Encounter Data Work Group Summary Notes for Third Party Submitters: Key Findings and Recommendations

Third Party Submitters

Work Group 2 of 3

This report summarizes the findings of the Third Party Submitters Encounter Data Work Group conducted on February 23, 2011. Twenty-one organizations participated in this Work Group and included:

- Alliance PPO
- ARDX
- Brand New Day
- Cirdan Health System
- CMS
- CSSC Operations
- Dynamic Healthcare Systems
- Health Risk Partners
- IMPAQ International
- Infocrossing
- Ingenix
- Ingenix Consulting
- Leprechaun, LLC
- MedAssurant
- MetroPlus Health Plan
- MMC 20/20, Inc.
- National PACE Association
- Outcomes Health Info
- PopHealthMan
- TMG Health, Inc.
- TriZetto Group, Inc.

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

The goals for this series of sessions for Third Party Submitters include:

- Identifying a strategy to receive and transmit data in the 5010 format,
- Determining the capabilities of third party submitters to handle the increased data volume and file size of encounter data submissions, and
- Identifying the storage capacity for full data claims.

The discussion topics for this session were:

- Submitting adjustment data using the 837.
- Chart review data and the 5010 data elements needed for processing and submission.
- Use of the *Amount Fields* on the 5010.
- Process for submitting dental data using an 837-I or 837-P.

- Capturing additional diagnostic data and the needed segments and loops on the 5010 to submit additional diagnoses.
- Best practices for utilizing transaction reports and required data elements on reports.
- Process for submitting vision data.

The second session of the Third Party Submitters Work Group focused on processes for MA submission of adjustment, chart review, and dental/vision data, population of 5010 amount fields for capitated and staff model arrangements, and utilization and expectations of transaction reports.

Introduction and Review of Materials

Before opening the forum for discussion a review of the materials sent to plans prior to the work group was provided. Information regarding data collected from the first Third Party Submitters session was discussed as well as assignment feedback obtained from participants of the first working session via eds@ardx.net. The following were the main points discussed during review of the work group materials and feedback regarding action items assigned during the first Third Party Submitters work group.

Encounter Data Front-End System (EDFES) Testing

Testing of the front-end system will run from March 30, 2011 through June 30, 2011. All MA organizations are required to fill out a new submitter's package which must be signed by the appropriate authorized personnel.

- This must be completed before plans send a test file to the front-end system.
- The Submitter's package will be posted on the CSSC operations website (www.csscoperations.com) by March 15, 2011.

During the front-end testing phase plans should submit at least one (1) institutional (837-I) and one (1) professional (837-P) test file containing no more than 100 claims each.

Connectivity

MAOs may use any of the following CMS approved connections to transmit 5010 X12 encounter data transaction files to the Encounter Data Front-End System (EDFES):

- Connect:Direct (NDM)
- Secure File Transfer Protocol (SFTP)
- Hypertext Transfer Protocol Secure (HTPPS)
- Gentran

For encounter data submission, Gentran and SFTP users must limit the number of ST-SE segments (claims) submitted per file to 2,500 claims and NDM users will be limited to 15,000 ST-SE segments (claims) per file.

Review of Action Items for the First Third Party Submitters Work Group and Participant Feedback

Assignment 1: Paper claims vs. the 5010

During the first working session, participants stated that some paper claim fields are not accounted for on the 5010. CMS requested that participants send a list of gaps between paper claims and the 5010 format. The following represents information that participants submitted in response to this request:

- Participants reported the following data elements could be missing:
  - Diagnosis Code Pointers – Loop ID 2400 SV107-1 through SV107-4 of the 837-P.
  - Condition Codes – Loop ID 2300 HI segment of the 837-I.
  - Paid Units – Loop ID 2400 SV104 of the 837-P.
- A participant submitted a list of required fields on the 5010 837-I and 837-P that are not included or limited on paper claim submissions. Tables 1-2 reflect the list of data elements submitted.

Table 1: List of required fields on the 5010 837-I that are not included or limited on paper claim submissions.

Field Name	Loop ID	Segment	Paper Claim Limitation
Claim Number	2300	CLM01	Absent-Only Subscriber number is present
Patient Reason for Visit	2300	HI	Absent
Additional External Cause of Injury	2300	HI	1 or 2
Diagnosis Related Group (DRG) Information	2300	HI	Absent
Procedure Code	2300	HI	6
Occurrence Codes	2300	HI	3
Occurrence Span Codes	2300	HI	2
Value Information	2300	HI	3
Condition Codes	2300	HI	11
Treatment Code Information	2300	HI	Absent
Other Insurance Coverage Information	2320	OI	Absent
Other Subscriber Name	2330A	NM1	Absent
Other Payer	2330B	NM1, N3, N4, DTP, REF	Absent
Other Payer Attending Provider Secondary Identification	2330C	REF	Absent
Claim Check or Remittance Date	2330B	DTP	Absent

Table 2: List of required fields on the 5010 837-P that are not included or limited on paper claim submissions.

Field Name	Loop ID	Segment	Paper Claim Limitation
Claim Number	2300	CLM01	Absent-Only Subscriber number is present
Payer Name	2010BB	NM1	Absent
Payer City, State, and Zip Code	2010BB	N4	Absent
Claim Frequency Code	2300	CLM05	Absent
Release of Information Code	2300	CLM09	Absent
Diagnosis Code	2300	HI	4
Service Facility Contact Information	2310C	PER	Absent
Ambulance Pickup Location City/State/Zip	2310E	N4	Absent
Ambulance Drop Off Location Address	2310F	N3	Absent
Other Insurance Coverage Information	2320	OI	Absent
Other Payer Referring Provider Secondary Identifier	2330C	REF	Absent
Other Payer Rendering Provider Secondary Identifier	2330D	REF	Absent

- A participant submitted a list of Institutional (837-I) and professional (837-P) 5010 data elements that are not currently required by their state of residence. Table 3 reflects these data elements submitted.

Table 3: Institutional 5010 elements not currently required.

Loop ID	Loop Description	Segment	Segment Description
2000A	Billing Provider	CUR	Foreign Currency Information
2010AA	Billing Provider	PER	Billing Provider Contact Information
2010BC	Credit/Debit Card Holder Name	NM3	Loop Deleted/No Description
		NM4	Loop Deleted/No Description
2300	Claim Information	PWK	Claim Supplemental Information
		K3	File Information
		HCP	Claim Pricing/Re-Pricing Information
2310A	Attending Provider	PRV	
2320	Other Subscriber Information	MIA02	Monetary Amount
		MIA03	Quantity (Lifetime Psychiatric Days)
		MIA04	Monetary Amount (DRG Related Amount)
		MIA05	Reference Identification
		MIA06	Monetary Amount (Disproportionate Share Amount)
		MIA07	Monetary Amount (MSP Pass Through Amount)
		MIA08	Monetary Amount (PPS Capital Amount)
		MIA09	Monetary Amount (PPS Capital, Federal Specific

			Proportion, DRG Amount)
		MIA10	Monetary Amount (PPS Capital, Hospital Specific Proportion, DRG Amount)
		MIA11	Monetary Amount (PPS Capital, Disproportionate Share, Hospital DRG Amount)
		MIA12	Monetary Amount (Old Capital Amount)
		MIA13	Monetary Amount (PPS Capital Indirect Medical Education Claim Amount)
		MIA14	Monetary Amount (Hospital Specific DRG Amount)
		MIA15	Quantity (Cost Report Days)
		MIA16	Monetary Amount (Federal Specific DRG Amount)
		MIA17	Monetary Amount (PPS Capital Outlier Amount)
		MIA18	Monetary Amount (Indirect Teaching Amount)
		MIA19	Monetary Amount (Professional Component Amount Billed Not Payable)
		MIA24	Monetary Amount (Capital Exception Amount)
		MOA01	Reimbursement Rate Percentage
		MOA02	Monetary Amount (HCPCS Payable Amount)
		MOA08	Monetary Amount (ESRD Payment Amount)
		MOA09	Monetary Amount (Non-Payable Professional Component Billed Amount)
2330A	Other Subscriber Name	Entire Loop	N/A
2330B	Other Payer Name	N3	Other Payer Address
		N4	Other Payer City, State, Zip Code
		REF	Other Payer Secondary Identifier, Prior Authorization Number, Referral Number, Claim Adjustment Indicator, Claim Control Number
2330C	Other Payer Attending Provider	Entire Loop	N/A
2330D	Other Payer Operating Physician	Entire Loop	N/A
2330E	Other Payer Other Operating Physician	Entire Loop	N/A
2330F	Other Payer Facility Location	Entire Loop	N/A
2330G	Other Payer Rendering Provider Name	Entire Loop	N/A
2330H	Other Payer Referring Provider	Entire Loop	N/A
2330I	Other Payer Billing Provider	Entire Loop	N/A
2400	Service Line Information	PWK	Line Supplemental Information
		AMT	Service Tax Amount, Facility Tax Amount
2420A	Operating Physician Name	Entire Loop	N/A
2420B	Other Operating Physician Name	Entire Loop	N/A
2420C	Rendering Provider Name	Entire Loop	N/A

Table 4: Professional 5010 elements not currently required.

Loop ID	Loop Description	Segment	Segment Description
1000A	Submitter	PER05	Communication Number Qualifier
		PER06	Communication Number
		PER07	Communication Number Qualifier
		PER08	Communication Number
2010AA	Billing Provider	PER	Billing Provider Contact Information
2000B	Subscriber Information	SBR03	Reference Identification
		SBR04	Name
		SBR05	Insurance Type Code
		PAT	Patient Information
2010BB	Payer Information	N3	Payer Address
		N4	Payer City, State, Zip Code
2010CA	Patient	REF	Property and Casualty Claim Number
2300	Claim Information	CR1	Ambulance Transport Information
		CR2	Spinal Manipulation Service Information
		HCP	Claim Pricing/Re-Pricing Information
2310A	Referring Provider	PRV	
2310B	Rendering Provider	PRV	Rendering Provider Specialty Information
2310C	Service Facility Location	Entire Loop	N/A
2310D	Supervising Provider Name	Entire Loop	N/A
2310E	Ambulance Pick-Up Location	Entire Loop	N/A
2310F	Ambulance Drop-Off Location	Entire Loop	N/A
2330A	Other Subscriber Name	NM104	First Name
		NM105	Middle Name
		NM106	Name Prefix
		NM107	Name Suffix
		N3	Other Subscriber Address
		N4	Other Subscriber City, State, Zip Code
		REF	Other Subscriber Secondary Identification
2330B	Other Payer	PER	
2330C	Other Payer Referring Provider	Entire Loop	N/A
2330D	Other Payer Rendering Provider	Entire Loop	N/A
2330E	Other Payer Service Facility Location	Entire Loop	N/A
2330F	Other Payer Supervising Provider	Entire Loop	N/A
2330G	Other Payer Billing Provider	Entire Loop	N/A
2330H		Entire Loop	N/A

2400	Service Line	SV111	Yes/No Condition or Response Code
		SV115	Co-pay Status Code
		SV5	Durable Medical Equipment Service
		PWK	Line Supplemental Information
		CR1	Ambulance Transport Information
		CR3	Durable Medical Equipment Certification
		CRC	Ambulance Certification
		AMT	Sales Tax Amount
		K3	File Information
		PS1	Purchased Service Information
		HCP	Line Pricing/Re-Pricing Information
2420A	Rendering Provider	PRV	Rendering Provider Specialty Information
2420B	Purchased Service Provider	Entire Loop	N/A
2420C	Service Facility Location	Entire Loop	N/A
2420D	Supervising Provider	Entire Loop	N/A
2420E	Ordering Provider	Entire Loop	N/A
2420F	Referring Provider	Entire Loop	N/A
2420G	Ambulance Pick-Up Location	Entire Loop	N/A
2440	Form Identification	Entire Loop	N/A

Proposals to Assignment 1

- Paper claim fields submitted by participants (Tables 1-4) of the previous work group would be needed for encounter data submission and accurate pricing of services.
- Increased provider outreach may be necessary for collection of these data elements that may be currently missing due to providers not submitting these data elements, lack of field utilization, or use of non-standard "homegrown" formats.
- A crosswalk is available for plans to use in mapping standard paper claims formats to the 5010 at: http://www.palmettogba.com/Palmetto/Providers.Nsf/files/CMS1500_ANSI837v5010_Crosswalk.pdf/$File/CMS1500_ANSI837v5010_Crosswalk.pdf.
- Plans can assume that any required fields on the 5010 format are required for encounter data submission.
- Sections/pages of the companion guides containing up-to-date information will be released to plans as they are developed to provide further assistance.

Assignment 2: Non-Medicare Provider Types and NPI

NPI will be a required field on the 5010 837X format. During the first working session participants stated that some providers do not have assigned NPIs. Participants were requested to send a list of non-Medicare provider types that do not have an NPI. The following represents information that participants submitted in response to this request:

- Participants submitted the following examples of provider types without an NPI:
  - Personal Care Attendant
  - Home Health Care Service
  - Nursing Home (Facility Code)
  - Special Provider Agreements-Non-medical
  - Post Payment UR Clinic Review
  - Business Manager
  - Home and Community Based Services
  - Meals on Wheels

Proposals to Assignment 2

- The use of "000000000" as a placeholder for those provider types without an NPI was suggested. The plan would be to use a substitute or dummy ID for these providers.
- When applicable, providers can register for an NPI at https://www.cms.gov/nationalprovidentstand/. Assignment of an NPI occurs within 15 days of registration.
- Participants were requested to continue to send examples of types of providers without an NPI to eds@ardx.net.

Assignment 3: Systems Requirements for Adjudicating Claims using the 5010 Format

During the first working session participants stated there was an issue with sending adjudicated claims data. Participants were requested to provide feedback regarding this issue. The following represents information that participants submitted in response to this request:

- Clients have not yet mapped all data elements of the 5010.
- Some clients are implementing a data extract of the 5010 format as a remediation plan.

Proposals to Assignment 3

- Only adjudicated claims should be submitted to the Encounter Data System (those either paid or denied). If the claim is rejected by a plan for invalid or missing data, pending (i.e., not released for payment or denied due to errors in your system), then it should not be submitted for Encounter Data.

Updates and Discussion Points

The work group discussion topics were: processing updates regarding submission of adjustment, chart review, use of *Amount* fields, and dental and vision data. Following each discussion topic participant comments and questions related to the topic were addressed. The following information represents the discussion of process updates and participant comments/questions that were addressed for each of these issues.

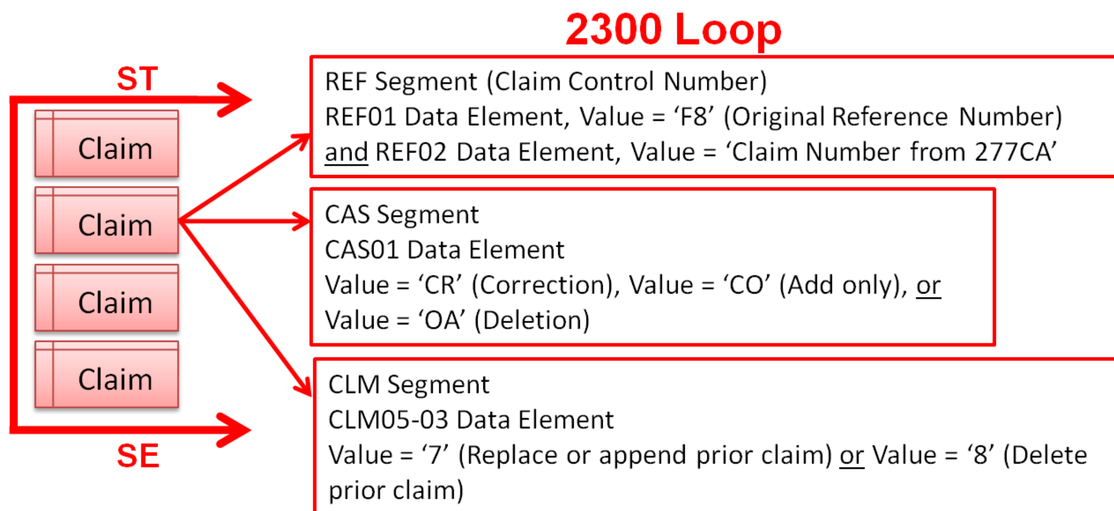
Submission of Adjustment Data

Adjustments will only be made at the claim level. Plans will not be able to submit line level adjustments. The CAS segment (CAS01 data element) within the 2300 loop of the 5010 will be used to identify the type of adjustment being made. Figure 1 below displays the adjustment process and the loop segments and values that should be used when submitting an adjustment to the Encounter Data System (EDS).

Plans must populate the following 3 segments in addition to the other required segment, for submission of an adjustment claim:

- REF segment (claim control number)
  - The REF segment REF01 data element must be populated with value 'F8' (original reference number), and
  - The REF segment REF02 data element must be populated with the ICN (claim control number) received via the 277CA report.
- CAS segment (CAS01 data element)
  - The CAS segment must be populated with one of the 3 value options available for submitting adjustment data:
    - 'CR'=Correction
      - This overwrites the submitted encounter and will replace any previously submitted data.
      - An adjustment indicator ('CR') within the CAS segment can only be used within the 2300 level loop not the 2400 level loop. Line level adjustments cannot be processed.
    - 'CO'=Add only
      - The 'CO' option will be used for MA plans adding more than the allowable number of diagnoses on a professional (837-P) or institutional (837-I) encounter (12 diagnoses are allowed on the 837-P and 25 diagnoses are allowed on the 837-I). Participants reported that more than 25 diagnoses would be associated with the majority of institutional encounters submitted.
    - 'OA'=Deletion
      - This allows a plan to delete previously submitted encounter data.
      - A deletion indicator ('OA') is submitted to delete an entire claim. Line level deletions cannot be processed.
- CLM segment (CMS05-03 data element)
  - The CLM segment (CLM05-03 data element) within the 2300 loop of the 5010 will be populated with value '07' for replacing or appending a prior claim. This corresponds to the CAS01 values of 'CR' or 'CO.' Or the CLM05-03 data element could be populated with a value '08' for deleting a prior claim. This corresponds to the CAS01 value of 'OA.'

Figure 1: Submitting Adjustment Data



Submission of Chart Review Data

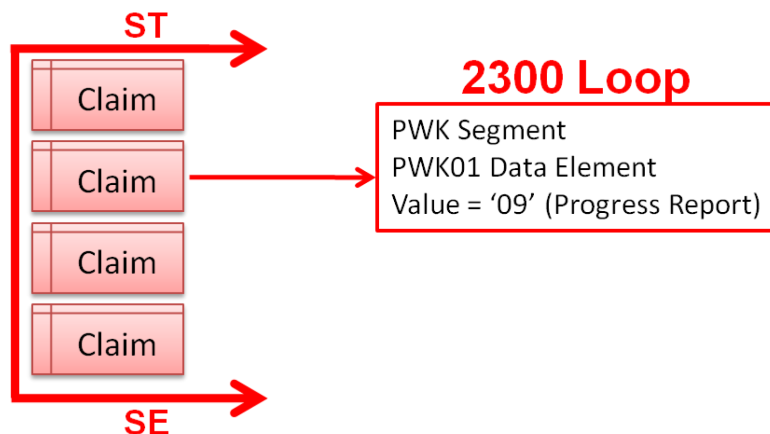
CMS will be collecting chart review data as part of the encounter data process. The PWK segment within the 2300 loop of the 5010 will be used to identify chart review data submissions. Figure 2 displays the chart review submission process in regards to the 5010 population requirements.

- When submitting chart review data the PWK01 data element should be populated with value '09'.
- Currently, the value '09' is defined as progress reports; however, once the companion guide is completed the definition will be changed to chart reviews for the purposes of Encounter Data.

Since chart reviews differ from regular claims submissions and are more limited in data content, flagging Chart Reviews using the PWK segment will allow these claims to process differently thereby allowing editing only on necessary elements as it is processed through the Encounter Data System (EDS).

- As much data as possible should be submitted for chart reviews.
- Chart review data must be linked to the original claim submitted by using the ICN (claim control number) provided on the 277CA report.
  - If Chart Review data is being submitted in addition to data that was previously submitted on an original claim, then the plan should populate the REF segment (REF02 data element) with the ICN obtained from the 277CA report.
  - If chart review data is being submitted and there was no previous claim submitted for the encounter, then the ICN from the 277CA report would not be required.
- CMS is in the process of establishing guidelines and instructions for submission of chart review data.

Figure 2: Chart Review Submission



Population Amount Fields on the 5010

Amount fields on claims submitted by capitated or staff model providers do not always have the accurate pricing amount populated. Participants of the work group were informed that for capitated or staff model arrangements submitting encounter data, '0.00' should be populated in amount fields before submitting to CMS. If pricing information is available on the encounter collected, then it should be submitted as is. Capitated claims submitted with '0.00' in the amount fields will be priced according to 100% of the Medicare allowable amount when processed through the Encounter Data System.

CMS is reviewing amount fields for capitated claims.

Dental and Vision Data

Participants were informed that dental data will not be collected using the 837-D format. MAOs should only submit dental data that are filed on an 837-I and 837-P. In addition, vision data should be submitted on the 837-I and 837-P using the CRC segment within the 2300.

5010 Acknowledgement Reports

Description of the reports that will be returned following claims processing was provided. Participants were asked what additional elements or reports would be beneficial for encounter data submission.

Description of Edits/Reports

For encounter data submission, edits will be applied on three levels during the Front-end processing:

- The TA1 (Translator Edits) performs transmission file X12 interchange level/ISA – IEA edits,
- The 999 (Translator, IG edits) performs X12 functional group/GS - GE validation editing, and
- The 277CA (CEM, CEDI edits) performs claim level/ ST- SE Medicare specific edits, CMS-selected IG edits that validate data content.

Therefore, MA Organizations will receive the following front-end reports from the EDFES (Figure 3 illustrates the types of acknowledgement reports that will be received following encounter data submission and the level of the transmission file they represent):

- A TA1 report will be received when an error occurs within the interchange ISA/IEA functional groups of the transmission file,
- A 999R will be received when an encounter is rejected due to a fatal error occurring at the transaction set or batch level (ST—SE) of the transmission file,
- The 999E will be received if an encounter passes the 999 edits at the transaction set level and is accepted for further processing through the Encounter Data System (EDS), and
- The 277CA will be received for each claim file and will show whether or not a claim was rejected as well as the reason for rejection.

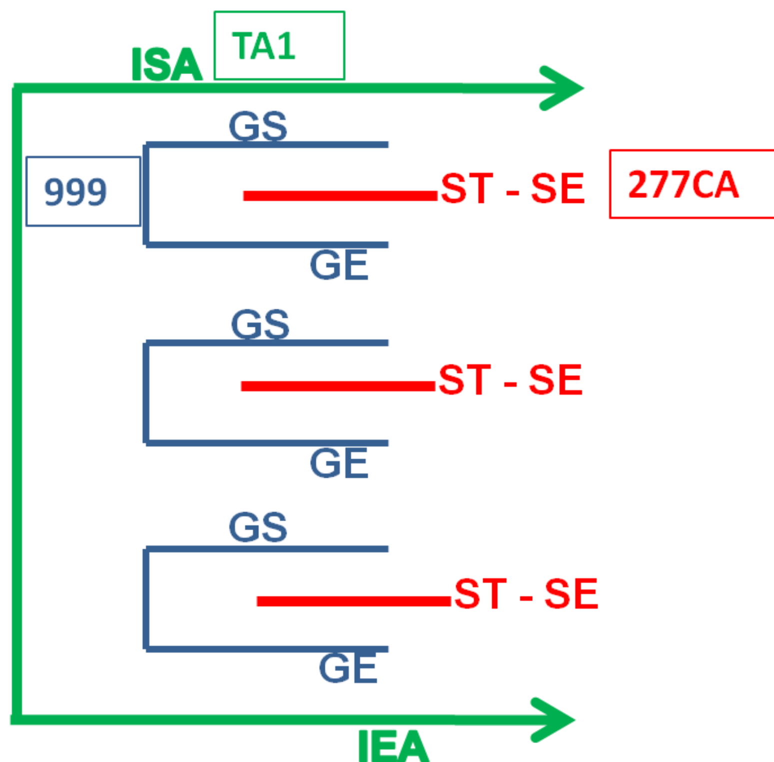
CMS is evaluating the development of additional/customized reports for reconciliation of encounter data, post-implementation. These include:

- Report of Claims Used for Risk Adjustment.
- Report of Final Pricing for Data. This report would display the final pricing associated with an encounter data claim.
- Report of Chart Review Data Submitted. This report would display claims submitted containing Chart Review data and submitted with the PWK segment populated with value '09.'

Participant's Recommendations/Suggestions

- Participants stated that the availability of pricing information on acknowledgement reports would be beneficial.
    - Pricing information could be used to compare how claims are priced following submission to CMS.
- Participants also stated that a report identifying data elements used for risk adjustment and data elements used for encounter data would be helpful.

Figure 3: Transmission File and 5010 Acknowledgement Reports



Additional Questions Addressed Throughout the Work Group

The following are questions asked by participants during the Third Party Submitters Work Group.

Questions asked by Participants

Q1: Should E-Codes be submitted as part of the 25 diagnoses allowed on an institutional claim (837-I) or 15 diagnoses allowed on a professional claim (837-P)?
A1: All information associated with an encounter should be submitted to CMS. If there is additional data including E-codes or V-codes that do not fit on the original claim submitted, they can be submitted as an adjustment using the 'CO' option (add only) in the CAS segment of the 5010.

Q2: When submitting "add only" adjustments using the CAS segment and 'CO' option, is the ICN (claim control number) from the 277CA report required?
A2: Yes, this is the only way to link the adjustment submission to the original claim. When claims are submitted a 277CA report will be returned to the plan identifying which claims were accepted or rejected. An ICN for each claim will be present on the 277CA report and may be different from the ICN submitted by the plan on the original claim. This is the number that should be populated in the REF02 segment when submitting an adjustment.

Q3: Are plans required to submit deletions/adjustments within the timely filing requirement period?

A3: Yes, any adjustments to an original encounter would have to be made within the timely filing requirement deadline. CMS is currently evaluating the timely filing requirements for the purposes of encounter data submission.

Q4: If a claim is rejected at the GS level of transmission file (999R report), would everything within the GS level need to be re-submitted to CMS?
A4: Yes, everything within the GS segment would need to be re-submitted.

Q5: Should Chart Review data be submitted as an adjustment (as an addition to an original claim)?
A5: If a chart review results in an adjustment to the original claim then the plan must submit the chart review data as an adjustment. If the chart review data is used solely for adding diagnoses, it should not be submitted as an adjustment. It should be identified as a chart review (using the PWK01 segment, populated with a value '09' to flag the claim as chart review data) and, if possible, link the chart review data to an original claim.

Q6: How will data collected from other sources in addition to regular claims submissions and Chart Reviews be transmitted to CMS?
A6: This is currently under evaluation. Participants should send examples of alternate data sources for encounter data to eds@ardx.net. The PWK segment should only be used for submitting Chart Review data.

Q7: Will plans be able to see how CMS is pricing claims on the response files returned?
A7: CMS is currently investigating the types of reports that would benefit MA organizations. Any ideas or suggestions for customized encounter data reports should be sent to eds@ardx.net.

Q8: Should diagnoses not related to the risk adjustment model be submitted to CMS?
A8: Yes, all data that is collected should be submitted for encounter data. The goal is to obtain as much data related to an encounter as possible.

Q9: Will edits beyond the standard 837 format fields be turned on?
A9: Yes, CEM module and processing edits (i.e., data validation edits) will be part of the processing system as well as any other edits that may impact pricing.

Q10: Will CMS' filtering logic and editing rules be included in the companion guide?
A10: Edits will not be published in the companion guide. However, plans may review a list of the CEM module edits on the CMS website. Note that some of the edits not needed for pricing encounter data may be turned off.

Q11: Will CMS be utilizing the 277CA report for encounter data?
A11: Yes, plans will receive the 277CA report following each claims submission. The standard HIPAA compliant format for the 277CA is available on the Washington Publishing Company (WPC) website at http://www.wpc-edi.com/content/view/817/1.

Q12: Will the 277CA report include diagnoses that were processed and stored for risk adjustment?
A12: No, the 277CA report only displays which encounters were accepted or rejected following processing through the CEM module edits.

Q13: On the 277CA report, if a claim is accepted can we assume that all diagnoses were accepted for risk adjustment?
A13: No, this only reflects if an encounter was successfully processed through the CEM and/or CEDI edits. Risk adjustment editing and storage would be completed after the claim processes through the CEM module edits.

Q14: Will the pricing rules be published in the implementation guide?
A14: CMS is using the standard Fee-for-Service PRICERs and fee schedules. The PRICER and fee schedule rules are available on the CMS website.

Q15: Today RAPS response reports are produced in one day. What will the new turnaround time be for encounter data response reports?
A15: The turnaround time is expected to be similar to current RAPS.

Q16: If one line on a claim rejects during processing, must the entire claim be resubmitted?
A16: Yes, if the claim rejects it will not be stored for risk adjustment and should be re-submitted as an initial claim submission.

Q17: Will the current rejection codes be used for encounter data?
A17: There will be more rejection codes than the current codes used for RAPS. Error messages and edits will be published on the CMS website.

Q18: Will there still be an MOR, MMR, and TRR reports?
A18: Yes, plans will continue to receive the MOR, MMR, and TRR reports. However, the MOR and MMR reports may be adjusted to reflect encounter data submission.

Q19: If the 277 rejects a claim and the claims data is not stored, should the claim be resubmitted as an adjustment or as an original claim?
A19: The claim should be submitted as the initial claim, not as an adjustment.

Q20: How will the differences between what diagnosis data plans should consider acceptable for risk adjustment and what CMS considers acceptable for risk adjustment be addressed?
A20: There will be no difference in what is acceptable data for risk adjustment between the plans and CMS. Plans are not filtering data prior to submission. CMS will filter data submitted based on established risk adjustment rules. However, there may be differences in payment due to data compliance with risk adjustment rules.

Q21: Will CMS use the 5% duplicate benchmark threshold?
A21: There will be a duplicate benchmark established for encounter data and CMS is evaluating what the benchmark percentage will be. Plans should not submit duplicate encounter data claims.

Q22: During parallel systems processing will there be a comparison between the RAPS and the Encounter Data System (EDS)?
A22: Payment will continue to be driven by RAPS during parallel processing until the Encounter Data System is validated. The RAPS system will remain on until it is determined that the EDS yields accurate

calculation of beneficiary risk scores and there is adequate data for calibration of the risk adjustment model.

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

Based on the information discussed in the Third Party Submitters Work Group held on February 23, 2011, the following recommendations were provided to promote the successful implementation of the collection of encounter data.

Recommendations

- Participants of the work group suggested that CMS publish internal filtering logic for data elements including revenue codes, type of bill, and CPT level codes.
  - For filtering at the CPT level, plans require a definitive list of allowable CPTs for face-to-face visits.
  - Participants would like to understand application of CMS' filtering rules to the Encounter Data Processing System (EDPS) data.
  - Participants would like to verify that the filtering rules of MAOs and the filtering rules of CMS result in the same HCCs stored for risk adjustment.
- Participants requested a list of bill types, revenue codes, and CPT codes acceptable for risk adjustment.
- CMS recommended that participants review and utilize the CEM edits table published on the CMS website to help with internal systems programming.
  - No additional CEM edits will be added to the table currently posted.
  - CMS is currently evaluating the CEM edits to determine if some edits should be turned off based on relevance to the Encounter Data System (EDS).

Action Items and information needed from Participants

The next Encounter Data Work Group for Third Party Submitters will be held on April 20, 2011. The next Industry Update will be held on March 16, 2011.

Work group participants should send the following items to eds@ardx.net:

- Other sources of data collection of importance, in addition to regular claims submissions and chart reviews.
- Examples of internal claims denials which would also cause denial or rejection following submission to the Encounter Data System (EDS).
- Requests for specific data element and/or formatting ideas for customized encounter data transaction reports.