Encounter Data User Group
Q&A Documentation

Questions and Answers

The following were questions submitted by participants for discussion during the November 3, 2011 Encounter Data User Group Call.

Q1: What are the standard denial codes mentioned in the industry update on October 27th?

 A1: While there are no standard denial codes, there are two (2) sets of codes, Remittance Advice Remark Codes and Claim Adjustment Reason Codes. Remittance Advice Remark Codes are used to convey information about remittance processing. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. When and MAO or other entity is submitting an encounter with any lines that were denied by the plan's adjudication system, the submitter must include the standard Remittance Advice Remark Code to identify the reason for denial using the NTE field. As CMS continues to work through examples of the use of the CAS segment, CMS will provide further guidance regarding populating the Claim Adjustment Reason Code.

Q2: What is the definition of a linked chart review?

A2:   The definition of a linked chart review is a chart review submission that is populated with the original encounter's ICN and therefore will be linked to the original encounter.

Q3: What is the definition of an unlinked chart review?

A3:   The definition of an unlinked chart review is a chart review submission that is not associated with an original encounter and is not populated with an ICN and therefore will not be linked to an original encounter.

Q4: Could you please clarify the claim filing indicator code logic. In the companion guide it says that element SBR09 should have a value of "16" in both loops 2000B and 2320. It is my understanding that now the value in SBR09 should be "MA" in Institutional claims and "MB" in Professional claims. Does this apply to both loops 2000B and 2320? If not, what values should go on element SBR09 on each loop?

A4:   MAOs and other entities must populate Loop 2000B, SBR09 with a value of "MB" for Professional encounters and "MA" for Institutional encounters. Loop 2320, SBR09 must be populated with a value of "16" for both Institutional and Professional encounters.

Q5: It is my understanding that pricing will only be done on claims/encounters for services normally covered by FFS, is that a true statement?

A5: Yes, CMS will price using the FFS pricers and fee schedules based on FFS covered services.

Q6: Are the CEM edit documents that were discussed on the Thursday 10/27 Industry Update specific to MAOs? If not, is that something that will be published once the CEM edits for MAOs are finalized, which should be within the next 30 days?

A6: The CEM edits documents published on the CMS website are designed for Medicare FFS claims processing. EDS has incorporated the Medicare FFS CEM editing into the Encounter Data Process and will use the existing Medicare FFS CEM edits as a baseline. As the EDS test data results continue to be analyzed, CMS will determine which edits in the Medicare FFS CEM will need to be turned off for encounter data processing and publish that information on the CSSC website.

Q7: Where would MAOs and other entities populate a Claim Control Number (CCN) on the 837-I or 837-P?

A7: The CCN should be populated in the Loop 2300, CLM01.

Q8: For FTP and NDM users, is there a limit to the number of ST-SE segments submitted in a file?

A8: Yes. FTP and NDM users may submit up to, but no more than 85,000 encounters per file. The TR3 guidance allows up to 5000 CLMS per ST-SE. When the TR3 guidance is followed with 5,000 claims in each ST-SE, only 17 ST-SEs can be sent, which would complete the total of 85,000 encounters. The 85,000 encounters per file may be submitted in any combination of number of encounters per ST-SE and is not required to be exactly 85,000, but must not exceed 85,000.

Due to system processing overhead associated with smaller numbers of encounters within the ST-SE, it is highly recommended that larger numbers of encounters within the ST-SE be used.