Encounter Data Work Group Summary Notes for Editing and Reporting: Key Findings and Recommendations

Editing and Reporting
Work Group 1 of 2

This report summarizes the findings of the Editing and Reporting Encounter Data Work Group conducted on January 12, 2011. Forty-one industry organizations participated in this Work Group and included:

- Abrazo Advantage
- Aetna
- ArchCare
- ARDX
- ATRIO Health Plans
- Blue Care Network of Michigan
- Blue Cross and Blue Shield of Alabama
- Blue Cross and Blue Shield of Florida
- Blue Cross Blue Shield of Massachusetts
- Blue Cross Blue Shield
- Blue Cross Blue Shield of California
- Brand New Day
- Bravo Health
- CDPHP
- CIGNA HealthCare of Arizona
- CMS
- Commonwealth Care Alliance
- CSSC Operations
- Emblem Health
- ESSENCE Healthcare
- Gateway Health Plan
- Group Health Cooperative
- Health Alliance Plan of Michigan
- Health Net
- Health Net of Arizona
- Humana
- Independent Health Care Plan
- Inland Empire health
- Leprechaun (LLC)
- MMM Holdings Inc.
- Molina Health Care of California
- National PACE Association
- Presbyterian Health Plan
- Primetime Health Plan
- Regence Blue Cross Blue Shield
- Samaritan Health Plan
- Security Health Plan of Wisconsin
- Senior Whole Health
- Tufts Health Plan - Medicare Preferred
- University Physicians Health Plans

The primary purpose of the Encounter Data Work Groups is to provide a forum for communication between the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage Organizations (MAOs), and Third Party Submitters to determine and discuss issues while creating possible solutions for final implementation of Encounter Data.

The goals for this series of sessions for Editing and Reporting include:

- Discussion of edits to be used for claims processing and collection of encounter data,
- Identification of the reports to be used for encounter data and discussion of the reports reconciliation process, and
- Determining methodologies for linking data to show incremental data collection with the original encounter claim.

The expected discussion topics for this session were:

- Description of current connectivity methods in use by MA Organizations,
- Identification of plans preparations to transmit and receive 5010 acknowledgement reports,
- Discussion of elements of 277CA edits and MA Organizations ability to populate those edits,
- Preferences for sending return reports to multiple individuals per submitter ID, and
- Capacity of plans to read return reports in a flat file format, which requires plans to translate data.

The first session of the Editing and Reporting Work Group focused on addressing questions of MA organizations and discussion of issues or concerns regarding transmission of 5010 acknowledgement reports, elements of 277CA edits along with the ability of plans to populate those edits, and the capacity of plans to read acknowledgement reports in a flat file format.

Introduction and Review of Editing and Reporting Discussion Slides

The Editing and Reporting Work Group began with an introduction to the purpose of Encounter Data, a discussion on the flow of data through the Encounter Data Front-End with examples of edits based on file (format), batch (format), and claims (validation) level editing used in processing, and a discussion of the three front-end acknowledgement reports used by the Encounter Data System – TA1, 999, and 277CA – and the different data elements of importance.

Purpose of Encounter Data Collection

The primary use of Encounter Data is to correctly price an encounter according to the Fee-For-Service (FFS) pricing methods. The priced encounter will be used for risk adjustment payment calibration. The process for risk adjustment calculation will not change and will continue to be based upon demographic and diagnosis data. However, the dataset that the risk adjustment models are calibrated against will change.

Data Flow through the Encounter Data Front-End

A Plan submits a 5010 file to the Encounter Data Front-End System.

Edits will be applied on three levels during the Front-end processing.

1. The TA1 (Translator Edits) performs Transmission file X12 interchange level/ISA – IEA edits.
    - If Interchange errors are present, they reflect technical problems that must be addressed by the software preparing the EDI transmission. Processing stops, the entire file, and TA1 Report are returned to the Submitter for correction, and resubmission of the entire interchange.

2. The 999 (Translator, IG edits) performs X12 functional group/GS - GE validation editing.
    - If fatal functional group errors are present, they reflect technical problems that must be addressed by the software preparing the EDI transmission. Processing stops, the entire file, and 999R Reject Report are returned to the Submitter for correction, and resubmission.

3. The 277CA (CEM, CEDI edits) performs Claim level/ ST- SE Medicare specific edits, CMS-selected IG edits that validate data content. The report provides information on which claims were rejected and their reason for rejection.

CMS is developing an Encounter Data Risk Adjustment Companion Guide that will provide details on the required fields for processing Encounter Data.

Submitter Packet

MA Organizations are required to submit a new submitter packet and enter into an EDI Agreement with the Customer Service and Support Center (CSSC) prior to testing beginning in March 2011. New and existing MAOs/Submitters will submit a new submitter packet. CSSC provides the EDI authorization paperwork, assigns the Submitter ID, and only accepts data in the 5010 X12 format.

Preparations to Transmit and Receive 5010 Acknowledgement Reports

MA organizations need to be able to receive 5010 acknowledgement reports (TA1, 999, and 277CA) following submission of encounter data through internal systems. All reports returned to plans are flat files. Discussion during the Work Group focused on the purpose of data contained in the 277CA report and the usefulness of data for Submitters.

Elements of 277CA Edits and Ability to Populate Those Edits

A 277CA acknowledgement report will be received by MA organizations upon rejection of claims due to Medicare validation edits on claims data content. MA organizations must be able to properly populate required data fields on the 5010 based on policy edits turned on for encounter data submission.

The 277CA is a standard report received following each claims submission and does not require a 276 transaction. CMS is considering using the 276 as an optional transaction for plans to request information on the status of a claims submission.

- The 277CA report will provide the status of each claim received.
- Data used by RAPS and the Encounter Data System (EDS) during parallel processing cannot be differentiated on the 277CA acknowledgement report.
    - CMS is currently developing a customized report to show the data fields filtered by RAPS and EDS.

Participant's Suggestions Discussed

A cumulative report for the 277CA would be helpful for MA organizations to show a summary listing of all rejected claims (weekly or monthly report).

- This enables plans to pull a list of outstanding rejected claims.
- CMS is currently designing customized acknowledgement reports for encounter data submissions.

- Development of a cumulative report of outstanding claim rejects can be discussed further in the next Work Group session.

Edits Related to Amount Fields

Edits related to deductible amounts or benefit coverage based on plan benefits is an issue. Editing will be performed to verify valid dollar amounts are included. An example provided in the Work Group discussion was an edit to detect errors in deductible amounts.

- Deductible amounts are specific to plans and their plan-specific benefits.
- To standardize use of amount field edits, a global comparison table would be needed (i.e. deductible calculation) specific to each type of plan and services provided.

Resolutions Discussed

- CMS is currently evaluating edits to suppress or retain for implementation of the Encounter Data System.
  - All edits currently utilized in Fee-For Service (FFS) will not be applied for collection of Encounter Data.
  - Currently, CMS does not intend to develop new customized edits in addition to those currently used in FFS.
- A global table to compare plan deductible amounts will not be used as this is not a viable option.
- To manage benefit coverage differences between MA plans, an informational code could be developed. The services could be accepted as informational and this avoids rejecting the encounter data.

Quality of Data Received from Providers

Providers often submit data that is not sufficient quality for the MA organizations.

- Receiving low quality data triggers a large volume of edit errors. However, some of these errors occur based on fields that are not needed for claims pricing. This happens if plans do not filter their data prior to submitting to CMS.
  - In example, data on the beneficiary address does not impact risk adjustment payment but may cause a larger volume of edit errors to occur if not formatted properly. However, data that does impact payment, in this example, is the beneficiary Zip Code.

Participant's Recommendations Discussed

In order to determine other data elements and associated edits that do not impact payment, participants should submit a list of data elements that do not impact payment to eds@ardx.net. This will assist with the evaluation of edits to be suppressed for the EDS.

Differences between Paper Claims and Electronic Claims Data Submission

Participants identified that there are differences between the paper format currently in use by some in the industry and the electronic 5010 format that is being implemented. Not all elements of the 5010 are available on paper claims format. Default values are needed for fields that are not accounted for on paper claims format.

- Currently, plans convert paper claims to an 837 format and use default values to populate fields where data are missing.
- When determining fields to use as placeholders, the translator may not accept the data if these fields are not used as originally intended.

Action Item
Participants should send a list of defaults currently in use for paper claims as the industry converts to the electronic format to the eds@ardx.net inbox. This allows CMS to assess potential elements that can be utilized to reduce the affect of difference between the paper format and electronic.

Reason Codes
Plans expressed that HIPAA reason codes are very generic and do not explain the specific reason for the denial.

Participant's Suggestions Discussed
The Washington Publishing Company ARC list of reason codes should not be utilized for claim rejection reason code logic.

- The codes are not detailed and do not provide enough information regarding rejection of a claim.

Capacity of Plans to Read Acknowledgement Reports in a Flat File Format and Translation of Data

All 5010 acknowledgement reports will be received in a flat file format, in which plans will have to read and translate data. Since Encounter Data collection will require a much larger volume of claims data to be received and submitted by plans, it is important to discuss the capacity of MA organizations to read and translate data that is included in 5010 acknowledgement reports that will be sent to plans upon file submission.

Translation of Data
Participants discussed their current capabilities to translate a flat file in order to reconcile data through internal system processes.

- However, plans must develop their internal systems to receive 5010 acknowledgment reports and translate the associated data.
  - There is no online system to view acknowledgement reports of claim submissions (i.e. TA1, 999, or 277CA).
- The 5010 format is more complicated with regard to data mapping and claims processing than the RAPS format. RAPS files do not include complex loops or segments that are not well known by the industry.

Questions Addressed Throughout the Work Group
The following are additional questions discussed by participants during the Editing and Reporting Work Group.

Questions asked by Participants
Q1: When will plans receive the published encounter data submitters' package?
A1: The submitters package will be published on the csscoperations.com website by March 15, 2011. MA Organizations will need to complete and return the forms by March 30, 2011.

Q2: Will details be provided on filters used for risk adjustment versus encounter data submissions?
A2: Yes, details will be a part of the new training modules and companion guides.

Q3: Where can plans locate the 5010 acknowledgement report layouts?
A3: The report layouts are available online at the Washington Publishing Company website at http://www.wpc-edi.com/content/view/817/1. A link for the report layout specifications will be provided.

Q4: Are the 5010 response reports industry standard?
A4: Yes, they are the industry standard.

Q5: Can we assume that for all 5010 response reports there will be a corresponding flat file that plans can use for internal systems processing?
A5: All reports will be in the form of a flat file upon receipt.

Q6: For adjustments, the plan needs to make sure all diagnosis codes are present in the adjustment encounter because all previous diagnoses for the original claim will be overwritten. Is this a true statement?
A6: Yes.

Q7: If a claim is rejected, should a reversal or a new claim be submitted?
A7: If a claim is rejected, the plan would need to send a new claim, since the rejected claim was not stored.

Q8: Will the submission of adjustment claims take into consideration payment amounts?
A8: Yes, the adjusted claim should be submitted with the updated and correct payment amounts included.

Q9: Will adjustments be deleted from the cumulative report of rejects (if this report is established)?
A9: Rejects will be kept for a certain period. Rejects are not currently stored in RAPS only adjustments. The adjustment supersedes the reject. The linking of adjustment claims submissions to the cumulative report needs to be further discussed in the Work Groups.

Q10: For adjustments, do plans always populate the CAS segment to supersede the original claim with the adjusted claim? Does this handle reversals?
A10: Yes, you can submit a correction or a deletion. For adjustments, use the CAS "CR" for correction or CAS "OA" for deletion and CLM05-3 frequency "1" original claim, "7" replace prior claim, "8" void/cancel/delete prior claim indicators.

Q11: For adjustment submissions, how will plans reference the original claim?
A11: The original claim will be referenced by using CLM01, which is the patient control number, CAS "CR" for correction CLM05-3 frequency "7" replace prior claim.

Q12: For remediated claims that were rejected and resubmitted, are these sent back with a claim frequency of '01'?

A12: No, they should have a CLM05-3 frequency of "7" if the desire is to replace the claim prior claim, "1" is used to denote the original claim.

Q13: If the CAS segment balances charges and paid amounts, do plans use the 'CAS 01' for the correction reason?
A13: Yes, along with CLM05-3. CAS "CR" for correction or CAS "OA" for deletion and CLM05-3 frequency "1" original claim, "7" replace prior claim, "8" void/cancel/delete prior claim indicators.

Q14: What is the deadline for plans to submit the list of fields that do not impact payment calculation?
A14: One week from the work group, January 19, 2011.

Q15: Is the plan for Encounter Data still to run the Risk Adjustment (RA) system and Encounter Data System (EDS) in parallel?
A15: Yes, the systems will be run in parallel until the encounter data is reliable.

Q16: How will CMS validate providers?
A16: Plans can expect data to edit against the National Provider Identification (NPI) number. The NPPES will be used to validate the NPI number.

Q17: Will MA organizations receive a provider file so that plans can validate providers and compare data?
A17: CMS will determine if there is a resource that can be made available to the MA organizations.

Q18: Will plans be responsible for applying the new licensing provider requirements?
A18: Plans are already responsible for credentialing providers. For non-contracted providers that do not meet the credential requirements as approved providers, use of an NPI indicates the provider is credentialed.

Q19: Has CMS established duplicate criteria?
A19: Duplicate claims information will be provided during the training sessions conducted in the Summer of 2011.

Q20: Is the ICN the plan's number or is CMS assigning this number?
A20: The ICN can be the pay-to-plan number as long as the 2010AC Loop is populated with the Pat to Plan information.

Q21: If the National Provider Identification (NPI) number determines provider acceptability, what fields will CMS use for Risk Adjustment?
A21: CMS will be using NPPES. NPI to determine whether a service or facility is acceptable (i.e., data source). Plans must submit all data received without filtering. CMS plans to provide a report showing fields that were used for Risk Adjustment based on CMS filters.

Q22: If a claim is rejected, the claims status code field is populated and it is flagged in the database. What loop is this in?
A22: 2300 loop 2000B CLM 17.

Q23: For the 5010, do we populate all 'R's (required fields)?
A23: Yes, all required fields should be populated.

Q24: Will the companion guide be available before the first test file submission deadline in March?
A24: The companion guide will not be completed before the start of testing on March 30, 2011. However, the testing phase runs from March 30, 2011—June 30, 2011. Plans must submit a 5010 test file sometime within this time period. The objective of the test is to make sure that the 5010 file can communicate with the Front-End System. Plans do not need an entire month of data for the test. A minimum of 10 claims should be submitted. The companion guide will be made available to plans in phases as it is developed. Also, the Industry Updates scheduled for January 19, March 16, and May 11, 2011 will provide up-to-date information on decisions made or changes to encounter data requirements.

Q25: When a claim is submitted, will it continue through all edits until all claim rejections are identified?
A25: This depends on the type of error encountered. If there is enough data to continue the editing logic, then the claim will continue until it fails. Plans will receive the logic for edit errors.

Q26: How will taxonomy be populated on the 5010, will it be taken from the provider claims (taxonomy is not currently used in RAPS and providers often do not accurately submit taxonomy information)?
A26: The taxonomy will be pulled from NPPES.

Q27: Will the Medicare provider ID be accepted in addition to the National Provider Identification (NPI) number for encounter data claims submissions?
A27: Only NPI will be accepted. All providers should have an NPI.

Q28: For providers that are not required to have an NPI, what do plans use for identification/acceptability?
A28: CMS is currently in the process of developing alternative codes for these providers.

Q29: Is there an alternative online system in place for submitting claims?
A29: Currently, the only way to submit claims is through batch submission through the 837X. In the future an online Direct Data Entry (DDE) system may be developed.

Q30: Is there a web link available for obtaining all of the required fields for submission of encounter data?
Q30: The information can be found at: http://store.x12.org/
https://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp
http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

Q31: Will there be both required and informational fields on the 5010?
Q31: Yes

Q32: How will additional HCCs found during our HRA process be submitted (typically a contracted physician or nurse practitioner visits plan members to fill out a medical risk assessment in which they may identify an HCC for a diagnosis code not reported on a previous claim submission)?
Q32: MA organizations will submit data using the PKW01, CAS and CLM5-03 segments and data elements.

Q33: Will CMS be drafting a Custom Reject Reason Code list for the 277CA report?
Q33: Further information will be provided in the coming months regarding the possible customization of reports.

Q34: What is the definition for "denied claims"? It was stated that plans should only submit paid or denied claims, but not claims rejected by the plan for invalid claim submission.
Q34: A claim that the plan did not pay, payment to provider was denied.

Key Conclusions and Recommendations for Encounter Data Editing and Reporting Work Group

Based on the information discussed in the Editing and Reporting Work Group held on January 12, 2011, the following recommendations are provided to CMS to ensure successful implementation of the collection of encounter data.

Recommendations

- Development of a weekly or monthly cumulative report of outstanding rejected claims for the 277CA acknowledgement reports.
- To manage benefit coverage differences between MA plans, an informational only code could be developed. The services could be accepted as informational versus rejecting the entire encounter.
- Regarding use of the ICN, participants prefer to provide their own identifier rather than having CMS provide the identifier.
- CMS should utilize a 'bottom up' approach by first requiring plans to submit the minimum data needed for pricing rather than requiring all 5010 fields to be populated. CMS could suppress any unnecessary edits as the Encounter Data process is implemented.
- MAOs/Submitters should download the Implementation Guide from the Washington Publishing Company (http://www.wpc-edi.com/content/view/817/1), which provides updated information on reports and other requirements essential for collection of encounter data.

Action Items and information needed from Participants

The next Encounter Data Work Group for Editing and Reporting will be held on March 2, 2011.

By Wednesday, January 19, 2011, Work Group participants should send the following items to eds@ardx.net:

- List of edits with no impact on payment calculations.
  - For example, "address" of beneficiary would not affect payment calculation. However, it would trigger a high volume of edits to occur if not properly entered or formatted on the submitted encounter (i.e. additional spacing, etc.).

- List of default values and fields currently in place for submission of paper claims data.
  - Identify the differences between the paper format and the 5010 electronic format.
  - Plans currently convert paper claims to electronic version and place default values in fields that are not available.