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Encounter Data System

Test Case Specifications

Encounter Data Test Case Specifications related to the 837 Health Care Claim: Professional Transaction based on ASC X12 Technical Report Type 3 (TR3), Version 005010X222A1

Test Case Specifications: <u>Version 2.0</u>
Created: January 16, 2012
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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.

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REVISION HISTORY

Version	Date	Organization/Point of Contact	Description of Changes
1.0	09/30/11	ARDX / Angela Reddix	Base Document
2.0	1/12/12	ARDX / Angela Reddix	Timing for the return of the 999 and 277CA files was changed to "within 24 hours of submission".
2.0	1/12/12	ARDX / Angela Reddix	Timing for the return of the EDPS reports is "within 7 business days of submission".
2.0	1/12/12	ARDX / Angela Reddix	PWK02 = "AA" was added to specifications for the Chart Review – Linked test case.
2.0	1/12/12	ARDX / Angela Reddix	Updated enrollment eligibility date specifications for all beneficiary eligibility test cases.
2.0	1/12/12	ARDX / Angela Reddix	Updated the links for TC 23, 24, and 25 leading to Fee Schedules specific to those cases.
2.0	1/12/12	ARDX / Angela Reddix	Removed all bullets referring to Encounter Data Summary, Disposition, or Detail Reports.
2.0	1/12/12	ARDX/Angela Reddix	Added Member Eligibility Testing tips for TC-01, TC-02, TC-03, TC-04

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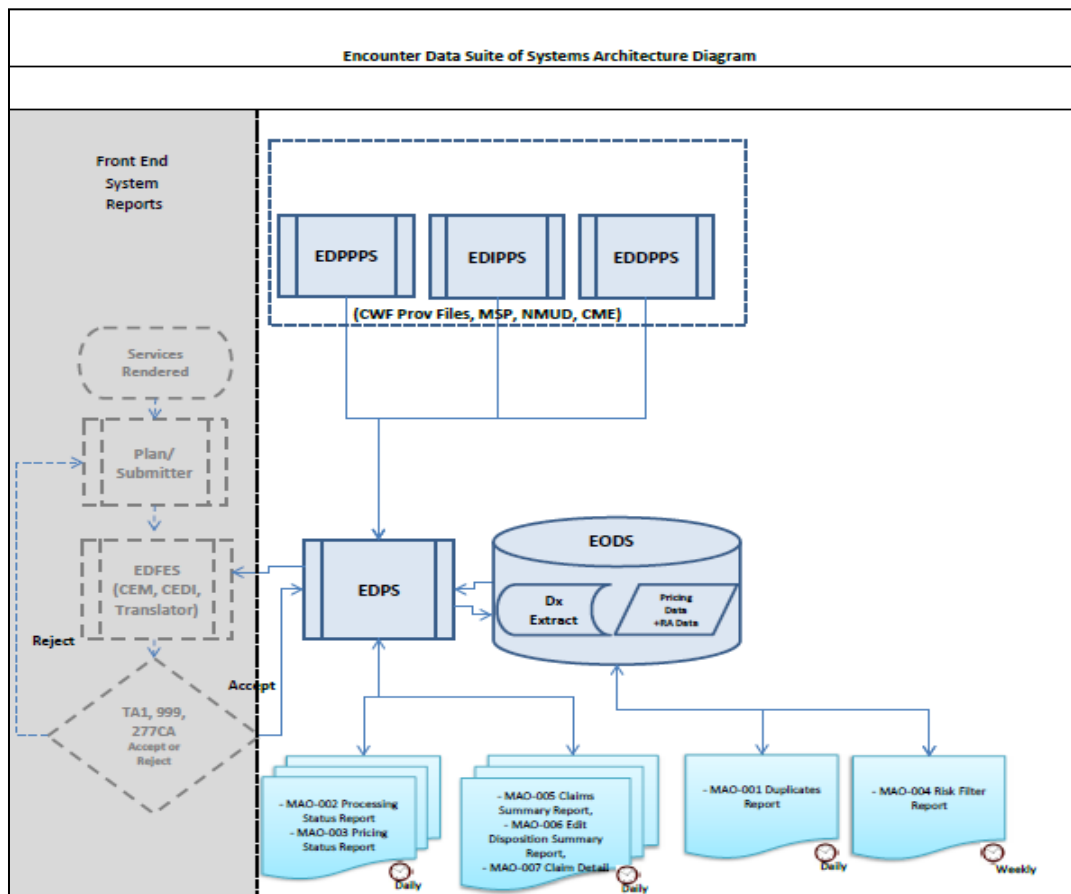## 1.0   Introduction

This document may be used in conjunction with the business case examples referenced in the EDS 837 Professional Transaction Companion Guide. Additional Test Scenario Specification documents may be incorporated and referenced at a later date.

The purpose of EDS end-to-end testing is to validate the following:
- Files are received by the EDFES
- Files are processed through the translator
- Files are processed through CEM
- Submitter receives front-end reports from EDFES
- Data are received by EDPS
- Data are processed and priced in EDPS
- Submitter receives processing and pricing reports from EDPS

Encounter Data Suite of Systems Architecture Diagram

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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 Member Submission
          i. Original MA (New Enrollee)
          ii. Traditional FFS Medicare to MA
          iii. Changing MAs (MA to MA)
          iv. Special Enrollment to MA
   b. Standard MA Member Submission

II.   Provider Data Validation Submissions
   a. Non-contracted Providers
   b. Atypical Providers
   c. Foreign Providers
   d. Capitated Provider
   e. Ambulance TOS
   f. Coordination of Benefits (COB)

III.   Processing
   a. Correct/Replace
   b. Void/Delete
   c. Chart Review – Linked
   d. Chart Review – Unlinked
   e. Duplicate
   f. Bundled Payment
   g. Paper Generated
   h. Zip Code + 4
   i. Medically unlikely edit

IV.   Risk Adjustments
   a. Diagnoses not included in the model diagnoses
   b. Diagnoses included in the model diagnoses

V.   Pricers (Ambulance Fee Schedules are tested under the Provider Data Validation module and the Durable Medical Equipment Fee Schedule will not be tested at this time.)
   a. MPFS
   b. ASC
   c. Clinical Labs

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Test Case Summary Table

Test Case/Script Identifier	Test Case/Script Title
Beneficiary Eligibility-New Member Submission	TC01-Original MA
Beneficiary Eligibility-New Member Submission	TC02-Traditional to MA Member
Beneficiary Eligibility-New Member Submission	TC03-MA to MA Member
Beneficiary Eligibility-New Member Submission	TC04-Special Enrollment to MA Member
Beneficiary Eligibility-Current MA Member	TC05-Standard MA Member Submission
Provider Data Validation	TC06=Non-Contracted Provider Submission
Provider Data Validation	TC07-Atypical Provider Submission
Provider Data Validation	TC08-Foreign Provider Submission
Provider Data Validation	TC09-Capitated Provider Submission
Provider Data Validation	TC10-Ambulance TOS Submission
Provider Data Validation	TC11-Coordination of Benefits Submission
Encounter File	TC12-Correct/Replace
Encounter File	TC13-Void/Deleted
Encounter File	TC14-Chart Review – Linked
Encounter File	TC15-Chart Review – Unlinked
Encounter File	TC16-Duplicate
Encounter File	TC17-Bundled Payment
Encounter File	TC18-Paper Generated
Encounter File	TC19-Zip Code +4
Encounter File	TC20-Medically Unlikely Edit
Risk Adjustment	TC21-Diagnoses Included in Model Diagnosis Codes
Risk Adjustment	TC22-Diagnoses Not Included in Model Diagnosis Codes
Pricing Data Validation	TC23-Medicare Physician MPFS Submission
Pricing Data Validation	TC24-Ambulatory Surgical Center (ASC) Submission
Pricing Data Validation	TC25-Clinical Laboratory Submission

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

Type of test encounter requested for testing.

5.19 TC24-Medicare Physicians (MPFS) Submission

5.24.1 The purpose of TC24-Medicare Physicians (MPFS) Submission is to test Medicare Physicians pricing edits.

This line defines the purpose for testing this type of encounter.

5.24.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

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

5.24.3 Test Procedure

Table 26: Test Procedure Steps for TC24-Medicare Physicians (MPFS) Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a Medicare participating provider using the Medicare Physicians fee schedule for rendering provider paid amounts.	• Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 24 hours of submission. • 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. • Pricing errors found will return the ED Pricing Status Report, identifying the pricers and errors identified for the encounter. • Encounters Summary, and Encounters Detail Reports are also returned within 24 hours of submission.

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

5.24.4 Assumptions and Constraints

There are no assumptions or constraints currently identified.

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

3.0   Test Case Details

5.1   TC01-Original MA Submission

5.1.1   Purpose

The purpose of TC01-Original MA Submission is to test a newly enrolled MA member encounter.

5.1.2   Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

5.1.3   Test Procedure

Table 1: Test Procedure Steps for TC01-Original MA Submission

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit a newly enrolled MA member encounter on the standard 837P.
	
	Tip: Identify a member that is enrolled with an Election Type of 'E' for IEP and an enrollment effective date in 2011.
		• The 999A and 277CA Reports are returned within 24 hours of submission. If the new beneficiary HICN is not found, the encounter submission will not be assigned an ICN and will not continue through the EDPS.
		• Validation on the file for a unique encounter is based on the following data fields:
		  o Beneficiary HICN
		  o Beneficiary Name
		  o Date of Service
		  o Place of Service
		  o Type of Service
		  o Procedure Code (and 4 modifiers)
		  o Rendering Provider NPI
		  o Paid Amount.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.1.4 Assumptions and Constraints

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

5.2 TC02-Traditional to MA Member Submission

5.2.1 Purpose

The purpose of TC02-Traditional to MA Member Submission is to test eligibility for a beneficiary previously enrolled in Medicare Part A and/or B and is then changing to a Medicare Advantage Plan.

5.2.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

5.2.3 Test Procedure

Table 2: Test Procedure Steps for TC02-Traditional to MA Member Submission

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit an encounter for a Medicare Part A and/or B member that changed to a MA plan.
	
	Tips: Select a beneficiary entitled to Medicare Part A prior to 1998.
		• The 999A and 277CA Reports are returned within 24 hours of submission.
		• Validation on the file for a unique encounter is based on the following data fields:
		  ○ Beneficiary HICN
		  ○ Beneficiary Name
		  ○ Date of Service
		  ○ Place of Service
		  ○ Type of Service
		  ○ Procedure Code (and 4 modifiers)
		  ○ Rendering Provider NPI
		  ○ Paid Amount.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.2.4 Assumptions and Constraints

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

5.3 TC03-MA to MA Member Submission

5.3.1 Purpose

The purpose of TC03-MA to MA Member Submission is to test eligibility rules for a beneficiary changing from one MA plan to another MA plan.

5.3.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

5.3.3 Test Procedure

Table 3: Test Procedure Steps for TC03-MA to MA Member Submission

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit an encounter for a beneficiary that changed from one MA plan to another MA plan during October 15 – December 7, 2011.
	
	Tip: Identify a member that is enrolled with an Election Type of 'A' for AEP and an enrollment effective date January 1, 2012.
		• The 999A and 277CA Reports are returned within 24 hours of submission.
		• Validation on the file for a unique encounter is based on the following data fields:
		  ○ Beneficiary HICN
		  ○ Beneficiary Name
		  ○ Date of Service
		  ○ Place of Service
		  ○ Type of Service
		  ○ Procedure Code (and 4 modifiers)
		  ○ Rendering Provider NPI
		  ○ Paid Amount.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.3.4 Assumptions and Constraints

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

5.4 TC04-Special Enrollment to MA Submission

5.4.1   Purpose

The purpose of TC04-Special Enrollment to MA Submission is to test eligibility rules on an encounter for new Medicare Advantage members under the Special Enrollment Period.

5.4.2   Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

5.4.3   Test Procedure

Table 4: Test Procedure Steps for TC04-Special Enrollment to MA Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a Medicare Advantage member that is eligible during the special enrollment period. Tip: Identify a member that is enrolled with an Election Type for one of the SEP options and an enrollment effective date during 2011.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Validation on the file for a unique encounter is based on the following data fields: o Beneficiary HICN o Beneficiary Name o Date of Service o Place of Service o Type of Service o Procedure Code (and 4 modifiers) o Rendering Provider NPI o Paid Amount. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.4.4 Assumptions and Constraints

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

5.5   TC05-Standard MA Member Submission

5.5.1   Purpose

The purpose of TC05-Standard MA Member Submission is to test eligibility rules for a standard Medicare Advantage encounter submission.

5.5.2   Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

5.5.3   Test Procedure

Table 5: Test Procedure Steps for TC05-Standard MA Member Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a standard Medicare Advantage member.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Validation on the file for a unique encounter is based on the following data fields: ○ Beneficiary HICN ○ Beneficiary Name ○ Date of Service ○ Place of Service ○ Type of Service ○ Procedure Code (and 4 modifiers) ○ Rendering Provider NPI ○ Paid Amount. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.5.4   Assumptions and Constraints

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

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5.6 TC06-Non-contracted Provider Submission

5.6.1 Purpose

The purpose of TC06-Non-contracted Provider Submission is to test encounters submitted by non-Medicare providers.

5.6.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

3. Include the billing provider employee tax identification number or social security number.

5.6.3 Test Procedure

Table 6: Test Procedure Steps for TC06-Non-contracted Provider Submission

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit an encounter with a non-Medicare provider NPI.
	
	Tip: Use the following link to identify a non-contracted provider:
	https://spreadsheets.google.com/spreadsheet/pub?key=0Aqnmn7qC9bcHdHpLZlR0dTczNm82dkRfZFd3MjI5dWc&gid=0
		• The 999A and 277CA Reports are returned within 24 hours of submission.
		• Validation on the file for a unique encounter is based on the following data fields:
		  ○ Beneficiary HICN
		  ○ Beneficiary Name
		  ○ Date of Service
		  ○ Place of Service
		  ○ Type of Service
		  ○ Procedure Code (and 4 modifiers)
		  ○ Rendering Provider NPI
		  ○ Paid Amount.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.6.4 Assumptions and Constraints

It is assumed that non-contracted providers will still submit appropriate Medicare required information to process the encounter.

5.7 TC07-Atypical Provider Submission

5.7.1 Purpose

The purpose of TC07-Atypical Provider Submission is to test encounters submitted by atypical providers with the designated default NPI and tax ID number.

5.7.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

5.7.3 Test Procedure

Table 7: Test Procedure Steps for TC07-Atypical Provider Submission

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit an atypical provider 837P file using the following default codes:
	Payer ID-80882
	NPI-1999999984
	EIN – 199999998
	ICD-9 diagnosis code:
	 '78099' – Other General Symptoms
		• The 999A and 277CA Reports are returned within 24 hours of submission.
		• Validation on the file for a unique encounter is based on the following data fields:
		  ○ Beneficiary HICN
		  ○ Beneficiary Name
		  ○ Date of Service
		  ○ Place of Service
		  ○ Type of Service
		  ○ Procedure Code (and 4 modifiers)
		  ○ Rendering Provider NPI
		  ○ Paid Amount.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.7.4 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

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captured from atypical provider types (as notated by the default atypical provider NPI) will not be priced or used for risk adjustment calculation; however, it will be stored for beneficiary utilization data and analysis.

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5.8 TC08-Foreign Provider Submission

Foreign Provider submission specifications are still in development and will be released at a later date.

5.9 TC09-Capitated Provider Submission

5.9.1 Purpose

The purpose of TC09-Capitated Provider Submission is to ensure capitated encounters are edited, processed, priced, and stored accordingly in EDS.

5.9.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

3. Remember to populate loop 2400, CN101 data element with "5" for capitated submissions on the line level and claim level.

5.9.3 Test Procedure

Table 9: Test Procedure Steps for TC09-Capitated Provider Submission

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit a capitated encounter on an 837P file, to the EDFEC. Submit 0.00 in the amount field otherwise submit the amount as is for the capitated encounter.	• The 999A and 277CA Reports are returned within 24 hours of submission.
		• Validation on the file for a unique encounter is based on the following data fields:
		   ○ Beneficiary HICN
		   ○ Beneficiary Name
		   ○ Date of Service
		   ○ Place of Service
		   ○ Type of Service
		   ○ Procedure Code (and 4 modifiers)
		   ○ Rendering Provider NPI
		   ○ Paid Amount.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.9.4 Assumptions and Constraints

If pricing information is available on the encounter collected, then it should be submitted as is; however, the sum of the SV1 (Professional) and 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.

5.10   TC10-Ambulance TOS Submission

5.10.1 Purpose

The purpose of TC10-Ambulance TOS Submission is to test editing, processing, and appropriate pricing of ambulatory services.

5.10.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least 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.

4. Ensure a valid zip code is included in the submission file.

5.10.3 Test Procedure

Table 10: Test Procedure Steps for TC10-Ambulance TOS Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with a valid pick-up service address in Loop 2310E.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Validation on the file for a unique encounter is based on the following data fields: ○ Beneficiary HICN ○ Beneficiary Name ○ Date of Service ○ Place of Service ○ Type of Service ○ Procedure Code (and 4 modifiers) ○ Rendering Provider NPI ○ Paid Amount. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

Step #	Action	Expected Results/ Evaluation Criteria
		• Pricing data and diagnosis data are updated and stored in the EODS database.

5.10.4 Assumptions and Constraints

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

5.11 TC11-Coordination of Benefits Submission

5.11.1 Purpose

The purpose of TC11-Coordination of Benefits Submission is to test editing, processing, and appropriate pricing of multi-payer or Medicare secondary payer submissions.

5.11.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions in the 837-P format.

2. At least two (2) encounters are submitted for each type of test case scenario.

3. Submit an original transaction to a primary payer.

5.11.3 Test Procedure

Table 11: Test Procedure Steps for TC11-Coordination of Benefits Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a true coordination of benefits submission from a secondary payer using the 2nd iteration of loops 2320, 2330, and 2430.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Validation on the file for a unique encounter is based on the following data fields: 　○ Beneficiary HICN 　○ Beneficiary Name 　○ Date of Service 　○ Place of Service 　○ Type of Service 　○ Procedure Code (and 4 modifiers) 　○ Rendering Provider NPI 　○ Paid Amount. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.11.4 Assumptions and Constraints

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

5.12 TC12-Correct/Replace

5.12.1 Purpose

The purpose of TC12-Correct/Replace is to ensure accurate processing and pricing validations are applied to replacement submissions.

5.12.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. The original submission must be identified as "Accepted" status on the ED Processing Status Report. This submission must be sent with the ICN associated with the "Accepted" encounter.

3. At least two (2) encounters are submitted for each type of test case scenario.

5.12.3 Test Procedure

Table 12: Test Procedure Steps for TC12-Correct/Replace

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit an encounter with a correction/replacement code '7' in Loop 2300, CLM05-3 on the 837 P.
	• Populate Loop 2300, REF01='F8' and REF02 = ICN of the prior encounter.
		• The 999A and 277CA Reports are returned within 24 hours of submission.
		• Validation is performed against the original encounter stored in the EODS:
		  o Loop 2300
		  o REF01=F8
		  o REF02=ICN
		• Files pass duplicate validation, paid amount balancing and continue processing.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.
		• Pricing and diagnosis data are updated in the EODS database and stored.

5.12.4 Assumptions and Constraints

It is assumed that MAOs have access to the CMS website where diagnosis models for risk adjustments are available as a reference. There are no constraints identified for the submission of a replacement encounter.

5.13 TC13-Void/Deleted

5.13.1 Purpose

The purpose of TC13-Void/Deleted submission is to ensure an original encounter is deleted from the system.

5.13.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. The original submission must be identified as "Accepted" status on the ED Processing Status Report. This submission must be sent with the ICN associated with the "Accepted" encounter.

3. At least two (2) encounters are submitted for each type of test case scenario.

5.13.3 Test Procedure

Table 13: Test Procedure Steps for TC13-Void/Deleted

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with a void/deleted code '8' in Loop 2300, CLM05-3 on the 837 P. • Populate Loop 2300, REF01='F8' and REF02 = ICN of the prior encounter.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.13.4 Assumptions and Constraints

It is assumed that any information that is incorrect for a void/deleted submission is captured and rejected at the CEM/CEDI edit level therefore would reach the processing level. There are no constraints identified for the submission of a deletion file.

5.14   TC14-Chart Review – Linked

5.14.1 Purpose

The purpose of TC14-Chart Review – Linked submission is to ensure supplemental chart review information associated with an encounter is captured in EODS.

5.14.2 Prerequisite Conditions

1. System will accept 5010 version X12 standards for HIPAA transactions.

2. The original submission must be identified as "Accepted" status on the ED Processing Status Report. This submission must be sent with the ICN associated with the "Accepted" encounter.

3. At least two (2) encounters are submitted for each type of test case scenario.

4. Remember to include a valid Provider Tax ID and the Rendering Provider NPI number.

5.14.3 Test Procedure

Table 14: Test Procedure Steps for TC14-Chart Review Linked Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a chart review linked to an existing ICN with a PWK01 = "09" and PWK02 = "AA". • Submit the chart review with a minimum of four (4) diagnosis codes for testing.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission. • Diagnoses data are updated and stored in the EODS database.

5.14.4 Assumptions and Constraints

An existing ICN must be linked to the chart review submission.

5.15   TC15-Chart Review – Unlinked

5.15.1 Purpose

The purpose of TC15-Chart Review-Unlinked Submission is to ensure supplemental chart review information without an associated encounter is captured in EODS.

5.15.2 Prerequisite Conditions

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. Remember to include a valid Provider Tax ID and the Rendering Provider NPI number.

5.15.3 Test Procedure

Table 15: Test Procedure Steps for TC15-Chart Review – Unlinked Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a chart review with no link to an ICN with a PWK01 = "09" and PWK02 = "AA".	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission. • The chart review with no linked ICN is processed through the EDPS. Encounter data is checked against processing edits. • Diagnoses data are updated and stored in the EODS database.

5.15.4 Assumptions and Constraints

There can be no existing ICN linked to the submission of a chart review – unlinked, and the data will not be priced in EDPS.

5.16   TC16-Duplicate

5.16.1 Purpose

The purpose of TC16-Duplicate Submission is to ensure information is not duplicated and stored for pricing and risk adjustment in EODS.

5.16.2 Prerequisite Conditions

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. 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 ISA-IEA interchange header file.

5.16.3 Test Procedure

Table 16: Test Procedure Steps for TC16-Duplicate Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a duplicate 837P encounter, to the EDFES with duplicate data in all of the following fields: • Beneficiary HICN • Beneficiary Name • Date of Service • Place of Service • Type of Service • Procedure Code (and 4 modifiers) • Rendering Provider NPI • Paid Amount	• The 999A and 277CA Reports are returned within 24 hours of submission. • The file is rejected due to duplicate data contained in EODS. • ED Duplicates Report is generated and returned within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.16.4 Assumptions and Constraints

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

5.17 TC17-Bundled Payment

5.17.1 Purpose

The purpose of TC17-Bundled Payment Submission is to ensure bundled payment submissions outside of the NCCI requirements are not accepted for pricing and data analysis.

5.17.2 Prerequisite Conditions

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. An original submission can be submitted prior to the submission of a bundled payment line.

5.17.3 Test Procedure

Table 17: Test Procedure Steps for TC17-Bundled Payment Submission

Step #	Action	Expected Results/ Evaluation Criteria

1.	Submit an encounter with bundled codes and use SVD06 in Loop 2430 to identify a bundled payment submission.	• The 999A and 277CA Reports are returned within 24 hours of submission.
		• Validation on the file for a unique encounter is based on the following data fields:
		  o Beneficiary HICN
		  o Beneficiary Name
		  o Date of Service
		  o Place of Service
		  o Type of Service
		  o Procedure Code (and 4 modifiers)
		  o Rendering Provider NPI
		  o Paid Amount.
		• Files pass duplicate validation and continue processing.
		• ED Processing Status Report is returned with "Accepted" status within 7 business days of submission.
		• Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.17.4 Assumptions and Constraints

Submit bundled payments as they were adjudicated in your internal system. EDPS will edit, process, price, and store the bundled payments as submitted.

5.18   TC18-Paper Generated

Paper generated submission specifications are still in development and will be released at a later date.

5.19 TC19-Zip Code + 4

5.19.1 Purpose

The purpose of TC19-Zip Code + 4 Submission is to test and collect data for accurate pricing.

5.19.2 Prerequisite Conditions

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.

5.19.3 Test Procedure

Table 19: Test Procedure Steps for TC19- Zip Code + 4 Submissions

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter with the zip code + 4 postal box identifier. • 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.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.19.4 Assumptions and Constraints

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

5.20 TC20-Medically Unlikely Edit

5.20.1 Purpose

The purpose of TC20-Medically Unlikely Edit Submission is to test for medically unlikely edits.

5.20.2 Prerequisite Conditions

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.

5.20.3 Test Procedure

Table 20: Test Procedure Steps for TC20-Medically Unlikely Edit

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a medically unlikely procedure code; where the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service is determined unlikely as defined by the CMS MUE (Medically Unlikely Edit) file.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Rejected" status within 7 business days of submission.

5.20.4 Assumptions and Constraints

Assumptions are that the medical procedure codes are not applicable for selected genders.

5.21 TC21-Diagnoses Included in Model Diagnosis Codes

5.21.1 Purpose

The purpose of TC21-Diagnoses Included in Model Diagnosis Codes Submission is to test the risk filter edits.

5.21.2 Prerequisite Conditions

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.

5. 21.3 Test Procedure

Table 21: Test Procedure Steps for TC21-Diagnoses Included in Model Diagnosis Codes Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a standard encounter with four (4) diagnoses from the model diagnoses spreadsheet.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.21.4 Assumptions and Constraints

It is assumed that MAOs have access to the CMS website where diagnoses models for risk adjustment are available for reference. There are no constraints identified for the submission of original encounter data.

5.22 TC22-Diagnoses Not Included in the Model Diagnosis Codes

5.22.1 Purpose

The purpose of TC22-Diagnoses Not Included in Model Diagnosis Codes Submission is to test the risk filter edits.

5.22.2 Prerequisite Conditions

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. Remember that ICD-9 codes are to be submitted until October 1, 2013 therefore any ICD-10 codes submitted will return with errors.

5.22.3 Test Procedure

Table 22: Test Procedure Steps for TC22-Diagnoses Not Included in Model Diagnosis Codes Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit a standard encounter with four (4) diagnoses not listed in the model diagnoses spreadsheet.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.22.4 Assumptions and Constraints

It is assumed that MAOs have access to the CMS website where diagnoses models for risk adjustment are available for reference. There are no constraints identified for the submission of original encounter data.

5.23 TC23-Medicare Physicians (MPFS) Submission

5.23.1 Purpose

The purpose of TC23-Medicare Physicians (MPFS) Submission is to test Medicare Physicians pricing edits.

5.23.2 Prerequisite Conditions

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.

5.23.3 Test Procedure

Table 23: Test Procedure Steps for TC23-Medicare Physicians (MPFS) Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter for a Medicare participating provider using HCPCS from the 2012 Fee Schedule. Tip: Provided is the Physician Fee Schedule search tool: https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx. Use the 2011 fee schedule just to select a HCPCS code.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.23.4 Assumptions and Constraints

There are no assumptions or constraints currently identified.

5.24 TC24-Ambulatory Surgical Center (ASC) Submission

5.24.1 Purpose

The purpose of TC24-Ambulatory Surgical Center (ASC) Submission is to test pricing edits.

5.24.2 Prerequisite Conditions

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.

5.24.3 Test Procedure

Table 24: Test Procedure Steps for TC24-Ambulatory Surgical Center (ASC) Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter using the ambulatory surgical center fee schedule for an outpatient procedure code. For further assistance with Test Case 24 – TC24 – Ambulatory Surgical Center Submissions, MAOs should use the fee schedule located online at http://www.cms.gov/apps/ama/license.asp?file=/ascpayment/downloads/Jan_2012_ASC_addenda_extenders.zip. Tip: Select the Jan_2012_ASC_addenda_extenders.xlsx file.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.24.4 Assumptions and Constraints

ASC submissions will be priced using the Ambulatory Surgical Center Fee Schedule.

5.25 TC25-Clinical Laboratory Submission

5.25.1 Purpose

The purpose of TC25-Clinical Laboratory Submission is to test pricing edits.

5.25.2 Prerequisite Conditions

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.

5.25.3 Test Procedure

Table 25: Test Procedure Steps for TC25-Clinical Laboratory Submission

Step #	Action	Expected Results/ Evaluation Criteria
1.	Submit an encounter using the clinical laboratory fee schedule for rendering provider paid amounts located online at http://www.cms.gov/apps/ama/license.asp?file=/ClinicalLabFeeSched/downloads/12CLAB.ZIP. Tip: Select the CLAB2012.xlsx file.	• The 999A and 277CA Reports are returned within 24 hours of submission. • Files pass duplicate validation, paid amount balancing and continue processing. • ED Processing Status Report is returned with "Accepted" status within 7 business days of submission. • Any errors found on the file will generate the ED Processing Status Report with a "Rejected" status within 7 business days of submission.

5.25.4 Assumptions and Constraints

Encounters submitted with clinical laboratory tests will be priced according to the clinical laboratory fee schedule.

ACRONYMS

ASC	Ambulatory Surgical Center
CMS	Centers for Medicare & Medicaid Services
EDFESC	Encounter Data Front End System Contractor
EDFES	Encounter Data Front End System
EDIPPS	Encounter Data Institutional Pricing and Processing System
EODS	Encounter Data Operational Data Store
EDPPPS	Encounter Data Professional Pricing and Processing System
EDDPPS	Encounter Data DME Pricing and Processing System
EDPS	Encounter Data Processing System
EDPSC	Encounter Data Processing System Contractor
EDS	Encounter Data System
MA	Medicare Advantage
MAO	Medicare Advantage Organization

ENCOUNTER DATA SYSTEM PROFESSIONAL SYSTEM MEMBER ELIGIBILITY TEST CASE TIPS

TC01-Original MA Submission

The purpose of TC01-Original MA Submission is to test a newly enrolled MA member encounter.

1. Review a 2011 Daily Transaction Reply Report (DTRR).
2. Identify a member that is enrolled with an Election Type of 'E' for IEP and an enrollment effective date in 2011.
   (Note: IEP is for Initial Enrollment Period – 7-month timeframe, 3 months before month of date of birth, the month of the date of birth, and the 3 months following the date of birth.)
3. Review the Monthly Membership Report (MMR) for January 2012 (released in December 2011). If the member is enrolled in the plan for January 2012, they will appear on the MMR and a claim can be submitted.

TC02-Member Previously Enrolled in Traditional Medicare Prior to Enrolling in an MA Plan Submission

The purpose of TC02-Traditional to MA Member Submission is to test eligibility for a beneficiary previously enrolled in Medicare Part A and/or B prior and is then changing to a Medicare Advantage Plan.

1. Review 2011 Daily Transaction Reply Report (DTRR).
2. Identify a member that is enrolled with an Election Type of 'O' for OEP and an enrollment effective date in 2011.
   (Note: OEP is for Open Enrollment Period)
3. Determine if beneficiary was enrolled in Traditional/Original Medicare prior to 1997 by checking the entitlement start (effective) dates through the BEQ or in the MARx UI (see below for additional tips).
4. Review the Monthly Membership Report (MMR) for January 2012 (released in December 2011). If the member is enrolled in the plan for January 2012, they will appear on the MMR and a claim can be submitted.

Steps for verifying beneficiary eligibility for test case using the Batch Eligibility Request (BEQ):
1. Submit the BEQ Request file with the beneficiary HIC number.
2. Receive a BEQ Response file that provides the entitlement/enrollment start (effective) dates for Part A and Part B.
3. If dates are prior to 1997, the beneficiary was enrolled in Traditional Medicare.

Steps for viewing beneficiary eligibility for test case using the MARx UI:
1. Beneficiary eligibility provides information regarding a beneficiary's entitlement start date for Part A and Part B

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2. Plans can view the Beneficiary: Eligibility (M232) screen from the main menu – go to Beneficiaries, and then click on Eligibility from the submenu. Then enter the HIC number to pull up the eligibility information.
3. Under Eligibility Information are the start dates for Part A and Part B.
4. If dates are prior to 1997, the beneficiary was enrolled in Traditional Medicare.

TC03-MA to MA Member Submission

The purpose of TC03-MA to MA Member Submission is to test eligibility rules for a beneficiary changing from one MA plan to another MA plan.

Steps for identifying beneficiary for test case using reports:
1. Review Daily Transaction Reply Report (DTRR) from the period between October and December 2011.
2. Identify a member that is enrolled with an Election Type of 'A' for AEP and an enrollment effective date January 1, 2012.
   (Note: AEP is for the Annual Enrollment Period)
3. Review the Monthly Membership Report (MMR) for January 2012 (released in December 2011). If the member is enrolled in the plan for January 2012, they will appear on the MMR and a claim can be submitted.

TC04-Special Enrollment to MA Submission

The purpose of TC04-Special Enrollment to MA Submission is to test eligibility rules on an encounter for new Medicare Advantage members changing from another Medicare Plan.

Steps for identifying beneficiary for test case using reports:
1. Review a 2011 Daily Transaction Reply Report (DTRR).
2. 2. Identify a member that is enrolled with an Election Type for one of the SEP options and an enrollment effective date during 2011.
4. (Note: SEP is for Special Enrollment Period and the SEP codes include 'R' for 5 Star SEP, 'S' for Other SEP, 'U' for Dual/LIS SEP, 'V' for permanent change of residence SEP, 'W' for EGHP SEP, 'X' for Administrative Action SEP, or 'Y' for CMS/Case Work SEP)
5. Review the Monthly Membership Report (MMR) for January 2012 (released in December 2011). If the member is enrolled in the plan for January 2012, they will appear on the MMR and a claim can be submitted.