NATIONAL MEETING

Questions & Answers

October 29, 2010

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1.0 Approach to the collection of encounter data.

Q1: Currently, third party submitters are not authorized to participate in webinars and other CMS events unless they have an H, R, or S contract number. Will this policy be changed?
A1: The MA Organizations (MAOs) are ultimately responsible for all data that are submitted. Third party submitters will need to currently have a contract with an MAO and submit on behalf of the plan (H, R, or S contract numbers), who will provide feedback in the webinars and industry events. Third party submitters may use the contract ID for an MA plan they are already working with to participate in the webinars and other CMS events.

Q2: Where does CMS expect the industry to be as of January 1, 2012 in regards to the 5010?
A2: By January 2012, CMS expects that the 5010 encounters will process through the Encounter Data Front End System (EDFES) and the Encounter Data Processing System (EDPS). Processing reports will be sent back to the MA plan.

Q3: Once Encounter Data is collected, will the Risk Adjustment model include both encounter data and Fee-for-Service data or is it based solely on the plan's encounter data?
A3: The goal is to ultimately calibrate the RA model against encounter data. Once high quality encounter data is collected, the model can be recalibrated using the encounter data to reflect costs of the specific program (Managed Care or Prescription Drug). For a period, it may be necessary to simultaneously calibrate models as we currently do, in order to identify these differences and analyze the implications for payment.

Q4: Will the new encounter data process continue to use the CMS-HCC model for risk adjustment payment calculation?
A4: Yes, there is no change planned currently for risk adjustment payment calculations.

Q5: Since only a portion of the encounter data will be used for risk adjustment payment calculation, will there be an indication on the return files as to which of the submissions will be considered for payment?
A5: The scope and function of the Encounter Data Processing Reports are still being determined at this time. However, CMS intends to provide Encounter Data Transaction Reports, Management Reports, and possibly the Remittance Advice to show pricing to MA Organizations. CMS seeks industry input on the development of the reports for Encounter Data processing. MAOs can register to participate in the Editing and Reporting Work Groups to be held between December 2010 and May 2011 at www.tarsc.info.

Q6: For the Encounter Data Processing System (EDPS), will CMS accept both paid and denied claims?
A6: For the Encounter Data Processing System (EDPS), CMS will accept adjudicated insurer paid and denied claims.

Q7: What are the reasons for processing data through a new model versus the Fee-for-Service (FFS) model?

A7: Developing a new Encounter Data System (EDS) model versus using the FFS model, allows CMS to create a system that is tailored to the claims processing rules applicable for MAO encounter data processing. The EDS maintainers will have the ability to turn FFS like edits off if they are identified as un-necessary.

Q8: In the files returned to health plans following claims data submission to CMS, will feedback be provided regarding what was acceptable for risk adjustment payment calculation or reasons for edits not passed?

A8: CMS plans to develop reports that reflect what data was processed and stored for risk adjustment payment calculation.

Q9: Will all data elements on the 5010 version be collected? How will those elements that are received but not used for risk adjustment payment calculation be accounted for?

A9: Yes, all required 5010 segments and elements and those situational segments and elements identified as required will be collected as per the WPC Implementation Guides/ TR3. Those elements used and not used for Risk Adjustment calculation will be stored for later analysis and utilization reporting.

Q10: Is there a supplemental tool for submitting chart review data?

A10: Research is being conducted on the viability of using one of the 5010 837X segments in the 2300 Loop called Paperwork, data element: PWK01, value "09" as the identifier for Chart Reviews. More information will be communicated in the coming months during the "Chart Review" Work Group.

Q11: How will chart review data be incorporated into the new encounter data process?

A11: Research is being conducted on the viability of using one of the 5010 837X segments in the 2300 Loop called Paperwork, data element: PWK01, value "09" as the identifier for Chart Reviews. More information will be communicated in the coming months during the "Chart Review" Work Group.

Q12: In previous encounter data efforts, there was an incapacity for CMS to handle the volume of encounter data processing, has this issue been addressed?

A12: System capacity has been addressed. The EDS will be able to process the volume anticipated from MAO claim submissions. Previously when encounter data was collected, the concerns were centered around how MAO claims where being processed not volume.

Q13: Is there a limit on the number of diagnoses that can be submitted on the 5010 version?

A13: As per the June 30, 2010, HIPAA Version 5010: Seventh National Provider Call –837 Institutional meeting, adjudication capability of 'other' diagnosis codes increased from 8 to 24,

Q14: Will payment methodology be impacted by the Encounter Data System or will CMS continue to make payments based on RAPS data?

A14: The Risk Adjustment methodology is not changing. Payments will still be derived based on Beneficiary demographic/health status and diagnostic information. Eventually, the model will be calibrated based on encounter data.

Q15: What is the basis for risk adjustment payment calculation if the RAPS and EDPS will be running simultaneously for a period of time?
A15: The risk adjustment payment will be based on data submitted to RAPS until CMS validates the integrity of the data submitted to the EDS.

Q16: How should health plans submit data from retrospective reviews?
A16: CMS is currently investigating the viability of using one of the 5010 837X segments in the 2300 Loop called Paperwork, data element: PWK01, value "09" as the identifier for Chart Reviews. More information regarding chart reviews will be provided based on Workgroup discussions.

Q17: Will CMS use encounter data collected to update/change the HCC risk adjustment model? What model will risk adjustment payment calculation be based upon?
A17: The risk adjustment calculation is not changing at this time. The risk scores will continue to be calculated using the current CMS-HCC, CMS-HCC ESRD, and CMS-RxHCC. To mitigate any risks to MA Organization payment, CMS will process both the RAPS and Encounter Data System parallel until all testing is 100% complete. CMS will use the collected encounter data to recalibrate the model in the future using a Medicare Advantage population, instead of the currently used Fee-for-Service population. The ability to measure MA utilization and recalibrate the models used for MA payment may decrease the need for larger coding intensity factors.

Q18: Since only a portion of the encounter data will be used for risk adjustment payment calculation, will there be an indication on the return files as to which of the submissions will be considered for payment?
A18: The scope and function of the Encounter Data Processing Reports are still being determined at this time. However, CMS intends to provide Encounter Data Transaction Reports, Management Reports, and possibly the Remittance Advice to show pricing to MA Organizations. CMS seeks industry input on the development of the reports for Encounter Data processing. MAOs can register to participate in the Editing and Reporting Work Groups to be held between December 2010 and May 2011 at www.tarsc.info.

Q19: What accommodations will be made for those health plans that are having difficulties implementing their 5010 data file?
A19: HIPAA mandated that the industry use standard formats for claims transaction. The use of the 5010 format is required and the Encounter Data System will utilize this format to maintain compliance with industry standards. Implementation begins in 2011 and must be completed by January 3, 2012. To assist plans with the transition, CMS will provide technical assistance and support through the Encounter Data Work Groups, Industry Updates, quarterly newsletters and Training Sessions.

Q20: Will required fields for data submission on the 837 5010 be specified by CMS?
A20: All required 5010 segments and elements and those situational segments and elements identified as required will be collected as per the WPC Implementation Guides/ TR3.

Q21: Will CMS provide logic for the edits that are used to filter claims for risk adjustment payment calculation?

A21: CMS is currently evaluating the filtering logic that will be used in editing encounter data. At a minimum, plans can expect that CMS will filter based on Type of Bill to establish if the facility or service is acceptable for Risk Adjustment. CMS will provide further guidance on the filtering edits in the Operational Guidance manual.

Q22: What data will be used to update the risk adjustment payment models?

A22: The goal is to ultimately calibrate the RA model against encounter data. Once high quality encounter data is collected, the model can be recalibrated to reflect costs of the specific program (Managed Care or Prescription Drug). For a period, it may be necessary to simultaneously calibrate models as we currently do, in order to identify these differences and analyze the implications for payment.

2.0   Implementation Schedule.

Q1: Why is there a separate encounter data module for DME?
A1: Durable Medical Equipment (DME) currently processes in Fee-for-Service (FFS) using the Common Electronic Data Interchange (CEDI) and within the VMS shared system. Rules and guidelines associated with processing DME encounter data require specialized systems development. Therefore, CMS determined that it was best to develop separate modules for DME, Institutional, and Professional Services.

Q2: Does testing begin in March 2011 for both the 837I and 837P?
A2: Front-end Testing of the COTS Translator and Common Edits Module (CEM) for both 837-I and 837-P begins March 30, 2011.

Q3: Is training for the new system scheduled to begin in June 2011?
A3: Encounter Data training sessions will be held in June 2011 in Baltimore, Maryland. Information regarding registration for the Training Session will be provided by the end of the first quarter of 2011.

Q4: Why are MAOs required to submit test files in March 2011 but not receive training on the new system until June 2011?
A4: The formal Training Session will be held in June 2011. Prior to this training, MAOs can expect to receive information on testing and encounter data collection during the Industry Update Sessions held between January 2011 and May 2011. The information disseminated along with the industry updates provided will help plans to begin preparing internal systems for this implementation.

Q5: What are the Work Group sessions, and who can participate?
A5: The Work Group Sessions are small discussion groups where critical barriers to success can be identified, solutions investigated, and thus provide input to decisions. The outcomes of the workgroups will be communicated to the broad audience during the industry update sessions. The webinar-based sessions are limited to 50 participants. MAOs should consider which of the Work Group Topics most impacts their plan and systems and then make arrangements to register for participation in that session. The Work Group Topics are Third Party Submitters, Chart Reviews & Chart Audits, Editing & Reporting, Capitated & Staff Model Plans, and PACE Organizations. All sessions will be conducted at least twice. Registration information will be available on the www.tarsc.info website.

Q6: What are the Industry Update sessions, and who can participate?
A6: Industry Update Sessions will be in January, March, and May 2011. These update sessions are conducted by CMS via webinar. Industry Updates are open to all and can accommodate 500 participants. The update sessions will provide an opportunity for CMS to disseminate information and provide updates on the implementation and status of the collection of encounter data.

Q7: What is expected from the MA organizations in March 2011?
A7: Beginning in March 2011, plans will be testing the front-end systems using and 837 outbound file in the 5010 format. MAOs are expected to create an 837 outbound test file using test data within each plan's system and submit the test file to CMS for processing. If the 837 outbound test file is in a format

other that the 5010, such as the 4010 format, it will need to be translated into the 5010 format before it can be submitted to CMS so that the data can be processed.

Q8: Is January 2011 the start or finish of parallel testing?
A8: January 2011 is neither the start nor finish of parallel testing. Testing of the Encounter data Front-End System (EDFES) will begin March 30 2011 and finish June 30, 2011. The Encounter Data Processing System (EDPS) testing will begin July 18, 2011 for Institutional claims processing and begin September 12, 2011 for Professional claims processing and testing will end by November 18, 2011. Certification for Professional and Institutional processing must be completed by November 2011. DME EDFES and EDPS testing will start on February 6, 2012 and finish April 20, 2012. Certification for DME by March 20, 2012.

Q9: What are the specific obligations for the front end system testing beginning March 30, 2011?
A9: The expectation for the March 30, 2011, test, is that the submitter will transmit a HIPAA 5010 837X file that will be processed through the Encounter Data Front-End System's (EDFES's) COTS EDI Translator and then through the either the Professional or Institutional CEMs.

Q10: What are the start and end dates for parallel testing of RAPS and the encounter data?
A10: RAPS and EDS Parallel testing will start January 3, 2012 and continue until CMS is sure MAO payment is not impacted by the implementation of the EDS.

Q11: Do health plans need to have the companion and implementation guides for the 837 formats? What is CMS's approach to what the standard implementation is for the new encounter system?
A11: Yes, Plans will need to have the WPC Implementation Guides. A companion document is being considered to assist submitters with how to populate the 5010 data elements.
    HIPAA 5010 837I Example:
        Segment: Subscriber Name (NM1)
        Loop: 2010BA,
        Data Elements:
            NM102 = '1' – Person
            NM108 = 'MI' – Member Identification Number
            NM109 = 999999999 Identification (HIC#)

Q12: Is there a confirmed date for implementation of the Encounter Data Processing System (EDPS)?
A12: There are firm implementation dates for the Encounter Data Processing System (EDPS): January 3, 2012 Institutional and Professional, May 7, 2012 DME.

Q13: What is the process for data certification?
A13: The EDS certification process will be the same as it is for RAPS and DDPS. CSCC will require that the 837X transaction file process cleanly through both the Encounter Data Front-End and Encounter Data Processing Systems before certifications are issued.

Q14: What dates of service are expected for the production data that is required by January 3, 2012?
A14: The first production file can be submitted as early as January 3, 2012 and as late as March 30, 2012. The production file should include 2012 DOS.

Q15: When will health plans be required to send test data for the first time?
A15: Testing of the Encounter data Front-End System (EDFES) will begin March 30, 2011.

Q16: On January 3, 2012, are health plans submitting data from 2011? How much data are health plans required to submit on January 3, 2012 (year, month, etc.)?
A16: Health plans may begin to send production data on January 3, 2012, but are required to send a file by March 30, 2012. A volume estimate has not been established thus far.

Q17: What dates of service are expected for claims submission following the January 2012 deadline?
A17: Plans are required to submit 2012 DOS. Therefore, by March 30, 2012, it is expected that plans are submitting encounters with Jan and Feb (and possibly March) 2012 DOS.

Q18: Since there are different implementation dates for DME claim submission, are health plans suppose to filter out DME claims for the April and October 2011 deadlines?
A18: Plans should not filter DME encounters. Plans may submit all data and CMS will store and process once the DME modules are developed and tested.

Q19: When will the file layout for the 5010 version replace the RAPS file?
A19: The expectation for the March 30, 2011, test, is that the submitter will transmit a HIPAA 5010 837X file. The RARS format submission will continue in parallel until notified by CMS.

Q20: Are health plans required to submit DME claims separately, or with 837P claim files?
A20: Since the EDPS will process professional, institutional, and DME encounters, it is not necessary for plans to submit the DME claims separately.

3.0   High Level Requirements.

Q1: Do the new encounter data requirements apply to both MA organizations and cost plans?
A1: Yes, the new encounter data system applies to both MAOs and cost plans.

Q2: Is a MA organization required to apply for an EDI agreement with the Customer Service and Support Center (CSSC) if the organization is currently a CSSC submitter?
A2: MAOs are required to complete and submit another EDI agreement with the Customer Service and Support Center (CSSC) to receive an additional submitter id for EDS submissions.

Q3: The testing of 5010 submission will not be complete until December 2011. What data is CMS expecting to receive if the 5010 is not entirely implemented by the October 2011 deadline?
A3: Testing of the Encounter data Front-End System (EDFES) will begin March 30 2011 and finish June 30, 2011. The Encounter Data Processing System (EDPS) testing will begin July 18, 2011 for Institutional claims processing and September 12, 2011 for Professional claims processing and testing will end November 18, 2011. Certification for Professional and Institutional processing must complete by November 2011. DME EDFES and EDPS testing will start on February 6, 2012 and finish April 20, 2012. Certification for DME by March 20, 2012.

Q4: Will CMS provide specific guidance on the filtering edits that will be used for processing claims?
A4: Yes. CMS will provide guidance on the filtering edits in the Operational Guidance manual.

Q5: Can MA organizations utilize their current connectivity to submit 5010 data if one of the four acceptable connectivity channels for 5010 transmission (NDM, SFTP, HTTPS, Gentran) is already being used to submit claims data?
A5: MAOs may use either of the following CMS approved connectivity methods to transmit 5010 X12 encounter claim transaction files. These include: GENTRAN, NDM, SFTP, and HTTPS.

Q6: What information will be returned to health plans by CMS following submission of claims?
A6: Plans will receive reports from the EDFES and EDPS. From EDFES, plans will receive File acknowledgements identified: TA1 = Rejected Interchange ISA/IEA envelop, 999R = Rejected Functional groups/ transaction set, 999E = Accepted Functional groups/transaction sets, 277CA = for Rejected and Accepted claims with claim number returned. From EDPS, plans will receive transactional and management reports.

Q7: Regarding PACE MA organizations, what is the expectation of encounter data submission for interdisciplinary team encounters and physician encounters if there is not a claims adjudication process?
A7: Since PACE organizations have very unique needs, CMS will develop requirements for PACE Encounter Data after collecting information during PACE workgroups. The PACE workgroup is scheduled for January 26, 2011 and April 27, 2011.

Q8: For the new encounter data system, does an adjudicated claim include paid, denied, and pending claims?
A8: No. For Encounter Data system, an adjudicated claim is either paid (approved) or denied.

Q9: Is it required that all claims/encounter data be adjudicated?
A9: Yes, it is required that MAOs only submit adjudicated claims.

Q10: What is the definition of adjudicate?
A10: An adjudicated claim is one that has been finalized in the claims processing system. This could result in a paid (approved) or denied claim.

Q11: Should adjustment claims be submitted in the new system? How will adjustment claims be submitted/processed?
A11: MAOs should only submit adjudicated claims. Adjustment claims will be processed as they are in fee-for-service. The adjustment will supersede the previous encounter.

Q12: Will claims that are under medical review also be submitted, or just claims with a final disposition of payment or denial?
A12: Claims with a final disposition of paid (approved) or denied are adjudicated claims. CMS is requiring plans to submit adjudicated claims.

Q13: Could you explain the difference in the 12 month filing timeframes, which is required for the new encounter data system, and the risk adjustment filing timeframes?
A13: As the 2010 HIPAA rules and the Patient Protection and Affordable Care Act (PPACA) section 6404 state, claims must be submitted within 12 months of the date of service. We are asking MA organizations to change from submitting data quarterly (for Risk Adjustment) to submitting at least monthly for encounter data. Risk adjustment factors for each payment year are based on risk adjustment data submitted for services furnished during the 12-month period before the payment year specified by CMS.

Q14: How will retro enrollments be transmitted and processed regarding the new 12 month submission rule?
A14: Research is currently underway regarding retro enrollments, the methods for addressing, and the deadlines for reprocessing claims outside the 12 month period.

Q15: Why is there a 12 month rule in place for claims submission when the sweep dates and submission deadlines are remaining the same?
A15: As the 2010 HIPAA rules and the Patient Protection and Affordable Care Act (PPACA) section 6404 state, claims must be submitted within 12 months of the date of service. With the encounter data system, the data is going to be coming in on a continuous flow, reducing large bundles of claims submitted simultaneously. Especially while the Risk Adjustment Data System and Encounter Data System are running concurrently, the sweep dates and submission dates will remain as they currently are for true comparison.

Q16: Private Fee-for-Service health plans are required to allow providers up to 12 months from the date of service to submit claims information. For these health plans that receive claims from providers on or near the timely filing 12 month deadline and do not have sufficient time to adjudicate or submit the claim, will an alternative way to submit diagnosis information be permitted?

A16: Arrangements and policies for special circumstances regarding late submission of either diagnostic information or claim filing are currently under analysis. Once these policies are finalized, they will be published and shared with all affected parties.

Q17: Is the timely filing rule of submitting claims within 12 months of the date of service consistent with the current data collection rules for risk adjustment?
A17: The timely filing rule of submitting claims is based on the 2010 HIPAA rules and the Patient Protection and Affordable Care Act (PPACA) section 6404, stating all claims must be submitted within 12 months of the date of service. Currently, Risk Adjustment Data is recommended for submission on a minimum quarterly basis, whereas Encounter Data submission will be monthly.

Q18: Currently, MA organizations may submit claims data beyond 12 months from the date of service, what is the requirement for the new encounter data system?
A18: The requirement for the Encounter Data System is that all claims are submitted on a monthly basis, not to exceed 12 months from the DOS. The timely filing rule of submitting claims is based on the 2010 HIPAA rules and the Patient Protection and Affordable Care Act (PPACA) section 6404, stating all claims must be submitted within 12 months of the date of service.

Q19: If MA organizations must submit data within 12 months of the date of service, does this mean that plans will no longer be permitted to submit retrospective data for the previous year?
A19: Arrangements and policies for special circumstances regarding late submission of either diagnostic information or claim filing are currently under analysis. Once these policies are finalized, they will be published and shared with all affected parties.

Q20: What will the sweep months be for the submission deadlines in the encounter data system?
A20: The submission deadlines will remain the same for the Encounter Data System. September, March, and January will continue to be the sweep months at this time.

Q21: Regarding the 12 month timely filing rule, are health plans required to submit claims data 12 months from the date of service or 12 months from the date of adjudication?
A21: Health plans are required to submit claims data 12 months from the date of service.

Q22: What is the rationale behind the change to the 12 month timely filing rule?
A22: As the 2010 HIPAA rules and the Patient Protection and Affordable Care Act (PPACA) section 6404 state, claims must be submitted within 12 months of the date of service. With the encounter data system, the data is going to be coming in on a continuous flow, reducing large bundles of claims or diagnostic data submitted simultaneously.   This will provide for accurate reporting and accurate risk score calculation.

Q23: Regarding requirement 5 in the "High Level Requirements" session, is the timely filing rule 12 months or 24 months from the date of service?
A23: The required timely filing of data within 12 months of the date of service is also consistent with current data collection and submission rules according to CFR 422.310 section g, "Risk adjustment factors for each payment year are based on risk adjustment data submitted for services furnished during

the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate."

Q24: Does the 12 month timely filing rule apply to submission of retrospective chart review data?
A24: Decisions are still being made regarding retrospective chart review data and future updates will address this issue.

Q25: Since providers have 12 months from the date of service to submit claims to the MA organizations, will CMS allow MA organizations an additional 1-2 months for processing and submission of adjudicated claims?
A25: Currently the 12 month from date of service is the rule. CMS is open to discussion of these types of concerns and needs. There will be future updates to address these types of issues.

Q26: What is the value of obtaining the 276 data (claims data inquiry)?
A26: You are submitting the 276 data in order to receive the status of the claim that you have submitted. We may find as we go forward that some of the 276 data has no relevance to the MA encounter data world. If that is the case it may be discontinued at some point.

Q27: There are major field gaps between the 5010 and paper claims/chart review data. How will paper claims and chart review data be collected using the 5010 version?
A27: The WPC TR3 Manuals are the HIPAA standards to be followed. CMS is in the process of developing an 837X companion guide.

Q28: How will the transition to 5010 be enforced for those rural providers and physicians who continue to submit paper based and chart review claims data?
A28: For the chart review data, these details are being examined and this information will be forth coming within future updates.

Q29: What is a 276 (claims status inquiry)?
A29: The 276 transaction is the Claims Status Request and Response. It is used by the submitters to obtain claims status information.

Q30: How will CMS respond to submissions of claims in the 5010 version regarding edits and eligibility?
A30: There are four edits that will occur on the 837X file. File acknowledgements identified: TA1 = Rejected Interchange ISA/IEA envelop, 999R = Rejected Functional groups/ transaction set, 999E = Accepted Functional groups/transaction sets, 277CA = CEM and CEDI modules will produce this transaction for Rejected and Accepted claims, high-level eligibility edits also performed.

Q31: Will the 277 transaction be returned in response to the submission of the 837 claims file?
Q31: 277CA will be returned from claims being processed through the CEM and/or CEDI modules. Translator Acknowledgements: TA1 = Rejected Interchange ISA/IEA envelop, 999R = Rejected Functional groups/ transaction set, 999E = Accepted Functional groups/transaction sets.

Q32: Will health plans receive 277 response files following claims submission?
A32: Yes. The 277 – Health Care Claim Acknowledgement will be sent following a claims submission.

Q33: What is the purpose of the 276 transaction (claims status inquiry)?
A33: The 276 transaction is the Claims Status Request and Response. It is used by the submitters to obtain claims status information.

Q34: Are health plans expected to include adjudication payment amounts and information in the 5010 format files?
A34: The MAOs will format the received data into an acceptable Washington Publishing Technical Report (TR3) 5010 X12 format. The MAOs ensures all required fields are populated prior to submission to the Encounter Data system. MAOs can locate reference and helpful information on the HIPAA 5010 rules and technical reporting formats: http://www.wpc-edi.com/content/view/817/1

Q35: Is a Companion Guide for the 837 5010 formats available for review?
A35: CMS is in the process of developing an 837X companion guide.

Q36: Why is CMS having MA organizations submit 276 transactions or remittance advice rather than providing an unsolicited 277 as response to files?
A36: The 276 status inquiry is an option, which will result in the 277 response. The following acknowledgements are not options: Translator acknowledgement, TA1 = Rejected Interchange ISA/IEA envelop, 999R = Rejected Functional groups/ transaction set, 999E = Accepted Functional groups/transaction sets.   CEM and/or CEDI modules, 277CA = Rejected and Accepted claims.

Q37: If MA organizations accept and adjudicate DME claims that are received from providers/suppliers on 837-P claims, can they be submitted to CMS? Will DME claims received from providers on 837-P claims be processed through the CEM or processed separately through the CEDI?
A37: DME claims should be submitted on a separate 837P file. The DME 837P claims will be processed by the CEDI module.

Q38: Where should payment information be submitted on the 837 formats?
A38: The 2300 loop is the claim level information, refer to the WPC TR3 for more information.

Q39: Will processing systems be shut down at 8:00PM on the deadline to submit claims data each month, or will health plans be permitted to submit claims data after 8:00PM for processing the following day?
A39: Medicare Advantage Organizations must submit data by 8 p.m. EST in order for the data to be counted for that day. This accommodates MAOs on the pacific coast to submit data by end of day at 5 p.m. PST. Data is available for transmission to the Encounter Data Front-End System 24 hours a day, seven days a week, except for scheduled maintenance and weekly on Sundays from 5 p.m. – 10 p.m. EST.

Q40: Are the dates firm for the encounter data test and production file submission deadlines/timeline?
A40: Yes, the dates for submission of test and production files have been established to ensure MAO systems are processing correctly. MAOs need to submit Institutional and Professional test files to the front-end by April 2011 and to the Encounter Data Processing System (EDPS) by November 2011. Testing for DME begins February 6, 2012.

Q41: If the expectation is for MA organizations to submit test files to the front end system by April 2011, are the same files being submitted for the October 2011 deadline?

A41: Testing for Encounter Data will be completed in two phases, with front-end testing completed first, and then processing testing. CMS separated the testing into two phases to allow more time to engage the industry and receive feedback from MAOs regarding the development of the systems and the process for collecting, editing, reporting, and pricing the encounter data. It is important that the data used to test the system in both the front-end and the processing systems accurately depicts the process so that CMS can ensure the system is functioning properly. It does not matter if the same files are used in both phases of testing.

Q42: According to the encounter data testing submission deadlines presented, testing for the front end system scheduled to start March 7th, 2011 and finish by April 2011, giving MA organizations an estimated one and a half month timeframe to submit. Is this correct?

A42: MA Organizations will begin front-end testing for Institutional and Professional Encounter Data by March 30, 2011. End-to-end testing begins July 18, 2011 for Encounter Data Institutional services and on September 12, 2011 for Encounter Data Professional services. To be considered a successful front-end test, MA organizations will need to submit a 5010 file that can be processed through the COTS Translator at the Encounter Data Front-End System (EDFES). The data will process through existing CEM edits to ensure that the file can be received. This testing verifies the logic for the envelope, that all data elements are aligned correctly, and that the file communicates with the front-end system.

Q43: Will the currently acceptable claims locations be used for risk adjustment payment methodology even though claims from all locations will be submitted starting in 2012?

A43: Yes, the current acceptable data sources will continue to be used in the calculation of risk adjustment payments, despite the collection of all types of service for encounter data beginning in 2012.

Q44: What data/content should be provided in the institutional and professional test files that are required to be sent to the EDFES by April 2011?

A44: To be considered a successful front-end test, MA organizations will need to submit a 5010 file that can be processed through the COTS Translator at the Encounter Data Front-End System (EDFES). The data will process through existing CEM edits to ensure that the file can be received. This testing verifies the logic for the envelope, that all data elements are aligned correctly, and that the file communicates with the front-end system.

Q45: Will the current submission deadlines for risk adjustment payment calculation remain the same throughout the encounter data process?

A45: The submission deadlines for risk adjustment will remain the same for encounter data. The submission deadlines are in September, March, and then January.

Q46: Will CMS still have sweep dates in the new encounter data system?

A46: The sweep dates will remain the same for encounter data as is currently used in risk adjustment.

Q47: Are the types of services captured with encounter data increasing from what was previously collected for risk adjustment?

A47: Yes, MAOs are responsible for collecting encounter data from these types of service: Inpatient Hospital, Inpatient Rehab, Inpatient Psychiatric, Long Term Care, Skilled Nursing Inpatient/Swing Bed, Skilled Nursing Outpatient, Hospice, Outpatient Hospital, Community Mental Health, Home Health (DME), End-Stage Renal Disease, Critical Access Hospital Inpatient/Swing Bed, Critical Access Hospital Outpatient, Rural Health Clinic, Federally Qualified Health Center, Outpatient Rehab (CORF/ORF), Physician/Provider, Clinical Laboratory, Ambulatory Surgical Center, Ambulance, and Durable Medical Equipment.

Q48: How will the collection of encounter data be used to impact quality patient care?
A48: The purpose of collecting Encounter Data is to provide quality measures that could globally impact the Medicare program. As Encounter Data is collected, CMS will be able to determine if quality benchmarks can be developed based on the data collected from MAOs.   CMS places importance on the quality of services provided. This demonstrates the value in the programs for beneficiaries as well as the quality of services. Key measures have already been developed for MAOs with regard to claims data and data auditing to ensure quality.

Q49: Regarding requirement eight in the "High Level Requirements" session, was the list of services to be collected for encounter data an all -inclusive list?
A49: Yes, MAOs may use this list to determine the full scope of their data collection efforts. MAOs are responsible for collecting encounter data from these types of service: Inpatient Hospital, Inpatient Rehab, Inpatient Psychiatric, Long Term Care, Skilled Nursing Inpatient/Swing Bed, Skilled Nursing Outpatient, Hospice, Outpatient Hospital, Community Mental Health, Home Health (DME), End-Stage Renal Disease, Critical Access Hospital Inpatient/Swing Bed, Critical Access Hospital Outpatient, Rural Health Clinic, Federally Qualified Health Center, Outpatient Rehab (CORF/ORF), Physician/Provider, Clinical Laboratory, Ambulatory Surgical Center, Ambulance, and Durable Medical Equipment.

Q50: Will radiology services be included in encounter data collection?
A50: Yes, radiology services are included in the collection of Encounter Data, but not included in Risk Adjustment factor.

Q51: Will health plans be permitted to submit DME claims prior to the March 2011?
A51: Plans can submit anything that is prepared at any-time when testing the Encounter Data Systems. CMS will hold the submitted data and run it through the system at the appropriate time.

Q52: Will health plans be required to submit value added service claims or can they be filtered out of the system prior to submission?
A52: At this time, CMS requests that all data be submitted and that plans refrain from filtering any of the data.

Q53: For data collection, what specific services are included in the Long Term Care category?
A53: Data collection for Long Term Care Hospital Services in encounter data will follow the guidelines established by Fee-for-Service FFS) for services provided in a Long Term Care Hospital (LTCH). Further information on the FFS LTCH data collection and pricing methods can be referenced at: http://www.cms.gov/LongTermCareHospitalPPS/01_Overview.asp#TopOfPage.

Q54: What is the purpose of separating DME claims from non-DME claims on the 837P? How will a DME claim be identified (if other than HCPCS coding)?

A54: Durable Medical Equipment (DME) currently processes in Fee-for-Service (FFS) using the Common Electronic Data Interchange (CEDI) and within the VMS shared system. Rules and guidelines associated with processing DME encounter data require specialized systems development. Therefore, CMS determined that it was best to develop separate modules for DME, Institutional, and Professional Services.   DME claims encounter data will be identified via HCPCS coding and the type of bill or place of service as is currently utilized in FFS claims processing.

4.0   Transition Plans Current System to the Encounter Data System

Q1: Can you explain the process of pricing the claim after the encounter data goes through the Encounter Data Processing System (EDPS)?
A1: Within Fee-for-Service (FFS), claims data processes through different pricing methodologies, specifically fee schedules or PRICERs, to determine the amount paid based on the type of service provided. Institutional claims data will process through a modified FISS system and priced according to PRICER methods. Further information on the FFS PRICERs can be found at: http://www.cms.gov/ProspMedicareFeeSvcPmtGen/. Professional claims data will process through a modified MCS system and priced according to Fee Schedule methods; and Durable Medical Equipment claims data will process through a modified VMS system and priced according to Fee Schedule Methods. Further information on the FFS Fee Schedules can be found at: http://www.cms.gov/FeeScheduleGenInfo/. CMS is modeling the Encounter Data Pricing after the FFS methods. Once the data is priced, it will be stored in a repository for CMS to utilize in the future to recalibrate the model.

Q2: For the Encounter Data Processing System (EDPS), will the 5% standard for duplicates remain in effect?
A2: There will be duplicate editing embedded in the processing system. CMS will determine benchmarks based on the new data set and communicate this information to plans.

Q3: Will encounter data be used for the HEDIS measure validation?
A3: HEDIS measures are currently outside of the current scope of the Encounter Data Project. However, once the data are collected, the Agency may use the data for quality measures in the future.

Q4: Why are pricing rules going to be applied to claims? Adjudicated claims will have already been priced by health plans, what is the value of applying pricing rules to the claims data?
A4: CMS expects that plans will price according to their pricing/processing rules. Once CMS receives the encounter, CMS will apply processing and pricing rules that closely mirror Fee-for-Service to ensure accuracy and consistency. This will provide a picture of the beneficiaries cost of care.

Q5: Will CMS be collecting encounter data or re-processing the data collected? If CMS is re-processing data collected, are additional files such as provider network, etc. required?
A5: CMS will process and price the encounter data collected. Additional processing files such as the provider specific file will be developed by CMS and used during processing and pricing.

Q6: Will CMS set up an EPS user group similar to the RAPS user group?
A6: CMS anticipates conducting regular User Groups following the Regional Training Sessions in the summer of 2011.

Q7: Can you please elaborate on the flow of claims from claims leaving the CEM and explain the FFS pricing system?
A7: After claims are processed by CEM, data will be transmitted to the Encounter Data Process System (EDPS) were eligibility, consistency, medical review, utilization, and duplication type edits will be performed.   The data will then flow through I/OCE or MCE editing as appropriate based on TOB. The

claim will be priced by one of the 17 pricing methodologies, which apply FFS rules and edits. The priced claim data will be stored and later retrieved by RAS.

Q8: Is the Encounter Data System (EDS) the same system as the Encounter Data Processing System (EDPS)? What is the difference between the Encounter Data System (EDS) and the Encounter Data Processing System (EDPS)?
A8: The Encounter Data System (EDS) includes two systems: the front-end system called Encounter Data Front-End System (EDFES), this system processing the 5010 file through a COTS Translator, CEM and/or CEM then sends a flat file to the processing system. The processing system called the Encounter Data Processing System (EDPS) takes the flat file and process it through FFS like systems, Encounter Data Institutional Processing and Pricing System, Encounter Data Professional Processing and Pricing System, and Encounter Data DME Processing and Pricing System.

Q9: How does encounter data collection compare to the current All Payer Claims Database (APCD) submissions that each state adopts through legislation to collect encounter data? If MA organizations report APCD data to individual states upon implementation of this National Encounter Data submission, will states then be able to obtain APCD encounter data from CMS directly, or will MA organizations still have to submit APCD data to individual states as well as to CMS?
A9: Once the encounter data is collected and the data are determined to be good quality data, the Agency may evaluate additional uses of encounter data that may include an opportunity to share this data on the state level.

Q10: What filtering is CMS applying before the data is passed on for risk adjustment payment calculation?
A10: CMS is currently evaluating the filtering logic. At a minimum, CMS will filter based on Type of Bill to establish if the facility or service is acceptable for Risk Adjustment.

Q11: Will the implementation of the Encounter Data Processing System (EDPS) eliminate the need for RADV audits?
A11: The purpose of the RADV audit is to ensure that what is reflected on the submission is supported by the medical record.   This does not change the need for RADV.

Q12: How will supplemental pricing information, not submitted on the 837 format, be processed?
A12: The same data required for a FFS claim submitted on an 837X transaction file, to include supplemental claims information, would be the requirement for EDS. These data elements are required to process the encounter data claim through FFS like pricing methodologies.

Q13: Is additional information that is not provided on the 837 format, necessary for pricing claims (provider contract status, etc.)?
A13: The same data required for a FFS claim submitted on an 837X transaction file, to include supplemental claims information, would be the requirement for EDS. These data elements are required to process the encounter data claim through FFS like pricing methodologies.

Q14: In the encounter data system, would the process of cancelling a claim or submitting claims adjustments remain the same?
A14: To cancel or delete a claim the appropriate transaction type 837P or 837I must be submitted with the claim number, along with populating the appropriate data elements that identifies the transaction/ claim as being a replacement.   More information can be obtained, in the WPC TR3 manual.

Q15: Will Durable Medical Equipment (DME) data be submitted through the same 837I and 837P formats or is there a different format for DME data submission?
A15: Plans will submit DME encounters using the 837P format. Upon receiving the encounter, CMS will process the data through the translator and the CEDI module.

Q16: Will penalization for submission of duplicate claims remain in the new encounter data system?
A16: There will be duplicate editing embedded in the processing system. CMS will determine benchmarks based on the new data set and communicate this information to plans.

Q17: Are health plans required to submit claims for salaried providers for which adjudication does not occur?
A17: Plans should submit claims for all Medicare beneficiaries.

Q18: If health plans will be submitting all data through the 5010 version in which some will be used for risk adjustment, pricing, and analysis, is the health plan required to conduct any filtering prior to submission of claims data?
A18: No. CMS is currently evaluating the filtering logic. At this current time, plans are not expected to filter prior to data submission of encounter data through the 5010 format.

Q19: Is it required that DME claims be submitted separately? What is the reason that DME claims are required to be submitted separately?
A19: Since the EDPS will process professional, institutional, and DME encounters, it is not necessary for plans to submit the DME claims separately.

Q20: How will the new Encounter Data Processing System (EDPS) accommodate submission of non-payable claims received from capitated providers?
A20: All claims both payable and non-payable will be submitted through the Encounter Data Processing System as a Final Bill.

Q21: How will the special needs of PACE plans be handled with the new system?
A21: PACE is a unique Plan and research is currently being conducted to address their special needs. There will be future updates designed to address questions regarding PACE claim processing.

Q22: How are health plans suppose to submit retrospective chart review data? Will retrospective chart review data have to be linked back to the claim?
A22: CMS is currently investigating the viability of using one of the 5010 837X segments in the 2300 Loop called Paperwork, data element: PWK01, value "09" as the identifier for Chart Reviews. More information regarding chart reviews will be provided based on Workgroup discussions.

Q23: Are health plans required to include payment for service information for encounter data submission?
A23: For the encounter to pass the processing edits, the field must be populated with the correct data type (numeric)

Q24: Are CEM and CEDI components of the Encounter Data Processing System (EDPS)?
A24: The CEM and CEDI are components of Encounter Data Front End System (EDFES). After the CEM edits are completed, the data moves on to the Encounter Data Processing System (EDPS).

Q25: Will CMS provide Implementation Companion Guides that clearly state edit requirements?
A25: Companion Guides will be developed and distributed during the Regional Training.

Q26: Will the concept of 502 error codes remain the same or be deleted under the encounter data model?
A26: There will be duplicate editing embedded in the processing system. CMS will determine benchmarks based on the new data set and communicate this information plans.

Q27: Where is the CEM module reference guide located (what is the web link)?
A27: The Common Edits and Enhancements Module (CEM) Manual can be located here: http://www.cms.gov/transmittals/downloads/R647OTN.pdf

Q28: Will MA organizations continue to receive RAPS return files within one business day?
A28: Yes, RAPS will continue to work the same way until it is replaced by EDPS.

Q29: Is CMS planning to apply Medicare benefit edits to encounter data? Will encounter data be rejected if MA organizations cover services not covered by Medicare Fee-for-Service (FFS)?
A29: CMS plans to apply Eligibility and Enrollment edits, as well as Utilization. However, the encounter data will not be rejected for services not covered by FFS. CMS will store the outcome of the pricing based on fee-for-service logic.

Q30: What are the details of the 837X edits that will be turned on for the Encounter Data System (EDS)?
A30: The Encounter Data Front-End System will perform translator and CEM/CEDI level edits, which are based on those published by WPC and the CEM edits spreadsheet that can be found.;http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

Q31: Will the remittance advice reports be returned by the 835 transaction?
A31: At present, the 835 remittance advice will not be used. Further research is being conducted to determine its viability.

Q32: Will health plans receive an 835 (remittance advice) throughout the entirety of the testing phase?
A32: At present, the 835 remittance advice will not be used. Further research is being conducted to determine its viability.

Q33: Will management reports specify RAPS specific components used for risk score calculation versus those components that are not used for calculation?
A33: Yes, it is CMS's desire to specify RAS specific components that impact risk score calculation from that of encounter data processing and pricing. In the coming months more information will be provided during the work groups regarding processing reports.

Q34: In the new encounter data system, will health plans be able to receive all reports, including transmission reports, which are currently only returned to the submitter?
A34: Submitters and plans have the ability to request transactional and Management Reports.

Q35: Will 5010 Errata be required by the encounter data implementation date of January 2012?
A35: Yes, it is anticipated that the EDS will be able to receive the latest HIPAA 5010 Errata version on January 3, 2012. The current mandate is for all entities to comply by January 1, 2012

Q36: Will CMS provide guidance in default data values/elements for missing fields of the 5010 format?
A36: Yes, CMS's intent is to provide a companion guide to assist plans and submitters with the population of required and most common segments and data elements.

Q37: Will health plans receive detailed response files similar to the RAPS return file following submission of claims? Will response files returned following submission of claims be in a 5010 compliant 835 transaction format?
A37: CMS is currently exploring types of reports and formats that will be distributed to the Plans. CMS will provide further information regarding the reports.

Q38: Will health plans be required to submit claims files in both formats during parallel testing of the RAPS and encounter data system? When will the parallel testing phase take place?
A38: As of right now, plans are required to submit claims in the RAPS and HIPAA 5010/ EDS format until CMS is sure payments are not affected by the implementation of the EDS. Plans will be notified when to stop the parallel submission. Testing of the Encounter data Front-End System (EDFES) will begin March 30 2011 and finish June 30, 2011. The Encounter Data Processing System (EDPS) testing will begin July 18, 2011 for Institutional claims processing and September 12, 2011 for Professional claims processing. Testing will end November 18, 2011. Certification for Professional and Institutional will be completed by November 2011. Go-live January 3, 2012. DME EDFES and EDPS testing will start on February 6, 2012 and finish April 20, 2012. Certification for DME by March 20, 2012. Go-live, May 7, 2012.

Q39: If a health plan currently has a third party submitter for RAPS and wants to transition to direct encounter data submission by the plan, will the plan be able to submit both a third party and plan submitter ID simultaneously?
A39: Plans are allowed to have a third party submit data for them in RAPS and they submit data in the HIPAA 5010/ EDS format or vice versa. MAOs are required to complete and submit another EDI agreement with the Customer Service and Support Center (CSSC) to receive an additional submitter id for EDS submissions.

Q40: How does CMS anticipate quantifying a beneficiary's health status with the Encounter Data Processing System (EDPS)?
A40: The health status is determined by the HIC number and the diagnosis codes.

Q41: What types of chart audits are anticipated (RADV, RAC, Encounter Data)?
A41: Initially CMS will perform RADV audits. As data is evaluated, CMS may expand the scope of the audit.

Q42: How will information be extracted from paper claims and chart reviews, for the new Encounter Data System (EDS)?
A42: CMS is requesting that data be submitted in the HIPAA 5010 format, exceptions are being considered and will be discussed in the coming months. During the Chart Review workgroup, discussions will be centered on what 5010 data element(s) will distinguish "Chart Review" claims.

Q43: If a 276 is not submitted will the health plan receive any feedback indicating whether or not the claims data was accepted or rejected (other than the TA and 999)?
A43: There is a team identifying Encounter Data Processing System (EDPS) reports (example: 5 Transaction type reports, 5 Management type reports, 5 Risk Adjustment type reports). More information will be communicated in the coming months regarding processing reports. The Encounter Data Front-End System (EDFES) which receives the 837X file will produce COTS Translator acknowledgements: TA1 = Rejected Interchange ISA/IEA envelop, 999R = Rejected Functional groups/ transaction set and 999E = Accepted Functional groups/transaction sets. CEM/ CEDI modules acknowledgement: 277CA = Rejected and Accepted claims with claim number returned.

Q44: Who is responsible for training the providers from which encounter data will be collected?
A44: CMS has provided provider education series regarding HIPAA and conversion to 5010. In preparation for ICD-10, there have been and will continue to be significant Provider Outreach. The Encounter Data Project is not asking the provider to perform outside of what is required for ICD-10 and HIPAA compliance.

Q45: What is the definition of an encounter?
A45: The definition of Encounter Data is "Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims". This definition can be found at: http://www.cms.gov/apps/glossary/default.asp?Letter=E&Language=English.

Q46: Is DME considered an encounter?
A46: Yes, DME claims data is considered an encounter and should be collected and submitted for processing and pricing in the Encounter Data System.

Q47: Are telephone calls considered an encounter?
A47: Based on Fee-for-Service guidelines, telemedicine is an acceptable source of encounter data. For further reference information regarding the regulations for telemedicine, please review 42 CFR 410.78 at http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr410.78.pdf.

Q48: Can you explain the process of pricing the claim after the encounter data goes through the Encounter Data Processing System (EDPS)?

A48: Within Fee-for-Service (FFS), claims data processes through different pricing methodologies, specifically fee schedules or PRICERs, to determine the amount paid based on the type of service provided. Institutional claims data will process through a modified FISS system and priced according to PRICER methods. Further information on the FFS PRICERs can be found at: http://www.cms.gov/ProspMedicareFeeSvcPmtGen/. Professional claims data will process through a modified MCS system and priced according to Fee Schedule methods; and Durable Medical Equipment claims data will process through a modified VMS system and priced according to Fee Schedule Methods. Further information on the FFS Fee Schedules can be found at: http://www.cms.gov/FeeScheduleGenInfo/. CMS is modeling the Encounter Data Pricing after the FFS methods. Once the data is priced, it will be stored in a repository for CMS to utilize in the future to recalibrate the model.

Q49: What is the purpose of pricing encounter data claims?

A49: Currently CMS has little insight into the utilization patterns in MA Organizations. As has been evident in past years, coding patterns in MAOs have diverged from Fee-for-Service (FFS) and this impacts MA payments. By collecting Encounter data claims, CMS will have the ability to measure MA utilization and recalibrate the risk adjustment models used for MA payment.

Q50: Are health plans required to send SVD segments (line adjudication segments indicating what was paid) under the new EDS? Is CMS going to publish which SVD segments (line adjudication segments indicating what was paid) are required for the Encounter Data system?

A50: Currently, CMS has determined plans will be required to submit the 5010 and the SVD segment included in the 5010. Prior to the collection of ED, CMS will communicate the final decisions to plans on the segments to include and/or exclude from the 5010.

5.0   Transition Plan From ICD-9 and ICD-10.

Q1: Can the RAPS and encounter data systems accommodate both the ICD-9 and ICD-10 coding processes at the same time?
A1: Yes, the 5010 format for collection of Encounter Data and the RAPS format can accommodate both the ICD-9 and ICD-10 codes.

Q2: Can providers submit ICD-10 codes for retrospective dates of service (prior to October 1st, 2013) after the ICD-9 to ICD-10 transition date of October 1st, 2013 has passed?
A2: All diagnosis codes will be evaluated against the date of service. If an ICD-10 diagnosis code is submitted prior to October 1, 2013, other than for testing, CMS will reject it. ICD-9 diagnosis codes submitted with a date of service after October 1, 2013 will be rejected by CMS.

Q3: Can you explain the process of pricing the claim after the encounter data goes through the Encounter Data Processing System (EDPS)?
A3: Within Fee-for-Service (FFS), claims data processes through different pricing methodologies, specifically fee schedules or PRICERs, to determine the amount paid based on the type of service provided. Institutional claims data will process through a modified FISS system and priced according to PRICER methods. Further information on the FFS PRICERs can be found at: http://www.cms.gov/ProspMedicareFeeSvcPmtGen/. Professional claims data will process through a modified MCS system and priced according to Fee Schedule methods; and Durable Medical Equipment claims data will process through a modified VMS system and priced according to Fee Schedule Methods. Further information on the FFS Fee Schedules can be found at: http://www.cms.gov/FeeScheduleGenInfo/. CMS is modeling the Encounter Data Pricing after the FFS methods. Once the data is priced, it will be stored in a repository for CMS to utilize in the future to recalibrate the model.

Q4: Will the HCC model be changed in 2013 following the ICD-9 to ICD-10 transition?
A4: CMS expects to utilize ICD-9 codes until October 1, 2013 and then there is a firm cut over to the use of ICD-10. The 5010 format was built to accept ICD-10 data. Since encounter data will be collected using the 5010, the structure is already established to pull in ICD-10 data. Payment for ICD-10 is complex to try to incorporate ICD-10 codes immediately. Therefore, in the 2013 data collection year, one option for payment could be that nine months of data would be ICD-9 codes and three months of data would be ICD-10 codes. Another option that could be proposed is to use data collected in the Fiscal Year (FY) instead of Calendar Year (CY) during the transition to ICD-10. MAOs would still have 12 months of data feeding the model for 2014; it would be a different set of 12 months. Data would be collected from October 2012 to October 2013 rather than January to December 2013.

Q5: Will the CMS-1500 paper claim form be updated to allow reporting of 12 diagnosis codes in order to match the allowable reporting limit for the 837-P 5010 format?
A5: There is a need to support those providers submitting data in the paper format. A final decision is still to be made with regard to when and how to modify the CMS-1500 paper claim form to best meet the needs of these providers.

Q6: Has CMS already mapped the ICD-10 codes into the HCC models?
A6: The General Equivalence Mappings (GEMS) provide guidance on the mapping of ICD-10 codes for payment systems, quality measures, payment and coverage edits, trend data, and risk adjustment. http://www.cms.gov/ICD10/12_2010_ICD_10_CM.asp#TopOfPage. CMS will provide further guidance on the mapping of ICD-10 codes to the appropriate CMS HCC Risk Adjustment models in the Payment Notices for 2014.

Q7: How will CMS handle mapping of ICD-9 codes that are sent by providers past the date of transition compliance to ICD-10?
A7: The firm cut over date for transition compliance to ICD-10 codes is October 1, 2013. There are no delays or grace periods in this transition.

Q8: Will there be separate ICD reporting requirements for paper claims as of October 1, 2013?
A8: All Health Insurance Portability and Accountability Act (HIPAA) of 1996 covered entities must implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2013. Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in noncovered entities' best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to noncovered entities. CMS will work with noncovered entities to encourage their use of ICD-10-CM/PCS. http://www.cms.gov/ICD10/Downloads/ICD-10MythsandFacts.pdf   The Administrative Simplification Compliance Act of 2001 (ASCA) required the use of electronic claims for providers to receive Medicare reimbursement after October 16, 2003. The HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10 Procedure Coding System (PCS) Final Rule adopted the use of these two code sets on January 16, 2009. http://www.cms.gov/ICD10/downloads/w5010BasicsFctSht.pdf

Q9: Will CMS include payers on their end to end testing plans for transition to ICD-10 codes (for example, looking at reports using test data)?
A9: End to end testing for ICD-10 implementation occurs from October 2012 to October 2013. Compliance timelines for ICD-10 transition can be located at: http://www.cms.gov/ICD10/03_ICD-10andVersion5010ComplianceTimelines.asp#TopOfPage.

Q10: Is the use of ICD-10 codes driven by date of service or by submission date after October 2013?
A10: All Health Insurance Portability and Accountability Act (HIPAA) of 1996 covered entities must implement the new code sets for ICD-10 with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2013.

Q11: How many diagnosis codes can the 837-P and 837-I currently accommodate?
A11: Per the June 30, 2010, HIPAA Version 5010: Seventh National Provider Call –837 meeting, adjudication capability of 'other' diagnosis codes increased from 8 to 24 for 837-P and 837-I.

Q12: What ICD codes will CMS accept for claims submission as of October 1, 2013?
A12: Covered entities must implement the new code sets for ICD-10 with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2013.

Q13: Will CMS release an updated list of ICD-10 codes prior to October 2013, so that plans and vendors can prepare for the model transition?
A13: The General Equivalence Mappings (GEMS) provide guidance on the mapping of ICD-10 codes for payment systems, quality measures, payment and coverage edits, trend data, and risk adjustment. http://www.cms.gov/ICD10/12_2010_ICD_10_CM.asp#TopOfPage. CMS will provide further guidance on the mapping of ICD-10 codes to the appropriate CMS HCC Risk Adjustment models in the Payment Notices for 2014.

Q14: When will health plans know which ICD-10 codes will be included in the HCC model for Medicare Part C and Part D?
A14: CMS will provide further guidance on the mapping of ICD-10 codes to the appropriate CMS HCC Risk Adjustment models in the Payment Notices for 2014.

Q15: Will the submission requirements for ICD-10 address ambiguity that might occur in GEMS mapping?
A15: The General Equivalence Mappings (GEMS) provide guidance on the mapping of ICD-10 codes for payment systems, quality measures, payment and coverage edits, trend data, and risk adjustment. The purpose of the GEMs is to create a useful, practical, code- to- code translation reference dictionary for both code sets, and to offer acceptable translation alternatives wherever possible. This should reduce any ambiguity in the mapping or submission of ICD-10 codes.
http://www.cms.gov/ICD10/12_2010_ICD_10_CM.asp#TopOfPage

6.0   Introduction to Workgroups

Q1: At what time on 11/15/2010 will the website be open for registration of work groups?
A1: Online registration will begin at 10:00 a.m., ET, on November 15, 2010, for Work Group and Industry Update sessions. The website link is www.tarsc.info.

Q2: What is the purpose of the Third Party Work Group? Will the strategy to receive and transmit 5010 data be discussed in another work group other than the Third Party Submitter Work Group?
A2: The purpose of the third party submitter Work Group is to have a discussion with those who are in business to submit data. These submitters have a distinct knowledge base that CMS could use to identify any risks with the collection and submission of encounter data prior to full implementation. In addition, in the Encounter Data Survey conducted in April 2010, 56% of participating MA Organizations identified use of Third Party Submitters for data collection, processing, or submission. To date, CMS has not discussed the collection and implementation of encounter data with third parties. Additional information needs to be discussed with this group regarding their specific needs and concerns. Elements of the strategy to receive and transmit 5010 data will also be discussed throughout all of the Work Groups.

Q3: Is there a work group for Special Needs Plans (SNPs)?
A3: At this time, a separate work group has not been identified for Special Needs Plans (SNPs). Since SNPs are MA Organizations, SNPs can participate in any Work Groups where they can add to the discussion and problem resolution development for the collection of encounter data.

Q4: Will Risk Adjustment User Group Calls resume in the future?
A4: Once the Encounter Data System testing begins and the Encounter Data Trainings are completed in the Summer of 2011, CMS will conduct weekly Encounter Data Work Group sessions to assist in the transition to the collection of encounter data.

Q5: Should PACE organizations participate in additional work groups other than the PACE specific work groups?
A5: PACE organizations have workgroups specifically dedicated to addressing their needs and concerns on January 26, 2011 and April 27, 2011.

Q6: Will the work group industry update sessions be conducted through distance learning technology?
A6: Work Group sessions will be conducted via webinar and teleconferencing in a manner similar to standards used in the National Meeting.

Q7: Once work groups are full, will it be possible for health plans to listen to the work groups via telephone or webinar? Will it be possible to access minutes following work groups?
A7: Each Work Group topic is offered as a series. Based on this, MAOs should register for those Work Groups that most closely align with their specific needs or concerns. Registration is on a first-come first-served basis. MAOs should register for one position in the Work Group and then gather the necessary resources within your organization to attend. Access to the Work Groups will be restricted to those registered. However, the basis of the discussion will be used to formulate the discussion points for the

next session. CMS responses to the discussion points from each work group will be published at a summary level in order to identify some of the decisions made.

Q8: Where will work group communications be published? If work group communications are distributed through listserv, what lists will be contacted?
A8: Work Group communications will be distributed through listserves. Communication is also sent to plans who have registered for updates through the Customer Service and Support Center (CSSC) at csscoperations.com. Those who registered for participation in the National Meeting, as well as those registered on CSSC will be the names in the distribution list. MAOs can also send an email to EDS@ardx.net to request addition to the distribution list.

Q9: How will participants of the work groups be selected (signing up, etc.)?
A9: Registration for the Work Groups is on a first-come, first-served basis. Registration opens on November 15, 2010 at www.tarsc.info.

Q10: Will the webinar National Meeting presentation be available on-line for review at a later date?
A10: The Questions and Answers from the National Meeting will be available for MAOs December 10, 2010 on the Encounter Data page on the askriskadjustment.com site.

Q11: Who should participate in the chart review and data submission work group?
A11: Attendees in the Chart Reviews and Data Submission Work Group sessions will help to identify methodologies for handling the data volume, receiving error messages and correcting those errors, submitting chart review data using the 5010 format, utilizing reports and reporting functions, and managing duplicate submissions of claims data.