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# Encounter Data System

## Test Case Specifications

Encounter Data test case specifications related to the 837 Health Care Claim: Institutional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X223A2

Test Case Specifications: 2.0

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**Preface**

The Encounter Data System (EDS) Test Case Specifications contain information to assist Medicare Advantage Organizations (MAOs) and other entities in the submission of encounter data for EDS testing. Following the completion of Encounter Data Front End System (EDFES) testing, Medicare Advantage Organizations (MAOs) and other entities are required to submit data for testing the Encounter Data Processing System (EDPS). This document provides an outline of test case submissions required for MAO end-to-end testing.

Questions regarding the contents of the EDS Test Case Specifications should be directed to [eds@ardx.net](mailto:eds@ardx.net).

**REVISION HISTORY**

<b>Version</b>	<b>Date</b>	<b>Organization/Point of Contact</b>	<b>Description of Changes</b>
1.0	01/17/12	ARDX	Base Document
2.0	04/02/12	ARDX	The document was modified to adjust for Institutional Testing.

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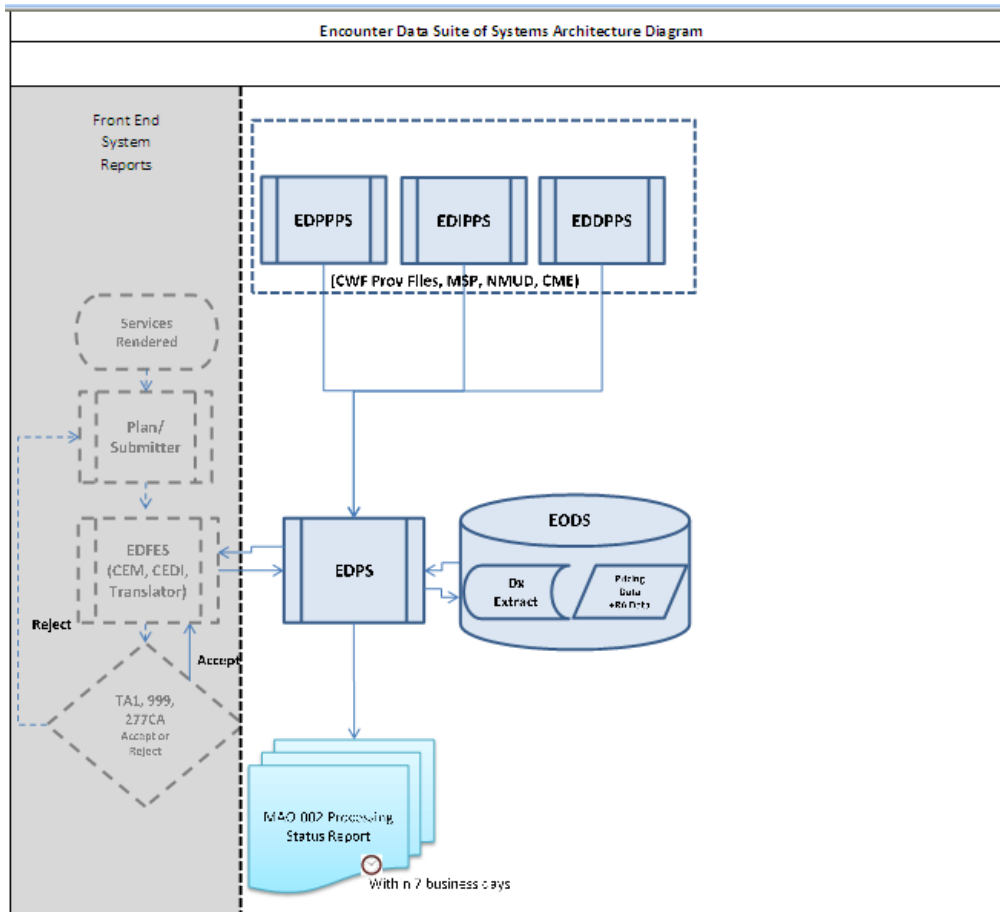
4.0 Acronyms

## 1.0 Introduction

This document may be used in conjunction with the business case examples referenced in the EDS 837 Institutional Transaction Companion Guide.

The purpose of EDS end-to-end testing is to validate the following:

- Files are received by the EDFES
- Files process through the translator
- Files process through CEM
- Submitter receives front-end reports from EDFES
- Data received by EDPS
- Data processed and priced in EDPS
- Submitter receives Encounter Data Processing Status MAO-002 from EDPS



Test case submissions allow CMS to ensure system functionality based on specifically designed test cases. It also allows MAOs and other entities to confirm that the CMS operational guidance has been properly programmed in their systems.

The 837-I certification files are submitted in two (2) files. The first file includes all unlinked test cases (24) and the second file includes the duplicate test case (2). All test cases included in the first file must be completely accepted as indicated on the MAO-002 report before the second file is submitted. MAOs and other entities must receive a 95% acceptance rate to be deemed certified.

The first test file must include the 26 encounters (2 encounters per test case) otherwise EDS will reject the file. Rejected files must be corrected and resubmitted until all 26 encounters pass front end editing (translator and CEM) at 100% before it can be processed in the EDPS. MAOs and other entities must use the following guidance when preparing all unlinked (26) and the duplicate (2) test cases:

- The encounters submitted must comply with the TR3, CMS edits spreadsheet and Encounter Data Companion Guide.
- All encounters must include 2012 DOS only (no future dates).
- Files must be identified as a test case submission using CLM01 by appending "TC<test case #>" to the end of the Plan Encounter ID (CCN).

MAOs must not submit any Professional test cases with the Institutional file submissions. MAOs should exclude Home Health, Skilled Nursing Facilities, and Part B Inpatient services for the testing submission at this time. MAOs and other entities will receive the TA1, 999, and 277CA within 48 hours of submission. The MAO-002 report will be returned to the submitter within 7 business days of submission. MAOs and other entities must correct errors identified on the reports and resubmit data with a 95% acceptance rate in order to pass end-to-end certification. Acceptance notifications will be communicated to MAOs and other entities upon certification.

## 2.0 Test Case Summary

During the end-to-end testing, the following types of test case scenarios are required:

- I. Beneficiary Eligibility
  - a. New MA Member
  
- II. Data Validation
  - a. Capitated Provider
  - b. Atypical Provider
  - c. Ambulance
  - d. Coordination of Benefits (COB)
  - e. Federally Qualified Health Center/Rural Health Clinic
  - f. Clinical Laboratory/End-Stage Renal Disease
  - g. Community Mental Health
  - h. Critical Access Hospital
  - i. Hospital- Outpatient
  - j. Hospital-Inpatient
  - k. Outpatient Rehab
  - l. Skilled Nursing Facility/Home Health (future testing)
  
- III. Processing
  - a. Duplicate

**Note: Submitters must exclude, from all test cases, the following Type of Bill (TOB) codes:**

- **Hospital-Inpatient: TOB 121-128 and 12A-12Z**
- **Skilled Nursing Facility (SNF): TOB 210-280 and 21A-28Z**
- **Home Health: TOB 320-349 and 32A-34Z**
- **Hospice: TOB 810-829 and 81A-82Z**

CMS will provide further guidance for the submission of these TOBs in the future.

### Test Case Summary Table

Test Case/Script Identifier	Test Case/Script Title
Beneficiary Eligibility	TC01- New MA Member
Data Validation	TC02-Capitated Provider
Data Validation	TC03-Atypical Provider
Data Validation	TC04-Ambulance
Data Validation	TC05-Coordination of Benefits
Data Validation	TC06-Federally Qualified Health Center/Rural Health Clinic
Data Validation	TC07-Clinical Laboratory/End-Stage Renal Disease
Data Validation	TC08-Community Mental Health
Data Validation	TC09-Critical Access Hospital
Data Validation	TC10-Hospital – Outpatient
Data Validation	TC11-Hospital – Inpatient
Data Validation	TC12-Outpatient Rehab
Data Validation	TC13-Skilled Nursing Facility/Home Health (future testing)
Processing	TC14-Duplicate

**Note: Submitters must exclude, from all test cases, the following Type of Bill (TOB) codes:**

- **Hospital-Inpatient: TOBs121-128 and 12A-12Z**
- **Skilled Nursing Facility (SNF): TOB 210-280 and 21A-28Z**
- **Home Health: TOB 320-349 and 32A-34Z**
- **Hospice: TOBs810-829 and 81A-82Z**

CMS will provide further guidance for the submission of these TOBs in the future.



For each test case scenario, details are provided to assist with encounter data test submissions:

**3.25 TC25-Zip Code + 4** Type of test encounter requested for testing.

**3.25.1** The purpose of TC25-Zip Code + 4 Submission is to test and collect data for accurate pricing. This line defines the purpose for testing this type of encounter.

**3.25.2 Prerequisite Conditions** Prerequisite Conditions list requirements and reminders to successfully submit the test encounter.

1. System will accept 5010 version X12 standards for HIPAA transactions.
2. At least two (2) encounters are submitted for each type of test case scenario.

**3.25.3 Test Procedure**

**Table 28: Test Procedure Steps for TC25- Zip Code + 4 Submissions**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with the zip code + 4 postal box identifier. <ul style="list-style-type: none"> <li>• Use "9999" as a default for the last four (4) digits of the zip code for one submission to test the case where this information does not exist on the original submission file.</li> </ul>	<ul style="list-style-type: none"> <li>• Files pass duplicate validation, paid amount balancing and continue processing.</li> <li>• ED Processing Status Report is returned with "Accepted" status within 24 hours of submission.</li> <li>• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status. The Encounter Edit Disposition Report will also be generated if errors are found.</li> <li>• Encounters Summary, and Encounters Detail Reports are also returned within 24 hours of submission.</li> <li>• Encounter Data Risk Filter Report is generated and returned within 1 week, providing diagnosis codes identified as model diagnoses for risk adjustment.</li> </ul>

This section provides steps for inputs and the expected outcomes from the submissions.

**3.25.4 Assumptions and Constraints**

It is assumed that all encounter submissions will include submitter names.

(Example Test Case Details)

This section lists any assumptions or constraints associated with the Test Case.

### 3.0 Test Case Details

#### 3.1 TC01-New MA Member

##### 3.1.1 Purpose

The purpose of TC01-New MA Member is to test eligibility rules on a new member encounter submission.

##### 3.1.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

##### 3.1.3 Test Procedure

**Table 1: Test Procedure Steps for TC01-New MA Member**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a new Medicare Advantage member enrolled in 2011 with effective in 2012.	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Validation on the file for a unique encounter is based on the following data fields:<ul style="list-style-type: none"><li>○ Beneficiary HICN</li><li>○ Beneficiary Name</li><li>○ Date of Service</li><li>○ Type of Bill</li><li>○ Revenue Code/ where applicable Procedure Code</li><li>○ Billing Provider NPI</li><li>○ Paid Amount.</li></ul></li><li>• ED Processing Status Report is returned with “Accepted” status within 7 business days of submission.</li><li>• Any errors found on the file will generate the ED Processing Status Report with a “Rejected” status within 7 business days of submission.</li></ul>

### **3.1.4 Assumptions and Constraints**

It is assumed that all beneficiaries are eligible and enrolled in the plan and can be found in Monthly Membership enrollment reports and the MARx UI table for verification.

### 3.2 TC02- Capitated Provider

#### 3.2.1 Purpose

The purpose of TC02-Capitated Provider is to ensure capitated encounters are edited, processed, priced, and stored accordingly in Encounter Operational Data Store (EODS).

#### 3.2.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.
3. Remember to populate claim level - Loop 2300, CN101 data element with "05" for the capitated submission.

#### 3.2.3 Test Procedure

**Table 2: Test Procedure Steps for TC02-Capitated Provider**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a capitated encounter on an 837-I file. Submit 0.00 in the amount field otherwise submit the amount as is for the capitated encounter.	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Validation on the file for a unique encounter is based on the following data fields:<ul style="list-style-type: none"><li>○ Beneficiary HICN</li><li>○ Beneficiary Name</li><li>○ Date of Service</li><li>○ Type of Bill</li><li>○ Revenue Code/ where applicable Procedure Code</li><li>○ Billing Provider NPI</li><li>○ Paid Amount.</li></ul></li><li>• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the ED Processing Status Report (MAO-002) with a "Rejected" status within 7 business days of submission.</li></ul>

### **3.2.4 Assumptions and Constraints**

If pricing information is available on the encounter collected, then it should be submitted as is; however, the sum of the SV2 (Institutional) service lines must balance to the total amount populated on Loop ID-2300, CLM02. Capitated encounters submitted with "0.00" in the amount fields will be priced according to 100% of the Medicare allowable amount when processed through the EDS.

### 3.3 TC03-Atypical Provider

#### 3.3.1 Purpose

The purpose of TC03-Atypical Provider is to test encounters submitted by atypical providers with the designated default NPI and tax ID number.

#### 3.3.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.3.3 Test Procedure

**Table 3: Test Procedure Steps for TC03-Atypical Provider**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an atypical provider 837-I file using the following default codes: NPI-1999999976 EIN – 199999997 ICD-9 diagnosis code - '78099' – Other General Symptoms	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Validation on the file for a unique encounter is based on the following data fields:<ul style="list-style-type: none"><li>○ Beneficiary HICN</li><li>○ Beneficiary Name</li><li>○ Date of Service</li><li>○ Type of Bill</li><li>○ Revenue Code/ where applicable Procedure Code</li><li>○ Billing Provider NPI</li><li>○ Paid Amount.</li></ul></li><li>• ED Processing Status Report (MAO-002) is returned with “Accepted” status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002) with a “Rejected” status within 7 business days of submission.</li></ul>

### **3.3.4 Assumptions and Constraints**

The default diagnosis codes provided are only used for testing purposes. Relevant diagnosis codes should be determined by coordinating with the provider and atypical service provider. Diagnoses captured from atypical provider types (as notated by the default atypical provider NPI) will not be priced or used for risk adjustment calculation; however, the diagnoses will be stored for beneficiary utilization data and analysis.

### 3.4 TC04- Ambulance

#### 3.4.1 Purpose

The purpose of TC04-Ambulance is to test editing, processing, and appropriate pricing of ambulance services.

#### 3.4.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.
3. Remember to submit an NPI that is valid for an ambulance type of service and the HCPCS codes listed are valid for ambulatory services.

#### 3.4.3 Test Procedure

**Table 4: Test Procedure Steps for TC04-Ambulance**

Step #	Action	Expected Results/ Evaluation Criteria
1.	<p>Submit an encounter for a Medicare participating provider using the ambulance Fee Schedule located online at <a href="http://www.cms.gov/AmbulanceFeeSchedule/02_afspuf.asp#TopOfPage">http://www.cms.gov/AmbulanceFeeSchedule/02_afspuf.asp#TopOfPage</a>.</p> <p>Tip: Select the CY 2012 zip file and then use the ambfspuf_2012_ext_final.xlsx file to submit a valid ambulance HCPCS code.</p> <p>In Loop 2400, data element SV204='UN' and SV205 must be populated with the ambulance mileage. Applicable type of bill codes for ambulance are '13', '22','23','83', and '85'.</p>	<ul style="list-style-type: none"> <li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li> <li>• Files pass duplicate validation and continue processing.</li> <li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li> <li>• Any errors found on the file will generate the (MAO-002) with a "Rejected" status within 7 business days of submission.</li> <li>• Pricing data and diagnosis data are updated and stored in the EODS database.</li> </ul>



Step #	Action	Expected Results/ Evaluation Criteria

#### 3.4.4 Assumptions and Constraints

The ambulance fee schedule will be used for pricing all services identified on the encounter submission.

### 3.5 TC05- Coordination of Benefits

#### 3.5.1 Purpose

The purpose of TC05-Coordination of Benefits is to test editing, processing, and appropriate pricing of multi-payer or Medicare secondary payer submissions.

#### 3.5.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.
3. Submit an original transaction to a primary payer.

#### 3.5.3 Test Procedure

**Table 5: Test Procedure Steps for TC05-Coordination of Benefits**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a true coordination of benefits submission using the following guidance:  <b>1st iteration of COB loops – MAO information (Primary Payer)</b> Loop 2320 o AMT01='D', AMT02=MAO Paid Amount Loop 2330B – MAO Information Loop 2430 – MAO Service Line Adjudication Information o SVD – Service Level Payment Amount o CAS – Service Level Amount NOT Paid	<ul style="list-style-type: none"> <li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li> <li>• Validation on the file for a unique encounter is based on the following data fields:               <ul style="list-style-type: none"> <li>o Beneficiary HICN</li> <li>o Beneficiary Name</li> <li>o Date of Service</li> <li>o Type of Bill</li> <li>o Revenue Code/ where applicable Procedure Code</li> <li>o Billing Provider NPI</li> <li>o Paid Amount.</li> </ul> </li> <li>• ED Processing Status Report (MAO-002) is returned with “Accepted” status within 7 business days of submission.</li> <li>• Any errors found on the file will generate the MAO-002 with a “Rejected” status within 7 business days of submission.</li> </ul>

Step #	Action	Expected Results/ Evaluation Criteria
	<p><b>2<sup>nd</sup> iteration of COB loops – True COB (Tertiary Payer)</b>            Loop 2320</p> <ul style="list-style-type: none"> <li>○ AMT01='D', AMT02=True</li> </ul> <p>COB Paid Amount</p> <ul style="list-style-type: none"> <li>○ CAS – Claim Level Amount NOT Paid by True COB</li> </ul> <p>Loop 2330B – True COB Information</p> <p><b>*NOTE – there is NO True COB Service Level Payment Amount information.</b></p>	

#### 3.5.4 Assumptions and Constraints

There are no assumptions and constraints identified at this time for coordination of benefits submissions.

### 3.6 TC06- Federally Qualified Health Center/Rural Health Clinic

#### 3.6.1 Purpose

The purpose of TC06-Federally Qualified Health Center/Rural Health Clinic is to ensure reimbursement threshold and payment edits are executed for pricing and storage in EODS.

#### 3.6.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.6.3 Test Procedure

**Table 6: Test Procedure Steps for TC06-Federally Qualified Health Center/Rural Health Clinic**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a federally qualified health center (FQHC)/Rural Health Clinic encounter with a type of bill code '77X' for FQHC or '71X' for Rural Health Clinic in CLM05-1. Populate a '1' in CLM05-3 to indicate an original encounter.	<ul style="list-style-type: none"> <li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li> <li>• Validation on the file for a unique encounter is based on the following data fields:               <ul style="list-style-type: none"> <li>○ Beneficiary HICN</li> <li>○ Beneficiary Name</li> <li>○ Date of Service</li> <li>○ Type of Bill</li> <li>○ Revenue Code/ where applicable Procedure Code</li> <li>○ Billing Provider NPI</li> <li>○ Paid Amount.</li> </ul> </li> <li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li> <li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li> </ul>

#### **3.6.4 Assumptions and Constraints**

Additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes in order to develop the FQHC PPS. The additional data will not be utilized to determine current Medicare payment to FQHCs. The Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology. There are no additional assumptions and constraints for the submission of Rural Health Clinic encounters.

### 3.7 TC07- Clinical Laboratory/End-Stage Renal Disease

#### 3.7.1 Purpose

The purpose of TC07-Clinical Laboratory/End-Stage Renal Disease is to test pricing edits.

#### 3.7.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.7.3 Test Procedure

**Table 7: Test Procedure Steps for TC07-Clinical Laboratory**

Step #	Action	Expected Results/ Evaluation Criteria
1.	<p>Submit an encounter with type of bill '14X' in CLM05-1, using the clinical laboratory fee schedule located online at <a href="http://www.cms.gov/apps/ama/license.asp?file=/ClinicalLabFeeSched/downloads/12CLAB.ZIP">http://www.cms.gov/apps/ama/license.asp?file=/ClinicalLabFeeSched/downloads/12CLAB.ZIP</a>.</p> <p>Tip: Select the CLAB2012.xlsx file.</p> <p>OR</p> <p>Submit an end-stage renal disease encounter with type of bill '72' in CLM05-1. Populate a '1' in CLM05-3 to indicate an original encounter.</p> <p>Tips: Use the 2011 PC Pricer User Guide for assistance in selecting condition or revenue codes for submission.</p> <p><a href="http://www.cms.gov/PCpricer/02e_ESRD_Pricer.asp">http://www.cms.gov/PCpricer/02e_ESRD_Pricer.asp</a></p>	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Files pass duplicate validation and continue processing.</li><li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li></ul>

#### **3.7.4 Assumptions and Constraints**

Encounters submitted with clinical laboratory tests will be priced according to the Clinical Laboratory Fee Schedule (CLFS). End-stage renal disease submissions will be priced according the ESRD Prospective Payment System (PPS). It is assumed that separately billed services such as laboratory services will be based on HCPCS on the Clinical Lab Fee Schedule (CLFS)

<http://www.cms.gov/apps/ama/license.asp?file=/ClinicalLabFeeSched/downloads/12CLAB.ZIP>.

### 3.8 TC08- Community Mental Health

#### 3.8.1 Purpose

The purpose of TC08-Community Mental Health is to test editing, processing, and appropriate pricing of submissions.

#### 3.8.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.8.3 Test Procedure

**Table 8: Test Procedure Steps for TC08-Community Mental Health**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with a Community Mental Health type of bill code '76X' in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Validation on the file for a unique encounter is based on the following data fields:<ul style="list-style-type: none"><li>○ Beneficiary HICN</li><li>○ Beneficiary Name</li><li>○ Date of Service</li><li>○ Type of Bill</li><li>○ Revenue Code/ where applicable Procedure Code</li><li>○ Billing Provider NPI</li><li>○ Paid Amount.</li></ul></li><li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li></ul>



#### **3.8.4 Assumptions and Constraints**

There are no assumptions and constraints identified at this time for Community Mental Health Centers (CMHC) submissions.

### 3.9 TC09- Critical Access Hospital

#### 3.9.1 Purpose

The purpose of TC09-Critical Access Hospital is to ensure accurate processing and pricing validations are applied to Critical Access Hospital submissions.

#### 3.9.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.9.3 Test Procedure

**Table 9: Test Procedure Steps for TC09-Critical Access Hospital**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an outpatient/inpatient critical access hospital, type of bill code '85X' for outpatient, '11X' for inpatient in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Files pass duplicate validation and continue processing.</li><li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li><li>• Pricing and diagnosis data are updated in the EODS database and stored.</li></ul>

### **3.9.4 Assumptions and Constraints**

Critical Access Hospitals outpatient or inpatient will be priced on reasonable cost, with separate pricers for providers billed separately using the Medicare Physician Fee Schedule located online using the Physician Fee Schedule search tool <http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>.

### 3.10 TC10- Hospital - Outpatient

#### 3.10.1 Purpose

The purpose of TC10-Hospital – Outpatient is to ensure this type of bill is validated for processing and pricing.

#### 3.10.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.10.3 Test Procedure

**Table 10: Test Procedure Steps for TC10-Hospital – Outpatient**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an outpatient hospital, type of bill code '13X' in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Files pass duplicate validation and continue processing.</li><li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li></ul>

#### 3.10.4 Assumptions and Constraints

Outpatient hospital encounters will be priced based on the Outpatient Prospective Payment System (OPPS), with separate pricers for providers billed separately using the Medicare Physician Fee Schedule (MPFS) located online using the Physician Fee Schedule search tool

<http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>.

### 3.11 TC11- Hospital - Inpatient

#### 3.11.1 Purpose

The purpose of TC11-Hospital – Inpatient is to ensure this type of bill is validated for processing and pricing.

#### 3.11.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.11.3 Test Procedure

**Table 11: Test Procedure Steps for TC11-Hospital – Inpatient**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an inpatient hospital, type of bill code '11X' in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	<ul style="list-style-type: none"><li>• Validation on the file for a unique encounter is based on the following data fields:<ul style="list-style-type: none"><li>○ Admit Date</li><li>○ Patient Status Code</li></ul></li><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Files pass duplicate validation and continue processing.</li><li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li></ul>

#### 3.11.4 Assumptions and Constraints

Inpatient hospital encounters will be priced based on the Inpatient Prospective Payment System (IPPS).

### 3.12 TC12- Outpatient Rehab

#### 3.12.1 Purpose

The purpose of TC12- Outpatient Rehab is to ensure this type of bill is validated for processing and pricing.

#### 3.12.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.12.3 Test Procedure

**Table 12: Test Procedure Steps for TC12- Outpatient Rehab**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an outpatient rehab, type of bill code '74X', '75X' in CLM05-1. Populate '1' in CLM05-3 to indicate an original encounter.	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• Files pass duplicate validation and continue processing.</li><li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li></ul>

#### 3.12.4 Assumptions and Constraints

Outpatient rehab encounters will be priced based on the Medicare Physician Fee Schedule (MPFS) located online using the Physician Fee Schedule search tool <http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>.

### 3.13 TC13-Skilled Nursing Facility/Home Health (future testing)

#### 3.13.1 Purpose

The purpose of TC13-Skilled Nursing Facility/Home Health submission is to test the edits for pricing and processing.

#### 3.13.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.

#### 3.13.3 Test Procedure

**Table 13: Test Procedure Steps for TC13-Skilled Nursing Facility/Home Health**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with type of bill '21' for inpatient SNF or '22', '23' for outpatient SNF in CLM05-1. Populate a '1' in CLM05-3 to indicate an original encounter.	<ul style="list-style-type: none"><li>• Validation on the file for a unique encounter is based on the following data fields:<ul style="list-style-type: none"><li>○ Admit Date</li><li>○ Patient Status Code</li></ul></li><li>• The 999A and 277CA Reports are returned within 24 hours of submission.</li><li>• Files pass duplicate validation and continue processing.</li><li>• ED Processing Status Report (MAO-002) is returned with "Accepted" status within 7 business days of submission.</li><li>• Any errors found on the file will generate the MAO-002 with a "Rejected" status within 7 business days of submission.</li></ul>

#### 3.13.4 Assumptions and Constraints

Skilled Nursing Facility encounter data submissions will be priced based on SNF Prospective Payment System (PPS). Any Home Health submissions will be priced based on the Outpatient Prospective Payment System (OPPS).

### 3.14 TC14-Duplicate

#### 3.14.1 Purpose

The purpose of TC14-Duplicate is to ensure information is not duplicated and stored for pricing and risk adjustment in EODS.

#### 3.14.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-I format.
2. Two (2) encounters are submitted for each type of test case scenario.
3. An original submission should be “Accepted” in EDPS prior to submitting a duplicate encounter submission.
4. Ensure that the interchange date and time (ISA09 and ISA10) are unique in the IDA-IEA interchange header file.

#### 3.14.3 Test Procedure

**Table 14: Test Procedure Steps for TC14-Duplicate**

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a duplicate 837I encounter, to the EDFES with duplicate data in all of the following fields: <ul style="list-style-type: none"><li>○ Beneficiary HICN</li><li>○ Beneficiary Name</li><li>○ Date of Service</li><li>○ Type of Bill</li><li>○ Revenue Code/ where applicable Procedure Code</li><li>○ Billing Provider NPI</li><li>○ Paid Amount</li></ul>	<ul style="list-style-type: none"><li>• The 999A and 277CA Reports are returned within 48 hours of submission.</li><li>• The file is rejected due to duplicate data contained in EODS.</li><li>• Any errors found on the file will generate the ED Processing Status Report (MAO-002) with a “Rejected” status within 7 business days of submission.</li></ul>



#### **3.14.4 Assumptions and Constraints**

It is assumed that the submission matches an existing encounter in the system.

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## 1. ACRONYMS

<b>CLFS</b>	Clinical Laboratory Fee Schedule
<b>CMHC</b>	Community Mental Health Centers
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>EDFEC</b>	Encounter Data Front End Contractor
<b>EDFES</b>	Encounter Data Front End System
<b>EDIPPS</b>	Encounter Data Institutional Pricing and Processing System
<b>ODS</b>	Encounter Data Operational Data Store
<b>EDIPPS</b>	Encounter Data Institutional Pricing and Processing System
<b>EDPS</b>	Encounter Data Processing System
<b>EDPSC</b>	Encounter Data Processing System Contractor
<b>EDS</b>	Encounter Data System
<b>FQHC</b>	Federally Qualified Health Center
<b>IPPS</b>	Inpatient Prospective Payment System
<b>MA</b>	Medicare Advantage
<b>MAO</b>	Medicare Advantage Organization
<b>MPFS</b>	Medicare Physician Fee Schedule
<b>OPPS</b>	Outpatient Prospective Payment System
<b>PPS</b>	Prospective Payment System
<b>SNF</b>	Skilled Nursing Facility
<b>TOB</b>	Type of Bill