I) and Professional (837-P) CEMs
October 05, 2011	October 28, 2011	EDPS Test Case Preparation and Education
October 31, 2011	November 30, 2011	Encounter Data Institutional Processing and Pricing System (EDIPPS) and Encounter Data Professional Processing and Pricing System (EDPPPS) Sub-System End-to-End Testing/certification
January 3, 2012	January 3, 2012	EDIPPS and EDPPPS roll-out

5.2.2 Encounter Data Durable Medical Equipment Processing and Pricing System (EDDPPS)

Durable Medical Equipment (DME) supplier claims will be processed through the Common Electronic Data Interchange (CEDI) module and EDDPPS. DME submission implementation, which includes testing, will follow a separate timeline. The phase-in of submission of DME encounter claims is illustrated in Table 5B. Testing of the DME CEDI module and the EDDPPS starts on February 6, 2012. The EDDPPS rolls out on May 7, 2012. Therefore, MAOs and other entities must submit DME production data by May 7, 2012 for dates of service beginning January 1, 2012.

- EDS will not have the capacity to store DME supplier claims submitted for DME processing through the CEDI module, until the CEDI module has been implemented. MAOs and other entities should not submit 837-P DME supplier claims until the scheduled testing start date of February 6, 2012.

- DME supplier claims are submitted on the 5010 837-P format and will be processed through the CEDI and EDDPPS according to the DME implementation timeline illustrated in Table 5B.

- DME claims data received from a provider should be submitted using the 837-P for processing through the CEM and EDPPPS according to original EDS implementation timeline illustrated in Table 5A.

TABLE 5B – TARGET IMPLEMENTATION DATES FOR DME

ENCOUNTER DATA DME PROCESSING TESTING	
DATE	**EVENT**
February 6, 2012	MAO and other entity front-end testing of Encounter Data DME CEDI module and EDDPPS begins.
May 7, 2012	EDDPPS rolls-out.

5.2.3 Target Implementation Timeline for Programs for All-inclusive Care for the Elderly (PACE)

Encounter data collection requirements for PACE organizations are delayed by 12 months. The target implementation timeline for collection and submission of encounter data in PACE Organizations is illustrated in Table 5C.

CMS will conduct a pilot test for submission of encounter data for PACE Organizations from February 15, 2012 to February 28, 2012. Testing of the EDFES will occur from March 30, 2012 to June 30, 2012 and testing of the EDPS will occur from July 18, 2012 to September 30, 2012.

- The Encounter Data Enrollment Package consisting of the EDI Agreement and Submitter ID Application must be completed prior to sending a test file to the EDS for testing of the EDFES.

TABLE 5C – TARGET IMPLEMENTATION TIMELINE FOR PACE ORGANIZATIONS

Event	Start Date	End Date
Execute Encounter Data Pilot Test For PACE Plans	February 15, 2012	February 28, 2012
Completion of the EDI Agreement and Submitter ID Application	March 30, 2012	June 30, 2012
Execute EDFES Testing	March 30, 2012	June 30, 2012
Execute EDIPPS and EDPPPS Sub-System End-to-End Testing	July 18, 2012	September 30, 2012
Encounter Data PACE Plans roll-out	January 3, 2013	N/A

5.3 Phase-Out of RAPS

Once the EDS is implemented, MAOs and other entities will continue submitting risk adjustment data to RAPS and begin submitting full encounter data to the EDS for the parallel systems processing. The RAPS will no longer be utilized after the parallel processing phase is complete and CMS validates that the EDS is functioning properly so that encounter data can be utilized to recalibrate the risk adjustment models for accurate risk score calculation. Upon completion of the parallel processing phase, all risk adjustment processing and payment calculations will occur through the EDS.

5.3.1 First Year Expectations

2012

MAOs and other entities are required to submit data to both RAPS and EDS beginning January 3, 2012, and throughout the 2012 payment year. The full 5010 HIPAA standard format should be submitted to the EDPS and the current RAPS format should be submitted for risk adjustment processing.

For the duration of 2012, MAOs and other entities are expected to comply with submission requirements of both the RAPS and EDS. Plans should continue to submit RAPS data according to the current timelines published in the risk adjustment submission schedule.

NOTE: Effective January 1, 2012 the RAPS file layout is changing.

5.3.2 Payment Reconciliation

2012

Plan payments will continue to be driven by RAPS during parallel processing and until the EDS is validated by CMS. Plans will continue to receive the Model Output Report (MOR), Monthly Membership Report (MMR), and RAPS Transaction Reports during parallel systems processing. Payment calculations and reconciliation will continue to be based on data that is submitted to RAPS. Plans should utilize the MOR, MMR, and RAPS Transaction Reports throughout the 2012 payment year to reconcile payment data and project beneficiary risk scores.

However, plans are also expected to utilize the encounter data return reports in conjunction with the RAPS return reports to reconcile data, ensure all data elements are captured, and project beneficiary risk scores to ensure the data submitted and calculated through the EDS is accurate. Once parallel systems processing has ended and the transition to the EDS is complete, payment calculations will be based solely upon the EDS and plans will reconcile payment through the EDS reports only.

Example

Live Well Health Plan receives the MOR and MMR reports from RAPS for April 2012, during parallel systems processing of RAPS and EDS. The plan utilizes the diagnosis data and demographic information provided on the reports to reconcile the risk score calculation for a beneficiary enrolled in their plan. Upon reconciliation of the beneficiaries risk score calculation, based on the data received in the MOR and MMR, the plan should then reconcile this data also on the reports received from the EDS to ensure the same information is provided and that there are no discrepancies. This will ensure the data is processing correctly through the EDS even though the actual risk score and payment calculation would still be based on the data submitted to RAPS at that time.

5.3.3 RAPS Phase-Out Schedule

CMS will use data submitted through EDS for benchmarking purposes for Payment Year 2013. Beginning in Payment Year 2014, the risk scores will be derived from data submitted through EDS. Table 5D illustrates RAPS Phase-out schedule.

TABLE 5D – PHASE-OUT SCHEDULE

PY	SUBMISSION DEADLINE	PAYMENT	RISK SCORE AND BENCHMARKING
2013	09/2012	Initial 01/2013	RAPS Risk Score EDS Benchmarking
	03/2013	Mid-Year 07/2013	RAPS Risk Score EDS Benchmarking
	01/2014	Reconciliation 08/2014	RAPS Risk Score EDS Benchmarking
2014	09/2013	Initial 01/2014	EDS Risk Score/ RAPS
	03/2014	Mid-Year 07/2014	EDS Risk Score
	01/2015	Reconciliation 08/2015	EDS Risk Score
2015	09/2014	Initial 01/2015	EDS Risk Score
	03/2015	Mid-Year 07/2015	EDS Risk Score
	01/2016	Reconciliation 08/2016	EDS Risk Score

- For payment year 2013, Plan A submits a claim from February 2012 by February 2013 (within 13 months from the date of service) and prior to the March 2013 deadline. If the diagnosis is in the model, it will be reflected in a RAPS risk score and be used by CMS for Encounter Data Benchmarking. The RAPS risk score will appear as the July 2013 Mid-Year risk score.

- For payment year 2014, Plan B submits a claim from January 2013 (the earliest possible submission month for a claim to count towards an Encounter Data risk score). Since plans have up to 13 months to submit the claim from the date of service, the claim must be submitted no later than January 2014. This claim would be captured for 2014 Mid-Year payment and be reflected in the Mid-Year risk score as an Encounter Data risk score.

- For payment year 2014, Plan C has a claim to submit from December 2013. Since plans have up to 13 months to submit the claim from the date of service, the claim must be

submitted no later than January 2015. This data would be captured for 2014 final payment and reflected in the final reconciliation risk score as an Encounter Data risk score.

5.4 Resources for Systems Transition to Submission of Encounter Data

The phase-in of encounter data collection will begin the transition from submission of abbreviated claims data through the RAPS to submission of full encounter data through the EDS. In doing so, submitters will transition to submitting data through the HIPAA compliant standard Health Care Claims transactions for professional data (currently using implementation guide ASC X12N 837/005010X222 with Errata for ASC X12N 837/05010X222A1) and institutional data (currently using implementation guide ASC X12N 837/005010X223 with Errata for ASC X12N 837/05010X223A2). MAOs and other entities should use the encounter data resources available regarding required fields for submission of encounter data through the 5010 as well as EDS edit checks for processing of claims data submitted. Encounter data will process according to current FFS requirements. Utilization of the resources available will assist with preparation and successful transition to encounter data submission according to FFS processing methodologies. Resources for systems transition include the following:

🕮 **X12 Version 5010 Standards**
http://www.cms.gov/Versions5010andD0/01_overview.asp

Information on the proposed 5010 Institutional (837-I) and Professional (837-P) CEM edits that will be used for encounter data and the 5010 format crosswalks for both the 837-I and 837-P. The CMS edit spreadsheet provides the CEM edits being used for Medicare FFS overall.

🕮 **CMS Edit Spreadsheet**
http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

MAOs will receive encounter data acknowledgment reports including the TA1, 999, 277CA for processing of data through the EDFES.

🕮 **Information on these report formats is located at:**
https://www.cms.gov/Versions5010andD0/downloads/Acknowledgements_National_Presentation_9-29-10_final.pdf

🕮 **Washington Publishing Company (WPC) provides all elements required for the V5010:**
http://www.wpc-edi.com/content/view/817/1

5.5 Provider Communication and Education in the Transition to Encounter Data Collection

The phase-in of encounter data collection requires MAOs and other entities to submit HIPAA compliant 5010X12 837 format files and International Statistical Classification of Diseases, Version 10 (ICD-10) codes to the EDS. It is recommended that a robust educational program for providers regarding the importance of sending encounter data HIPAA and ICD-10 compliant claims to MAOs and other entities is implemented, as submission of this data will allow for accurate risk adjustment payment calculation.

Communicating the requirements for successful transition from risk adjustment to EDS to physicians and providers can help to improve the quality and quantity of the data submitted by MAOs and other entities. By following the HIPAA and ICD-10 regulations, physicians and providers will understand the importance of accurate coding and medical record documentation, and their role in data validation. This section describes key messages to include in provider communications and characteristics of effective communication with physicians and providers when sending messages about encounter data collection.

To help ensure that communication regarding encounter data collection gets the attention of the provider community, it is important that organizations routinely include basic information about encounter data in a variety of provider communications. Some of the key communication messages to reinforce are:

- **What is the purpose of encounter data collection?**
  Once encounter data collection is implemented, future calibration of the risk adjustment model will be based upon MA beneficiary utilization data instead of FFS beneficiary utilization data. This data must be submitted on the HIPAA compliant version 5010 format and must include ICD-10 diagnosis codes. The payment and risk score calculation methodology will not change and diagnosis data will continue to drive payment. However, once transition to EDS is complete, calculation of beneficiary risk scores will be based solely on encounter data submitted through EDS and as a result will be more accurate.

- **Why is encounter data important to physicians and providers?**
  While the risk adjustment model will continue to rely on the ICD-9-CM/ICD-10-CM diagnosis codes to prospectively reimburse MAOs and other entities based on the health status of their enrolled beneficiaries, recalibration of the risk adjustment models will rely on the quality and adequacy of encounter data collected. Physicians and providers must focus attention on complete and accurate diagnosis reporting, as well as complete and accurate reporting of other now relevant information, such as Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS).

- **What are the responsibilities of physicians and providers?**
  Physicians must report services rendered to the highest level of specificity and accuracy in accordance with ICD-10 guidelines and HIPAA standards. This requires accurate and complete medical record documentation. They are required to alert the MAO or other entity of any

erroneous data submitted and to follow the procedures for correcting erroneous data. Finally, they must report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

5.5.1 Characteristics of Effective Communication

Physicians and providers tend to respond more positively to communications from MAOs and other entities when the messages are considered reliable, accurate, timely, and helps them make their organization or practice more efficient. For this reason, it may be helpful to consider the following characteristics when developing provider communications:

- **Authoritative**
  Make the "look and feel" of provider communications conservative, official, and factual. Be certain all information is accurate. Grammar, spelling, and punctuation must be perfect, or the errors will undercut the reader's level of confidence in the message.

- **Current**
  Ensure that encounter data information is the most recent available. Update provider handbooks, websites, job aids, and training materials routinely so all information is current. Physicians and providers will not spend time reading information they know is outdated.

- **Timely**
  Provide information to providers when they need to know it. For example, if MAOs need physicians and providers to send their diagnostic data via a specific format by a certain date, send that message to them with enough lead-time to allow them to prepare for and meet the deadline for the change.

- **Consistent**
  Send consistent messages about encounter data. MAOs and other entities can contact the Customer Service and Support Center (CSSC) anytime to confirm that information they are about to send out to providers is correct. Physicians and providers appreciate receiving the right information the first time and every time.

- **Practical, relevant, and well organized**
  Delete "background noise" from your physician and provider messages. Identify the primary message you want to send and provide the key information necessary to make the point. Focus the message and identify any specific actions that are required in clear, easy-to-read language.

- **Accessible**
  Create materials for physicians and providers that are easy to access. Information that physicians and providers can locate quickly helps to ensure compliance with encounter data requirements, whether that information is available on the Internet, or in a paper document.

5.5.2 Communication Methods

Many MAOs and other entities indicate that communicating to physicians and providers through a single medium, like a newsletter, is not effective. A multimodal approach is more successful at reaching the provider community because it reaches a broader audience and reinforces the message in a number of different formats.

When deciding the methods to communicate with physicians and providers, consider the following steps:

- **Identify the methods that tend to work best for the organization.** Many MAOs and other entities indicate that the organization's provider Web page and newsletters reach audiences, but small and large group training sessions are most successful for causing a change in action.

- **Determine the goal of the message.** If the message's intent is to raise awareness about a topic, then broad-based communication methods may be appropriate. However, if the message is intended to change the way physicians and providers do something, then group meetings, followed up by emails, and provider handbook and contract updates may be excellent options.

- **Consider the physician's and provider's response.** If the message is likely to provoke a negative reaction from the provider community, then meetings with them can be helpful in addressing and clarifying issues, and discussing possible solutions to problems.

🕮 **Additional information on provider outreach and education is available at:** http://www.cms.gov/home/outreacheducation.asp.

5.6 Summary

In support of the transition to encounter data collection, RAPS and EDS systems will run parallel to mitigate the risk of impact to MA plan payments. Therefore, on January 3, 2012, MAOs and other entities will begin submitting data to both the RAPS and EDS for parallel systems processing. The systems will run parallel at least throughout the 2012 payment year following the EDS implementation date. CMS will continue to run the RAPS until it is validated that encounter data can be used to accurately calculate beneficiary risk scores and recalibrate the CMS-HCC risk adjustment models. During parallel systems processing, payment will continue to be driven by RAPS and plan payment will be reconciled based on data submitted to RAPS

Table 5E illustrates the expectations for RAPS in 2012 and 2013.

Table 5E – SUMMARY OF EXPECTATIONS FOR RAPS FOLLOWING EDS IMPLEMENTATION

SUMMARY OF EXPECTATIONS FOR RAPS	
2012	**2013**
• MAOs and other entities will submit data to both RAPS and the EDS. • Plans must comply with the submission requirements of both RAPS and EDS. • Payment calculations and reconciliation will be based upon submission to RAPS. • Plans should follow the RAPS submission deadlines and sweep schedule for payment reconciliation.	• Further information on the expectations for the 2013 payment year will be released at a later date.