ENCOUNTER DATA SUBMISSION AND PROCESSING GUIDE

Medicare Advantage Program

May 2018 | Version 1.0

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Contents

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PREFACE

The *Encounter Data Submission and Processing Guide* is a technical guide on how to populate and submit encounter data records (EDRs) and chart review records (CRRs) that comply with guidance from the Centers for Medicare & Medicaid Services (CMS). In addition, the guide provides information on how these records are processed in CMS' systems, and provides tips on problem resolution in response to transaction and acknowledgement reports from CMS' systems.

The guide is organized as follows:

Chapter	Chapter Name	Appendices
1	Overview of Requirements and Systems for Risk Adjustment Data	
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3	MA Companion Guide for EDR & CRR Submissions	Appendix 3A. MA Companion Guide: CMS' Supplemental Instructions for EDR and CRR Data Elements Appendix 3B. Crosswalk from Retired Minimum Data Elements List to Appendix 3A MA Companion Guide Appendix 3C. MBI Edits for ED and RAPS Data
4	EDFES Processing	Appendix 4A. TA1 Acknowledgement Report Key Segments Appendix 4B. 999 Acknowledgement Report Key Segments Appendix 4C. 277CA Acknowledgement Report Key Segments Appendix 4D. Deactivated Edits
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6	Prevention and Resolution Tips for ED Submission Errors	

CMS = Centers for Medicare & Medicaid Services; EDR = encounter data record; CRR = chart review record; EDFES = Encounter Data Front-End System; EDPS = Encounter Data Processing System; ED = Encounter Data; RAPS = Risk Adjustment Processing System; FERAS = Front-End Risk Adjustment System; MA = Medicare Advantage; MDE = Minimum Data Elements; MBI = Medicare Beneficiary Identifier

The guide is a compilation into a single document of CMS guidance on risk adjustment data submissions from the following sources:

1. Health Plan Management System (HPMS) Memos
2. User Group slides and Questions and Answers
3. Mailbox Questions and Answers
4. Companion Guides

5. Participants Guides

6. Training materials

7. Bulletins and newsletters

With the release of version 1.0 of the *Encounter Data Submission and Processing Guide*, sources 4 through 7 are now archived on the CSSC Operations website (http://www.csscoperations.com/). This guide will become the key source of guidance for Medicare Advantage Organizations (MAOs) and other submitters of encounter data and RAPS data. New information from sources 1 through 3 will be incorporated into the guide on a regular schedule.

1.1. Topics Not Included in this Guide

The following three topics are **not** included in this guide. Documentation pertaining to these topics can be found on the CSSC Operations website (http://www.csscoperations.com/).

1. **How to connect and interface with front-end systems.** Submitters will still need to refer to the new *Medicare Advantage & Part D Communications Handbook* on how to connect to CMS' front-end systems for encounter data and RAPS data. The Handbook is a consolidation of previous guides for CMS' front-end systems that ingest encounter data, RAPS data, and Prescription Drug Event (PDE) data files: the *EDFES User Guide*, *FERAS User Guide*, and the *PDFS User Guide*. There are also other documents at this location pertaining to the submission of data to CMS.

2. **Filtering and risk score calculation.** See the December 22, 2015, Health Plan Management System (HPMS) memo "Final Encounter Data Diagnosis Filtering Logic" for information on filtering, and for information on risk score calculations, see Chapter 7 on Risk Adjustment, which can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf, and CMS' Advance Notices and Rate Announcements at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

3. **Guidance for Medicare-Medicaid Plans (MMPs)** can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

CHANGE HISTORY

Document version	Date	Description of changes
Version 1.0	May 2018	Initial version of the document

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Chapter 1. Overview of Requirements and Systems for Risk Adjustment Data

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1.1. General Submission Requirements Applicable to Both ED and RAPS Data

The Centers for Medicare & Medicaid Services (CMS) requires organizations offering Medicare Advantage plans and certain other Medicare private health plans to submit risk adjustment data that characterize the context and purpose of each item and service provided to a Medicare enrollee, as described in regulation at 42 CFR Section 422.310. Risk adjustment data refer to data submitted under this regulatory provision; CMS collects this data in two formats:

1. **Encounter data (ED):** data representing each item and service provided to an MA enrollee and submitted in the X12 837 5010 format. (ED is described at Section 422.310(d) as data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data.)
2. **Risk Adjustment Processing System (RAPS) data:** data submitted in an abbreviated format developed by CMS.

This guide sets forth requirements for the submission of encounter data to CMS.

CMS intends for this guide to be all-inclusive and to describe the encounter data submission guidance at the time it was published. However, certain guidance or information may have been inadvertently omitted and changes may occur. There may be revisions and additions in the future.

Note: In this guide, references to the term MA organization or MAO should be read as including other submitting organizations offering Medicare private health plans (cost plans and Programs of All-Inclusive Care for the Elderly (PACE) organizations) and their third-party submitters, unless otherwise indicated.

1.2. Overview of Processing Systems for Encounter Data and RAPS Data

This section provides a brief overview of CMS' systems that process encounter data. The Medicare Advantage Encounter Data System (EDS) was implemented to receive encounter data beginning in 2012 and consists of two main components: the Encounter Data Front-End System (**EDFES**), which receives EDRs and CRRs from MAOs and other submitters, and the Encounter Data Processing System (**EDPS**), which performs detail editing of EDRs and CRRs.

The Risk Adjustment Suite of Systems (RASS) was implemented in 2003 to receive RAPS data from MAOs and other submitters and to calculate risk scores. The RASS consists of three main components: the Front-End Risk Adjustment System (**FERAS**), which receives RAPS data from submitters; the Risk Adjustment Processing System (**RAPS**), which performs detail editing on RAPS data; and the Risk Adjustment System (**RAS**), which executes the risk adjustment models and calculates risk scores for each beneficiary using diagnostic data from both encounter data and RAPS data.

Figure 1.1 presents an overview of these processing systems.

Figure 1.1. Risk Adjustment Processing Overview – CMS' Encounter Data & RASS Data Systems
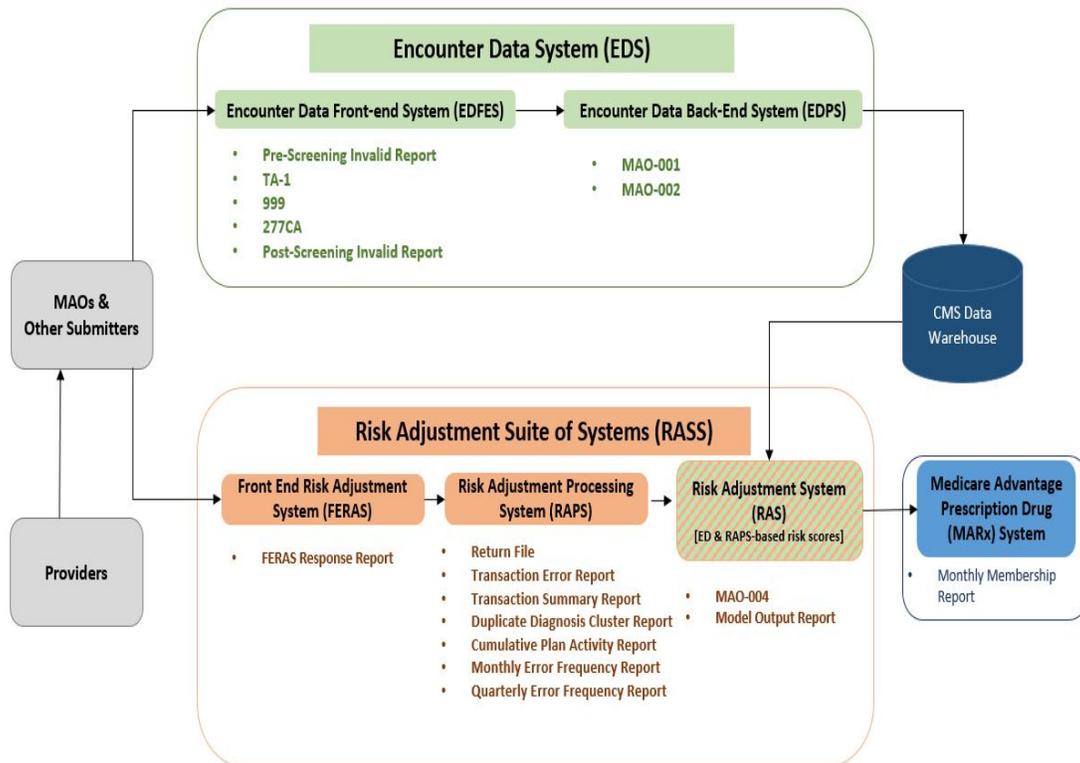
MAO = Medicare Advantage Organization; ED = encounter data.

1.3. Encounter Data Processing Systems

Each EDR must contain the loops, segments, and data elements from the X12 837 5010 format required to report a particular encounter. Most of the requirements for MA ED submission are the national standards established for the X12 837 5010, as set forth in the TR3 implementation guides. In addition, CMS has supplemental guidance for a subset of loops, segments, and data elements for requirements unique to MA EDRs and CRRs. CMS' supplemental requirements are described in Chapter 3, "MA Companion Guide for EDR and CRR Submissions" and in Appendix 3A. "MA Companion Guide: CMS' Supplemental Instructions for EDR & CRR Data Elements"

To process the loops, segments, and data elements necessary for ED submission, CMS' EDS implements several phases of processing for institutional, professional, and Durable Medical Equipment (DME) EDRs and CRRs.

Records passing the final round of edits are sent from the EDFES to the back-end system EDPS for detail processing and pricing.

Finally, as shown in Figure 1.1, data processed through EDPS from EDRs and CRRs are sent to a CMS data warehouse for storage. The subsystem RAS extracts accepted data from EDRs and CRRs from the data warehouse, identifies ("filters") risk adjustment eligible diagnoses for use in calculating encounter data-based risk scores (and also extracts RAPS data to calculate risk scores based on RAPS data; see next section). The RAS generates an MAO-004 report, which lists all diagnoses from accepted EDRs and CRRs, and identifies whether they are eligible for risk adjustment.

Chapters 4 and 5 provide details on all phases of ED processing.

1.4. Use of this Guide

Guidance in this document regarding the submission of EDRs and CRRs for institutional, professional, and DME services and items is not intended to be a stand-alone resource for requirements. To report an encounter in the X12 837 5010 format, MAOs and other submitters must refer to the national Technical Report Type 3 (TR3) guides listed below and must refer to CMS' supplemental guidance discussed in this guide, particularly in Chapter 3, "MA Companion Guide for EDR and CRR Submissions."

- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Institutional (837)
- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Professional (837)

  In addition, this guide must be used in conjunction with the following:

- The Medicare Advantage & Part D Communications Handbook (formerly called the EDFES User Guide), which can be found at http://www.csscoperations.com, has instructions on connecting to and transferring files with EDFES
- CMS' 5010 & CCEM Edits Spreadsheets reflect Medicare's supplemental instructions to the TR3 Guides. The links to the spreadsheets are listed in Table 1.1.

1.5. Resources for Risk Adjustment Data Submission

Table 1.1. Encounter Data and RAPS Data Resources

Resource Name	Resource Description	Resource Link
Type 3 Technical Report	The Washington Publishing Company (WPC) has a grouping of documents that addresses the 837-I and 837-P. It provides rules that MAOs and other entities must support in order to submit encounter data. It is intended to comply with the data standards mandated by the Health Insurance Portability and Accountability Act of 1996.	http://www.wpc-edi.com/
CMS CEM 5010 & CCEM Edits Spreadsheets	CMS provides X12 5010 file format technical edits spreadsheets for the 837-I and 837-P. The edits included in the spreadsheet pertain to requirements in the TR3 guides and also reflect supplemental instructions specific to Medicare.	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims.html
MA & Part D Communications Handbook	Supplemental guide for connecting to the ED & RAPS systems to submit data and receive reports. (The Handbook is a consolidation of the EDFES User Guide, the FERAS User Guide, and the PDFS User Guide.)	http://www.csscoperations.com
ED Submission and Processing Guide	A consolidated technical guide on how to populate and submit encounter data records and RAPS data records that comply with CMS guidance. In addition, the guide provides information on how these records are processed in CMS' systems and what reports submitters receive from CMS, and provides tips on problem resolution in response to system edits and reports.	http://www.csscoperations.com
User Group Slides and Q&As	As an outreach method, CMS conducts User Groups webinars to update the industry on key issues of interest. Presentation slides and post-webinar Questions & Answer documents are maintained on the CSSC Operations website.	http://www.csscoperations.com

CMS = Centers for Medicare & Medicaid Services; CEM = Common Edits and Enhancements Module; CCEM = Combined Common Edits/Enhancements Module; MA = Medicare Advantage; ED = encounter data; RAPS = encounter data; MAO = Medicare Advantage Organization; TR3 = Technical Report Type 3; EDFES = Encounter Data Front-End System; FERAS = Front-End Risk Adjustment System; PDFS = Prescription Drug Front-End System; CSSC = Customer Service and Support Center.

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Chapter 2. Encounter Data Submission Policies

2.1. Definition of an Encounter Data Record

MAOs and other entities are required to submit to CMS "the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee," as described in Chapter 1.

An encounter data record (EDR) is a report from a Medicare Advantage Organization (MAO) or other submitter to CMS about medical items or services a beneficiary received while enrolled in one of the MAO's plans. Thus, all information included on an EDR for an item or service must be related to the specific item or service about which the encounter data record is reporting.

In operational terms, we use the term *encounter data record* or *EDR* to refer to the current Version 5010 of the ASC X12 837 standard format, where X12 refers to healthcare transactions, 837 refers to an electronic format for institutional (837-I) and professional (837-P) encounters, and 5010 refers to the most recent version. CMS requires that MAOs and other entities submit EDRs using the X12 837 5010 format to fulfill the reporting requirements at 42 Code of Federal Regulations 422.310.

CMS expects that MAOs and other entities will submit EDRs for each service or item covered by the plan and provided to an enrollee, regardless of the payment status of the claim (for example, accepted, pending, or denied for payment by MAO). Because an EDR is a record of a service or item covered by the plan and provided to an enrollee while enrolled in that plan, the MAO's final adjudication status of a claim from a provider is not relevant to the MAO's submission of an EDR report to CMS.

Default data. See Chapter 3 regarding the limited set of circumstances where default data may be used for certain fields in the X12 837 5010 EDR.

For additional information on risk adjustment eligibility rules, see Chapter 7 on Risk Adjustment in the Medicare Managed Care Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf.

2.2. Definition of a Chart Review Record

A chart review record (CRR) is distinct from an EDR. Similar to the role of a Risk Adjustment Processing System (RAPS) data record, the role of a CRR is to allow MAOs to add risk adjustment eligible diagnoses or delete diagnosis codes previously reported for plan enrollees, as noted in the April 9, 2018, Health Plan Management System (HPMS) memo "Guidance for Chart Review Record (CRR) Submissions." Accordingly, diagnosis codes added through a CRR must be derived from a face-to-face visit and supported by a medical record, as discussed in Chapter 7 on Risk Adjustment in the Medicare Managed Care Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

Although existing guidance allows MAOs and other submitters to provide default values for Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes on CRRs, default data must be submitted consistent with the CMS filtering logic. In other words, diagnoses that are not risk

adjustment eligible should not be submitted with default HCPCS codes that would cause the diagnoses to be allowed. For example, a diagnosis code resulting from a lab test that would have been excluded from risk adjustment by the professional filtering logic because the CPT/HCPCS code for the lab visit was not included on the list of allowable CPT/HCPCS codes for the service year should not be submitted on a CRR with an allowable default CPT/HCPCS code.

Similarly, data elements such as beneficiary ID, beneficiary name, and the dates of service, should preserve the ability to identify the associated encounter and medical record from which the CRR was created.

Specifically, there are two scenarios when a CRR may be submitted:

1. The encounter generated more diagnosis codes than the maximum number of diagnosis code spaces on an EDR (12 for professional, 25 for institutional). CRRs are intended to allow for the addition of risk adjustment-eligible diagnoses if the additional diagnoses do not fit on the EDR.

2. The MAO performed a medical record review and identified risk adjustment-eligible diagnosis codes that should be added or diagnosis codes that must be deleted for a beneficiary, **and** these diagnosis codes are related to an encounter that has already been reported on an EDR. In other words, if an encounter is identified from a chart review, MAOs should submit the report of that encounter on an EDR, and if necessary, MAOs may use a CRR to report diagnoses that were not included when the EDR was submitted.

MAOs should report items and services on an EDR, whether or not the items and services resulted in the creation of a claim from the provider to the MAO. Items or services provided to an enrollee under the plan must be reported on an EDR. A CRR **should not** be the only record with information about a healthcare item or service provided to a plan enrollee. As stated above, a CRR may be used to add risk adjustment-eligible diagnosis codes or delete diagnosis codes to a previously submitted and accepted EDR.

2.3.   Linked and Unlinked Chart Review Records

There are two ways to submit a CRR in a 5010 format: linked and unlinked. Linking a CRR to a previously accepted EDR allows an MAO to associate risk adjustment-eligible diagnoses with specific items or services provided to a beneficiary. Although we do not edit to ensure the linked CRR matches the encounter it is linked to, identifying information, such as the beneficiary Health Insurance Claim Number or Medicare Beneficiary Identifier (MBI), must match in order to associate the diagnoses on the CRR with the beneficiary who received the associated services.

A **linked CRR** can be submitted to add diagnosis codes to a previously submitted and accepted EDR or CRR, or it can be submitted to delete diagnosis codes from a previously submitted and accepted EDR or CRR. Any CRR submitted to delete diagnosis codes from a previously accepted EDR or CRR **must** be linked.

An **unlinked CRR** may only be submitted to add risk adjustment-eligible diagnosis codes and does not identify a previously submitted EDR that the submitted diagnoses should be associated with.

Note: EDRs cannot be submitted to replace CRRs, and CRRs cannot be submitted to replace EDRs.

Additional guidance specific to linked and unlinked CRRs is provided below.

2.3.1.　　Linked CRRs

Although a single CRR is subject to the 837 5010 limit on the number of diagnosis codes, there is no limit on the number of CRRs that may be linked to an EDR or CRR.

Linked CRR-Add

A Linked CRR-Add contains the Internal Control Number of a previously submitted and accepted EDR or CRR. Further, the value in field CLM05-3 Claim Frequency Type Code (Loop 2300) must **not** equal 7 (replace) or 8 (void/delete), unless the intention is to replace (7) or void (8) another previously accepted CRR.

Linked CRR-Delete

A Linked CRR-Delete contains the Internal Control Number of a previously submitted and accepted EDR or CRR and the patient medical record number equal to 8 in the Loop 2300 segment (REF01 = "EA"/ REF02 = "8"). If an MAO wishes to delete one or more diagnosis codes from a previously accepted EDR or CRR, each diagnosis code to be deleted must be listed on the Linked CRR-Delete record.

For example, if diagnoses AAA and BBB were submitted on the EDR or CRR and are to be deleted, then the CRR-Delete must also be submitted with diagnoses AAA and BBB.

2.3.2.　　Unlinked CRRs

As noted above, Unlinked CRRs can only be used to add risk adjustment-eligible diagnoses. There is no limit to the number of unlinked CRRs that may be submitted. An Unlinked CRR should not contain the Internal Control Number of a previously submitted and accepted EDR or CRR. Unlinked CRRs attempting to delete diagnoses will be rejected with edit code 00805 – Deleted Diagnosis Code Not Allowed.

2.3.3.　　Replacement CRRs

A Replacement CRR-Add (with a Claim Frequency Type Code = 7) can only be used to replace a previously accepted linked or unlinked CRR.

A Replacement CRR-Delete cannot be submitted for a Linked CRR-Delete. Submitters must void the previously accepted Linked CRR-Delete to nullify the delete operation.

2.3.4.　　Void CRRs

A Void CRR-Add or Void CRR-Replacement submitted for a previously accepted Linked CRR-Add, Replacement, or Unlinked CRR will void the previously accepted CRR.

A Void CRR-Delete submitted for a previously accepted Linked CRR-Delete will void the previously accepted Linked CRR-Delete.

2.4. Entities Required to Submit Encounter Data

CMS requires organizations offering the following types of Medicare private health plans to submit encounter data for plan enrollees. Table 2.1 summarizes the requirements by type of organization and plan.

Table 2.1. Entities Required to Submit Encounter Data

Organization Type	Plan Types	Policy Requirements
Medicare Advantage Organizations (MAOs)	1. Coordinated Care Plans (CCPs)* • Health Maintenance Organizations (HMOs) • Local and Regional Preferred Provider Organizations (PPOs) 2. Private Fee-for-Service (PFFS) Plans 3. Medical Savings Account (MSA) Plans	Effective January 2012, submit encounter data records to report all items and services provided under the plan, regardless of the payment status of any claim—that is, regardless of whether a claim is accepted or denied for payment, as long as the item or service was received by the beneficiary. Submit encounter data records only for Medicare services, not for Medicaid services.
Organizations offering cost plans	Section 1876 Cost HMOs/Competitive Medical Plans (CMPs) Section 1833 Health Care Pre-payment Plans (HCPPs)	Effective January 2012, submit encounter data records to report all Medicare-covered items/services for which the plans claim Medicare costs on their CMS Cost Reports.
Program of All-Inclusive Care for the Elderly (PACE) Organizations	PACE plans	Effective January 2013, submit encounter data records for Medicare-covered items and services for which the organization collects claims.
Medicare-Medicaid Plan (MMP) demonstrations	MMPs	MMPs are not discussed in this guide. See the August 10, 2016, Health Plan Management System (HPMS) memos containing MMP requirements regarding encounter data available on the HPMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Annual.html.

* Special Needs Plans (SNPs) are a type of Coordinated Care Plan with enrollment open to beneficiaries with certain statuses. That is, SNPs can be HMOs or PPOs.

2.5.   Terminated Contracts – Submission Requirements

In general, MAOs and cost plans with nonrenewing contracts are required to submit risk adjustment data and attestations to CMS for the nonrenewing contracts. Risk adjustment data include both encounter data and RAPS data.

Generally, CMS annually releases instructions for terminated contracts that ended December 31 of a given calendar year, including deadlines for complying with the guidance. These letters include deadlines for data submission for terminated contracts. HPMS memos regarding terminated contracts can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Annual.html.

2.6.   ICD-9-CM and ICD-10-CM Diagnosis Codes

2.6.1.   Encounters with Dates of Service Spanning the ICD-10 Transition Date

For encounters with dates of service that span the ICD-10 transition date of October 1, 2015, MAOs are required to "split" these EDRs and include ICD-9 codes for dates of service through September 30, 2015, and include ICD-10 codes with "from" and "through" dates of service beginning October 1, 2015, and beyond.

2.6.2.   Use of ICD-9-CM Codes E and V

In ICD-9-CM Coding Guidelines, codes with a letter as first character in the coding sequence indicate a supplemental code. E-codes (External Causes of Injury) are used as supplemental codes to describe the circumstance causing an injury, not the nature of the injury. Therefore, based on ICD-9-CM rules, an E-code cannot be submitted as the primary diagnosis code for any EDR.

ICD-9-CM V-codes (Factors Influencing Health Status and Contact with Health Services) are supplemental codes used for coding services such as receiving a vaccination or having a history of an illness. When an ICD-9-CM V-code is acceptable as a primary diagnosis on an EDR, the EDS also will accept that V-code as a primary diagnosis on a CRR.

2.6.3.   Use of ICD-10-CM Codes V, W, Y, & Z

In ICD-10-CM, all codes have a letter as the first character in the code sequence. The E-code under ICD-10 CM is now used for Endocrine, Nutritional, and Metabolic Diseases. Supplemental codes for External Causes of Injury under ICD-10 CM are classified under codes V through Y (External Causes of Morbidity) and are secondary to codes for injury, poisoning, and certain other consequences of external causes (codes A through T). When an ICD-10-CM Z-code (Factors Influencing Heath Status and Contact with Health Services) is acceptable as a primary diagnosis on an EDR, the EDS also will accept the Z-code as a primary diagnosis for a CRR.

For information on ICD-10 coding, see the CMS website at https://www.cms.gov/Medicare/Coding/ICD10/.

2.7.   Level II HCPCS S-Codes

Level II HCPCS S-codes are primarily used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. Their purpose is to meet the particular needs of the private sector. These codes may also be used by Medicaid programs, but they are not payable by Medicare, as noted in CMS' document "Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures," which is available at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/HCPCSLevelIICodingProcedures7-2011.pdf.

MAOs may use S-codes on EDRs for any service types. The EDFES does not reject S-codes; that is, these codes have been added to a reference table in the CCEM.

2.8.   Health Insurance Prospective Payment System Codes for Home Health and Skilled Nursing Facility EDRs

Health Insurance Prospective Payment System (HIPPS) codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. Home Health Agency (HHA) HIPPS codes are determined based on assessments made using the Outcome and Assessment Information Set (OASIS) data collection tools. Skilled Nursing Facility (SNF) HIPPS codes are determined based on assessments made using the Minimum Data Set data collection tools.

Table 2.2. Summary of HIPPS Codes Submissions on SNF and HHA Encounter Data Records

SNF Encounter Data Records	HHA Encounter Data Records
TOB = 18X or 21	TOB = 32X
Claim From Date of Service (DOS) is equal to or greater than 07/01/2014	Claim From DOS is equal to or greater than 07/01/2014
Revenue Code = 0022	Revenue Code = 0023
Claim From DOS is equal to or greater than 07/01/2014	Claim From DOS is equal to or greater than 07/01/2014
Revenue Code = 0022	Revenue Code = 0023

TOB = Type of Bill.

If MAOs do not have information from the initial assessment, they are encouraged to submit the HIPPS codes from other comprehensive Omnibus Reconciliation Act (OBRA) assessments and/or Prospective Payment System (PPS) assessments (for SNF encounters) or the HIPPS codes from any completed assessment (for HHA encounters). HIPPS codes from SNF or HHA encounters with "from" dates prior to July 1, 2014, may be submitted (that is, they will not be rejected). SNF and HHA encounters that are submitted without a HIPPS code "from" dates July1, 2014, or after will be rejected.

SNF and home health encounters must be submitted in the 837-Institutional format. CMS encourages MAOs and other entities to continue to work with SNF and HHA providers to meet this requirement.

For additional information on HIPPS codes, see the May 23, 2014, HPMS memo "Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System" and the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html.

2.8.1.   Home Health Encounters and HIPPS Codes

For 2014 dates of service beginning on or after July 1, MAOs must submit a HIPPS code on an HHA encounter that comes from the initial Outcome and Assessment Information Set (Start of Care assessment), or OASIS. Applicable HHA Institutional encounters include TOB 32X (Home Health Inpatient Part B Services under a Plan of Treatment). HIPPS codes are not applicable on TOB 034X (for example, the MAO is providing supplemental benefits).

The OASIS assessments are federally mandated for all Medicare and/or Medicaid patients receiving skilled care from HHAs. For 2014 encounter data submissions, CMS does not require MAOs to submit HIPPS codes from any other assessments other than the initial assessment. Nevertheless, we encourage MAOs to submit the HIPPS codes from any completed assessments when available from the providers.

2.8.2.   SNF Encounters and HIPPS Codes

For 2014 dates of service beginning on or after July 1, MAOs must submit a HIPPS code on a SNF encounter that comes from the initial OBRA-required comprehensive assessment (Admission Assessment). Applicable SNF Institutional Inpatient facilities include **non-Critical Access Hospital** facilities with Type of Bills (TOBs), such as18X Hospital Swing Beds and 21X Skilled Nursing Inpatient (Medicare Part A).

SNF encounters with "from" dates July 1, 2014, or after that are submitted without a HIPPS code will be rejected. The OBRA-required tracking records and assessments are federally mandated for all residents of Medicare and/or Medicaid certified SNFs and nursing facilities.

For 2014 encounter data submissions, CMS does not require MAOs to submit HIPPS codes from any other OBRA-required comprehensive or noncomprehensive assessments other than the Admission Assessment. We also do not require submission of HIPPS codes for any scheduled or unscheduled SNF PPS assessments. Nevertheless,

we do encourage MAOs to submit the HIPPS codes both from other OBRA assessments and from PPS assessments when available from the providers. We especially encourage submission of the HIPPS code based on the Discharge Assessment, which is based on an OBRA-required assessment.

When no Admission assessment was completed during the MA-covered stay, MAOs shall follow the following guidance, originally released in a December 4, 2014, HPMS memo "Additional Guidance Regarding Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System":

I. **Stays of more than 14 days.** If the Admission assessment for a stay in the facility was completed prior to the MA-covered portion of the stay, MAOs must submit to CMS a HIPPS code by following the guidance in the order they are listed below.

    A. **Submit the HIPPS code from another assessment completed during the MA-covered portion of the stay.** If the OBRA Admission assessment was completed for the current stay prior to the MA-covered portion of the stay, and another assessment (for example, Quarterly Assessment or any PPS assessment required by the MAO) was completed during the MA-covered portion of the stay, the MAO shall submit the HIPPS code generated from that other assessment on their encounter submissions to CMS.

    B. **Submit the HIPPS code from the most recent assessment that was completed prior to the MA-covered portion of the stay.** If no assessment was completed during the MA-covered portion of the stay from which a HIPPS code could be generated, the MAO shall submit to CMS the HIPPS code from the most recent OBRA or other assessment that was completed prior to the MA-covered portion of the stay (which may be the Admission assessment).[1]

II. **Stays of 14 days or less.** If there was no Admission assessment completed before discharge for a stay of less than 14 days, MAOs must submit a HIPPS code to CMS by following the guidance in the order listed below.

    A. **When to submit the HIPPS code from another assessment from the stay.** If no OBRA Admission assessment was completed for a SNF stay of less than 14 days, the MAO shall submit to CMS the HIPPS code from any other assessment that was completed during the stay that produces a HIPPS code.[2]

    B. **When to submit a default HIPPS code of "AAA00".** MAOs may submit a default HIPPS code for SNF encounter submissions to CMS **only** if (1) the SNF stay was less than 14 days within a spell of illness, (2) the beneficiary has been discharged prior to the completion of the initial OBRA Admission assessment,

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[1] CMS understands that some MAOs require providers to conduct assessments similar to those used under traditional Medicare Part A PPS rules. Providers may submit to MAOs, and MAOs can submit to the EDS, HIPPS codes derived from the same item set and data specifications as those used under the SNF PPS. We note that in such cases, providers must not to submit these assessments through the traditional PPS assessment system.

[2] CMS understands that some MAOs require providers to conduct assessments similar to those used under traditional Medicare Part A PPS rules. Providers may submit to MAOs, and MAOs can submit to the EDS, HIPPS codes derived from the same item set and data specifications as those used under the SNF PPS. We note that in such cases, providers must not to submit these assessments through the traditional PPS assessment system.

and (3) no other assessment was completed during the stay.[3] To submit a default HIPPS code to the Encounter Data System, MAOs should use the default Resource Utilization Group code of "AAA" and Assessment Indicator "00" on encounter data submissions starting with "from" dates of service July 1, 2014.

MAOs may not use this default code in other situations, such as to avoid collecting the proper HIPPS code, or when the MAO's systems are not prepared to submit the HIPPS code to CMS. HIPPS codes are not applicable for SNF institutional outpatient encounters.

2.8.3. HIPPS Codes Not Required for CAH Encounters

When MAOs report encounters from Critical Access Hospitals (CAHs), CMS does not require the inclusion of HIPPS codes. Specifically, encounters for CAH swing bed services (using the code TOB 18X Hospital Swing Bed) are exempt from our HIPPS Code submission requirement. For additional information on CAHs, see the CMS website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs.html.

2.9. Medicaid Services

MAOs or other organizations that adjudicate Medicaid claims for their members may not submit Medicaid claims to CMS' encounter data systems. There is one exception: demonstration plans called Medicare-Medicaid Plans (MMPs) can submit Medicaid claims to the EDFES. MMPs are not addressed in this guide. For information on MMPs submission guidance, please refer to the CMS website https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

2.10. ED Monitoring and Compliance Policy

As required under sections 422.310(b) and (d), MAOs must submit risk adjustment data that characterize the context and purpose of each item and service provided to a Medicare enrollee, and must also conform to CMS' requirements for submitting these data and to all relevant national standards. In addition, at section 422.504(l), CMS requires MAOs to certify to the accuracy, completeness, and truthfulness of their encounter data (based on best knowledge, information, and belief).

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[3] Per the Assessment Management Requirements and Tips for Comprehensive Assessments (pp. 2–17, Resident Assessment Instrument Manual): "If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required." Federal statute and regulations require that SNFs and Nursing Facilities (NFs) promptly assess residents upon admission but no later than the 14th calendar day of the resident's admission (admission date + 13 calendar days).

As noted in the calendar year 2018 Call Letter section "CMS Monitoring and Compliance Activities Regarding Encounter Data," CMS stated that we expect that MAOs are conducting self-assessments regarding the accuracy and completeness of their encounter data submissions for each contract they have with CMS, and that each year MAOs apply the findings from their self-assessments to improve the accuracy and completeness of their encounter data submissions. In this Monitoring and Compliance section, CMS established a compliance framework, including identification of initial metrics for assessing completeness and accuracy, which can be found on pages 130 to 135 in the calendar year 2018 Call Letter, in Attachment VIII in the Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information, on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf.

In addition, CMS developed and distributes quarterly ED Report Cards for each contract, to report the status of encounter data submissions as the information relates to CMS' established benchmarks and submission requirements. CMS encourages MAOs and other entities to use the data provided in the Report Cards to self-assess and improve submissions as necessary.

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Chapter 3. MA Companion Guide for EDR and CRR Submissions

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3.1.   Contents of the MA Companion Guide

Typically, companion guides can contain two types of information: (1) instructions for electronic communications with the entity publishing the guide (communications or connectivity instructions) and (2) supplemental instructions for creating transactions with the publishing entity (that comply with standards in the associated Technical Report Type 3 [TR3] guides).

Regarding the first type of information, the Centers for Medicare & Medicaid Services (CMS) instructions for electronic communications are in the *MA & Part D Communications Handbook*, found on www.csscoperations.com.

Regarding the second type of information, this chapter and Appendix 3A include CMS' instructions on requirements unique to Medicare Advantage (MA) plan submissions of encounter data reports in the X12 837 5010 format, which supplement the TR3 guides.

3.1.1.   CMS' Supplemental Instructions

To reflect circumstances unique to Medicare health plans, CMS identified a subset of data elements (and their loop and segment locations in the 837 5010 format) for which CMS has specific instructions—for example, what values to use in certain data elements to submit encounter data records (EDRs) and chart review records (CRRs) for services and items received from capitated providers.

Previously, CMS provided three Companion Guides with instructions specific to the MA program, for institutional, professional, and DME encounter data submissions (found on the www.csscoperations.com website, and last updated in July 2016). For example, CMS provided instructions on how to submit EDRs and CRRs for services covered under capitated payment arrangements.

Going forward, CMS has streamlined the three Companion Guides for the MA program into a single file for institutional, professional, and DME encounter data records: see Appendix 3A, "MA Companion Guide: CMS' Supplemental Instructions for EDR & CRR Data Elements" for this consolidated listing of instructions specific to populating institutional, professional, and DME EDRs and CRRs for the MA program. Also see Chapter 3 for additional discussion of topics regarding EDR and CRR submissions in the X12 837 5010 format.

3.1.2.   Retiring the Minimum Data Element List

In addition to the three Companion Guides, previously CMS also released a Minimum Data Elements list to assist submitters, which offered a selected combination of TR3 guide instructions and CMS instructions supplemental to the TR3 guides.

With the release of this guide, CMS has retired the Minimum Data Element list. See Appendix 3B for a crosswalk from the retired Minimum Data Element List to Appendix 3A, the consolidated MA Companion Guide.

3.2.   X12N 837 5010 Format

CMS requires that MAOs and other submitters use the X12 837 5010 format for submitting EDRs and CRRs.

The acronym ANSI ASC X12N refers to a national set of inter-industry standards for electronic data interchange of insurance transactions. The X12N insurance standards include the transaction set *837, Health Care Claim,* which is used for billing and encounter transactions from providers to payers, and for reporting health care services.

- Version 5010 of the 837 transaction set establishes the 837-I (institutional), 837-P (professional), and 837-D (dental). CMS requires the 837-I and 837-P for MA encounter data transactions for institutional and professional encounters.

- DME transactions are provided in the 837-P format.

- As noted in the preface to this guide, the national implementation guides (IGs) for the X12N 5010 837-I and X12N 5010 837-P are known as the **TR3-I and TR3-P,** respectively, shorthand for *Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Institutional (837)* and *Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Professional (837)*.

- Version 5010 of the X12N 837 was implemented in 2006, and was labeled *5010 X223* and *5010 X222* for institutional and professional standards, respectively.

- **Version identifier.** In subsequent years, the Accredited Standards Committee (ASC) X12 made changes to the TR3 implementation guidance for the X12N 837 transaction sets. To identify the current versions, alphanumeric characters have been added. Currently, the TR3-I is labeled 5010 X223A2 and the TR3-P is labeled 5010 X222A1. (These identifiers are populated in the GS Functional Group field GS08, Version/Release, Industry Identifier Code.)

3.2.1.   Loops, Segments, and Data Elements

The X12 standard is organized as follows: loops consist of ordered segments (that is, a set of ordered segments that repeat); segments consist of data elements; and the data element is the smallest named unit of information in the ASC X12 standard. Data elements and segments are separated by delimiters (for example, an asterisk and a tilde). Each data element, segment, and loop have unique identifiers, described in the TR3-I and TR3-P guides.

In X12, the same segment can be used for different purposes. Thus, the meaning of data in a segment can change based on the loop in which a segment is located. For example, the NM1 segment is used for names; the names populated in the data elements of the NM1 segment depend on the loop: for example, Loop 2010AA Billing Provider Name**,** Loop 2010BA Subscriber Name, or Loop 2010BB Payer Name.

Finally, certain X12 segments are paired to form an X12 enveloping structure containing nested segments, as depicted in Figures 3.1 and 3.2. The levels of structure are the Interchange Control envelope (segments ISA, IEA,),

the Functional Group segments (GS, GE), and the Transaction Set segments (ST, SE). The ST/SE Transaction Set is the smallest meaningful set of information exchanged between trading partners, and contains the detail segments that have information on the claim, billing provider, subscriber, and patient.

**Figure 3.1. X12 837 Standard Format, Version 5010**
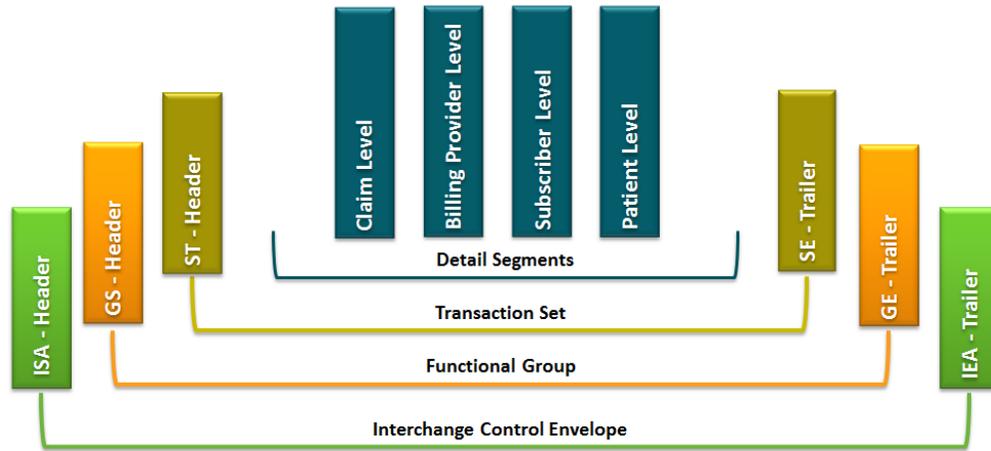
Figure 3.2. Example of X12 837 5010 Submission Format
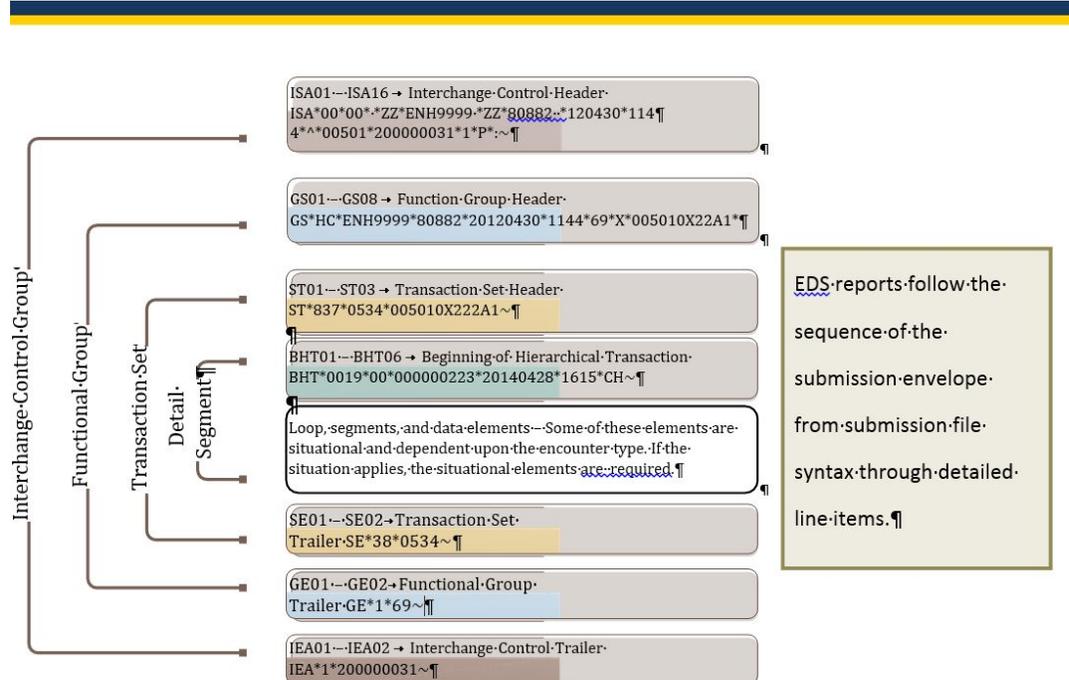
Note: The file structure overview populated in this figure is an example and does not provide full details for submission of all situational loops, segments, and data elements in the 837-P or 837-I.

3.2.2. How to Populate an EDR or CRR

When populating fields on EDRs or CRRs for submission to CMS, MAOs and other submitters should base their logic on the highest level of specificity.

- First, consult the WPC/TR3 guides.

- Second, consult the CMS 5010 edits spreadsheets.

- Third, consult this guide.

If broader options are expressed in the WPC/TR3 or the CMS 5010 edits spreadsheets than the options identified in this guide, MAOs and other entities must use the rules identified in this guide.

Finally, MAOs and other submitters must use the most current national standard code lists applicable to the X12 837 5010 transaction. The TR3 guides and code lists are accessible through the Washington Publishing Company (WPC) homepage at http://www.wpc-edi.com. The applicable code lists include, but are not limited to, the following:

- Claim Adjustment Reason Code (CARC)

- Claim Status Category Codes (CSCC)

- Claim Status Codes (CSC)

Table 3.1 lists the control segments and data loops required by the TR3 guides and additional situational loops listed in the MA Companion Guide (Appendix 3A) for example ambulance Loops 2310E and 2310F.

Table 3.1. Loops and Segments Required by the TR3 Guides and MA Companion Guide

Loop or Segment ID	Loop or Segment Name
Control Segments	
ISA	INTERCHANGE CONTROL HEADER
IEA	INTERCHANGE CONTROL TRAILER
GS	FUNCTIONAL GROUP HEADER
GE	FUNCTIONAL GROUP TRAILER
ST	TRANSACTION SET HEADER
SE	TRANSACTION TRAILER
Data Loops	
BHT	BEGIN HIERARCHICAL TRANSACTION
Loop 1000A	SUBMITTER NAME
Loop 1000B	RECEIVER NAME
Loop 2000A	BILLING PROVIDER HIERARCHICAL LEVEL
Loop 2010AA	BILLING PROVIDER NAME
Loop 2000B	SUBSCRIBER HIERARCHICAL LEVEL
Loop 2010BA	SUBSCRIBER NAME
Loop 2010BB	PAYER NAME
Loop 2300	CLAIM INFORMATION
Loop 2310E**	AMBULANCE PICK-UP LOCATION
Loop 2310F**	AMBULANCE DROP-OFF LOCATION
Loop 2320	OTHER SUBSCRIBER INFORMATION
Loop 2330A	OTHER SUBSCRIBER NAME
Loop 2330B	OTHER PAYER NAME
Loop 2400	SERVICE LINE
Loop 2430	LINE ADJUDICATION INFORMATION

** Professional EDRs only.

3.3.   New Medicare Card Project – the Medicare Beneficiary Identifier

The Medicare Access and CHIP Reauthorization Act (MACRA; CHIP is the Children's Health Insurance Program)) of 2015 (PL 114-10 s.501) included a mandate to remove the current Health Insurance Claim number (HICN) from Medicare cards by April 2019. Beginning in April 2018, a new Medicare beneficiary identifier (MBI) will replace the current Social Security number-based HICN. The new MBI numbers will be assigned to all Medicare recipients. CMS began the process of mailing new Medicare cards to beneficiaries in April 2018.

Information related to the new Medicare card project, previously known as the Social Security Number Removal Initiative (SSNRI), is available through the resources below:

- **Health Plan Management System (HPMS) memos:** Search HPMS using key words: SSNRI, MBI, and software releases

- **New Medicare cards homepage:** https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

3.3.1.   General MBI Information

As discussed in the December 22, 2017, HPMS memo "Updates to the Encounter Data System and Risk Adjustment Suite of Systems to Accommodate the New Medicare Card Project," CMS began issuing new Medicare cards with the new MBIs to Medicare beneficiaries on April 1, 2018, and will continue through April 2019.

- Generally, CMS systems will allow for a transition period from April 1, 2018, to December 31, 2019, during which MAOs can submit to CMS either the beneficiary's HICN or MBI in the same field that is currently used to submit the beneficiary's HICN.

- The EDS and the Risk Adjustment Suite of Systems (RASS) will allow for a longer transition period; MAOs can continue to include either the HICN or the MBI on EDRs and CRRs submitted to the EDS, as well as RAPS data records submitted to the RASS past the end of the broader CMS new Medicare card project transition period of December 31, 2019. We will determine and communicate the end of the MBI transitions at a later date.

- **For RAPS data submissions,** for the time being, MAOs must submit deleted items using the beneficiary identifier that was used on the original add submission. This includes instances in which MAOs submitted deletes that fell within the six-year overpayment look-back period and that were submitted using an HICN or Railroad Retirement Board (RRB) number at the time of original submission.

- **For encounter data submissions,** MAOs can submit both EDRs and CRRs, with either the MBI or HICN.

- All EDS and RASS transaction reports reflect the beneficiary identifier submitted to CMS by the MAO, starting April 1, 2018.

- When the beneficiary identifier field on transaction reports refers to the HICN, the field will be renamed from specific reference to the HICN to the use of a broader term, such as beneficiary identifier.

- There will be no change to file formats as the beneficiary identifier will be reflected in the same field currently used for HICNs.

3.3.2. Specific MBI-related Changes to Transaction Reports

This subsection mentions several reports that CMS sends to MAOs and other submitters for encounter data and RAPS data. Chapter 5 provides information on the MAO-001 report. . Also see Appendix 3C for information on MBI edits for ED and RAPS Data.

As described earlier, the file formats and beneficiary identifier field length and position will not change on transaction reports. However, the field name containing the beneficiary identifier will change and the timing of this change for each report will differ slightly for the reports as described next.

1. MAO-001 Reports

- As of April 1, 2018, the field currently labeled "Health Insurance Claim Number" (position 51-70) was renamed to "Beneficiary Identifier."
- As of April 1, 2018, the MAO-001 will return either the HICN or MBI, whichever was submitted by the MAO.

2. MAO-004 Reports

- As of April 1, 2018, the field currently labeled "Beneficiary HICN field" (position 17-28) was renamed to "Beneficiary Identifier."
- The MAO-004 report was updated to include the MBI, if received on a record, in the "Beneficiary Identifier" field.

3.4. Submitter Options for Populating Certain Data Elements

The EDR is a report from the MAO about medical items or services a beneficiary received while enrolled in one of the MAO's plans. Because the MAO is a report to CMS about items or services received, and not a provider bill, *examples of MAO options* follow for populating certain data fields in the EDR (as described in the October 30, 2017, HPMS memo "Guidance for Encounter Data Submission," which is available at www.cssoperations.com.

3.4.1. Default Data Reason Codes

For a limited set of situations, CMS had developed Default Data Reason Codes or DDRCs that should be populated in Loop 2300, NTE01='ADD', NTE02, to indicate the specific circumstance for populating certain data fields when an MAO did not have the required information from the provider or medical record. Table 3.2 lists the seven situations for which DDRCs were developed.

Loop 2300, NTE02 allows for a maximum of 80 characters and one iteration, which limits the submission of default data to one message per encounter.

To populate multiple default data messages in the NTE02 field, CMS will use a three-digit DDRC, which will map to the full default data message in the EDS.

MAOs and other entities may submit multiple DDRCs with the appropriate three-digit DDRC. Multiple DDRCs will be populated in a stringed sequence with no spaces or separators between each DDRC (that is, 036040048). Table 3.2 provides the specific circumstance and the CMS-defined DDRC.

Table 3.2. Default Data

Default Data	Default Data Message (NTE02)	DDRC
Rejected Line Extraction	REJECTED LINES CLAIM CHANGE DUE TO REJECTED LINE EXTRACTION	036
Medicaid Service Line Extraction	MEDICAID CLAIM CHANGE DUE TO MEDICAID SERVICE LINE EXTRACTION	040
EDS Acceptable Anesthesia Modifier	MODIFIER CLAIM CHANGE DUE TO EDS ACCEPTABLE ANESTHESIA MODIFIER	044
Default NPI for atypical providers	NO NPI ON PROVIDER CLAIM	048
Default EIN for atypical providers	NO EIN ON PROVIDER CLAIM	052
Chart Review Default Procedure Codes	DEFAULT PROCEDURE CODES INCLUDED IN CHART REVIEW	056
True COB Default Adjudication Date	DEFAULT TRUE COB PAYMENT ADJUDICATION DATE	060

3.4.2. Other Circumstances

Submitters should follow the guidance given by CMS, *with no DDRC needed,* in the specific circumstances when a plan does not know the following:

- The facility admission date on a professional claim for a service performed in an inpatient setting
- Whether the provider is a hospice employee on a professional claim for a service performed in a hospice setting
- The provider's address on a paper claim or a member reimbursement claim
- The service unit counts on an institutional claim due the payment arrangement between the MAO and the provider

Note: CMS guidance uses the term *default data* when discussing circumstances under which MAOs populate data fields on an EDR or CRR with a constant value, a value allowed by CMS guidance (for example, suggested procedural code modifiers for preventing duplicate line-level edits), or with data from a source other than a claim

from a provider when certain situations apply. Here we clarify that CMS is not providing default data values for populating data fields. Rather, MAOs and other submitters are responsible for identifying appropriate, accurate data for populating EDRs and CRRs, in accordance with the guidance stated in this guide.

3.4.3. Demographic Data

Populate the EDR with demographic information related to age, name, and sex using data that the MAO knows to be correct, instead of submitting to CMS incorrect data that a provider submitted to the MAO on a claim for payment.

3.4.4. Diagnoses

Report to CMS the data the MAO knows to be correct relative to providing that specific item or health care service being reported. Per CMS guidance (including Chapter 2 of this guide), diagnoses reported to CMS for risk adjustment must meet risk-adjustment rules, including that the diagnoses must be supported by the medical record. As with RAPS data, if an MAO determines that diagnoses have to be deleted because they are not supported by the medical record, there are a number of ways to delete diagnoses from the EDS, including submitting a CRR – Delete record, a replacement EDR with the unsupported diagnoses removed, or voiding the EDR and resubmitting.

Note: The diagnoses on a CRR can repeat diagnoses already submitted on a previously accepted EDR or CRR. However, as CMS suggests in the June 22, 2017, HPMS memo "Best Practices for Encounter Data Submission," CRRs should be submitted only if there are new diagnoses or changes in diagnosis codes to ensure that duplicate diagnosis information is not submitted, which reduces administrative burden for submitters and CMS.

3.4.5. Ambulatory Surgery Center Bypass

There is an additional bypass condition for ambulatory surgery center fee schedule EDRs: populate the field "Multiple Procedure Discount Indicator" with a value of "1" in order to bypass the duplicate line edit.

3.4.6. Line-level Duplicates Bypass

When the MAO has determined that the lines represent distinct items or services, but will be identified as duplicates by the CMS line-level duplicate logic, MAOs may report data on the EDR that were not submitted by a provider. MAOs can use the CMS-specified procedure code modifiers so that the line-level duplicate logic is bypassed. See Chapter 6, section on *Edit 98325*, for details on the bypass logic for line-level duplicates. Another option for preventing a duplicate line rejection is to include the actual payment amount on each line (assuming the actual payment amount for each line differs.

Note: the bypass logic described here is *not intended to be instructions for how providers should bill the MAO.*

When none of the data elements included in the EDPS duplicate logic check are changing, but other data elements on a line (edit 98325) or record (edit 98300) may have changed, CMS recommends submitting the subsequent EDR as a replacement or voiding the previously submitted and accepted EDR and resubmitting a new original record to prevent rejection for duplicate submission.

3.4.7.   More than One EDR for a Single Provider Claim

If the provider has submitted only one claim to the MAO but, for example, the provider then had to submit additional pre-authorization information, but the claim is still considered an original, or the MAO has to adjust the EDR that it has sent to CMS but the provider did not submit a new claim, the MAO may adjust its EDR for this encounter, as it is a report to CMS regarding a specific item or service received by the enrollee. We recognize that plans might want to track their data sources for populating an EDR for data integrity purposes; in such cases, CMS recommends as a best practice that MAOs track when and why provider-supplied information is modified for submission to the EDS. See Chapter 6 regarding Edit 98300—"Exact Inpatient Duplicate"—for additional information.

3.5.   National Provider Identifier and Employer Identification Number Guidance

CMS requires MAOs to follow the TR3 guides and use valid National Provider Identifiers (NPIs) and Employer Identification Numbers (EINs) for submission of EDRs. There may be limited circumstances in which MAOs and other entities are unable to obtain the provider's NPI information, as summarized in Table 3.3 and discussed in subsequent sections.

Table 3.3. Summary of Default NPI Guidance

NPI Scenario	NPI Solution
No NPI on Member Reimbursement Claim	• Look up the NPI in National Plan and Provider Enumeration System (NPPES) • Otherwise, use the default NPI for the applicable record type
Member Received Medical Services Out of the Country	• Use default NPI for the applicable record type • CMS expects low volume
No Referring Physician on DME Encounter	• Do not use default NPI • Use another NPI related to the DME encounter
No Billing Provider	• Do not use Default NPI • Use NPI of another provider associated with the encounter
Internal Billing Provider ID Maps to Multiple NPIs	• Do not use default NPI • Use any valid and current NPI associated with the internal provider ID# for the billing provider

3.5.1. Atypical Providers

Providers who are not considered health care providers and do not provide health care services are referred to as atypical service providers. An atypical provider is defined as an individual or business that bills for services rendered but does not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (for example, providers of non-emergency transportation, Meals on Wheels, and personal care services).

MAOs and other submitters should follow the default NPI guidance in Section 3.5.2 when the provider is an atypical provider.

3.5.2. Default NPI Guidance

CMS released clarifying guidance on populating NPI fields in the December 21, 2017, HPMS memo "Encounter Data Record Submissions—NPI Submission Guidance—Frequently Asked Questions (FAQ)," also provided here.

Note: CMS expects the number of EDRs with default NPIs for providers who would otherwise have an NPI (that is, providers that are *not* atypical providers) to be a very small percentage of an MAO's total EDR submissions. CMS is monitoring the level of default NPI use.

Foreign providers. For an EDR reporting a service or item an enrollee received while the enrollee was outside of the United States, the MAO should use the default NPI applicable to the record type in question from Table 3.2 (that is, professional, institutional, or DME).

Question: Should a plan report encounters to CMS for which it reimbursed an enrollee for medical services received that the enrollee has paid for out of pocket? If these encounters should be reported, what should we enter for the NPI because enrollee reimbursement claims do not have the provider NPI?

Response: MAOs and other entities are required to submit an EDR for all items and services received by a beneficiary under the contract, even when the beneficiary paid for the service directly. In the specific instance when the MAO submits an EDR for an encounter for which the beneficiary paid out of pocket, and the claim submitted to the MAO for reimbursement is not populated with a provider NPI, the MAO, in creating the EDR, should populate fields requiring NPIs with actual NPIs, if available. Submitters can look up NPIs on the National Plan and Provider Enumeration System at https://www.cms.gov/Regulations-and- Guidance/Administrative-Simplification/NationalProvIdentStand/DataDissemination.html.

Otherwise, the MAO should use the default NPI applicable to the record type in question from Table 3.4 to populate fields requiring NPIs on EDRs.

Table 3.4. Default NPI Values, by Service Type

System	Payer ID	Default NPI Value
Institutional	80881	1999999976
Professional	80882	1999999984
DME	80887	1999999992

Question: If the Referring Physician NPI is not available for a DME encounter, can a plan substitute the default NPI or the enrollee's primary care provider's NPI, if available, to resolve these errors?

Response: When the Referring Physician NPI is not available for populating the DME encounter, the MAO *cannot use* the default NPI on the EDR reporting this encounter. The MAO should use another NPI related to the DME encounter.

Question: When an EDR is being built from an electronic medical record (EMR), can the MAO substitute the Servicing Provider ID in place of the Billing Provider ID to complete the requirements around billing provider ID for the 837 record? If we cannot substitute, what is the recommended approach for us to use to submit EMR/EHR data on an 837?

Response: When there is no Billing Provider NPI available for a service or item being reported, such as when the data for an encounter are derived from an EMR, or when there is no encounter-specific bill, as with services provided by providers under capitated payment arrangements with the MAO, the MAO can use the NPI of another provider associated with the encounter in place of the Billing Provider NPI.

Question: When mapping an internal provider identification number from a claim to the NPI reference data in the MAO's system to populate the Billing Provider NPI data field for an EDR, we often find that an internal provider identification number maps to more than one NPI. Which NPI should we use to populate the Billing Provider NPI data field on an EDR?

Response: CMS guidelines related to NPIs do not specify which NPI to use to populate the EDR for providers having multiple NPIs. Accordingly, when an MAO's internal provider identification number maps to multiple valid and current NPIs, the MAO can populate the Billing Provider NPI field with any valid and current NPI that is associated with the internal provider identification number for the billing provider.

Also, when a submitter is using a default NPI, per our guidance, which is *not* due to the provider being atypical, the submitter should *not* populate the NTE02 with a Default Data Reason Code (DDRC). The use of the 048 DDRC is specifically associated with the regulatory definition of an atypical provider.

3.5.3.   Default EINs for Atypical Providers

When a default NPI is used, CMS strongly encourages MAOs and other entities to provide a valid EIN.

A default EIN should be submitted to the EDS only when the provider is considered atypical. MAOs and other entities are required to populate the provider's actual EIN of the provider when they submit a default NPI.

For atypical provider submissions, to submit a default EIN, MAOs and other entities should populate Loop 2010BB, REF01=EI, REF02=199999998 only if the provider's actual EIN is not available.

3.6. PWK Segment for Special Considerations

For encounter data purposes, two fields from Loop 2300, PWK segment (Claim Supplement Information) PWK01 and PWK02 must be populated under the following situations: CRRs, paper claim submissions, version 4010 submissions, and default ambulance zip codes. Table 3.5 presents CMS' instructions on the values to use in these two fields for each of these situations. This information is also available in Appendix 3.

Table 3.5 CMS' Instructions for Uses of Loop 2300 PWK Segment

Situation	PWK01 Value	PWK02 Value
Chart review records (CRRs)	09	AA
Paper claims	OZ	AA
Ambulance ZIP code default	AM	AA
4010 format submission	PY	AA

Paper claims. Whether submitted by providers or beneficiaries, paper claims must be converted to electronic EDRs in the X12 837 format before submission to CMS. For example, some MAOs that have capitated payment arrangements with providers do not require providers to submit claims for payment, instead allowing an image or other representation of the item or service provided. MAOs and other submitters must convert these paper claims to electronic EDRs.

See the Resources tab on www.csscoperations.com regarding the PC-ACE PRO32 software, which converts paper claims to an electronic format.

Diagnoses from paper claim-generated EDRs can be eligible for risk adjustment.

3.7. Items and Services Covered under Capitated Arrangements

CMS requires that submitters identify the EDRs associated with services covered under capitated payment arrangements. MAOs can also elect to identify services offered under staff model arrangements using the flags for capitated encounters. The following rules apply to submitted EDRs for these encounters for all service types.

Rule 1. Procedure codes. EDRs reporting encounters with capitated and staff model arrangements must populate and submit valid Current Procedural Terminology (CPT)/ Health Care Procedural Coding System (HCPCS) codes on the X12 837 5010.

Rule 2. Capitated institutional EDRs

- **All lines capitated.** If all services for an institutional encounter are paid on a capitated basis, then the EDR should be submitted with the field CN101 *at the header level* (LOOP 2300) set to "05."

- **Mix of capitated and noncapitated lines.** If an institutional encounter contains services covered under both capitated and noncapitated arrangements, the MAO should populate the EDR as follows:
  - LOOP 2300: leave blank the CN101 at the header level, that is, populate with " "
  - For capitated lines, under LOOP 2430: populate the CAS segment at the line level with a Group Reason Code "24" to indicate a capitated service line
  - For noncapitated service lines, populate the Group Reason Code using the codes submitted by the provider.

Rule 3. Capitated professional EDRs

- **All lines capitated.** If all services for a professional encounter are paid on a capitated basis, then the EDR should be submitted with the field CN101 *at the header level* (LOOP 2300) set to "05."

- **Mix of capitated and non-capitated lines.** If a professional encounter contains services covered under both capitated and noncapitated arrangements, the MAO should populate the capitated service lines as follows:
  - Loop 2300: leave blank the CN101 at the header level, that is, populated with " "
  - Loop 2400: populate CN101 (Contract Type Code) with the value of "05" for each capitated service line

Rule 4. Payment fields. Due to the capitated payment structure, amount fields on claims submitted by capitated providers to MAOs do not always have per-service pricing information populated. For EDRs for items or services covered under capitated (or staff model) arrangements, MAOs and other entities can populate payment fields (at a minimum, those required by CMS' Minimum Data Elements listed in Appendix 3) with '0.00' if and *only* if no amount information is available. If billed and/or payment information is available, it should be submitted as is.

3.8.   Appropriate Procedure Codes on CRRs

As discussed in Chapter 2, Section 2.2, existing guidance allows MAOs and other submitters to populate CPT/HCPCS fields with codes that best reflect what happened in the encounters. However, in populating CPT/HCPCS fields on CRRs, submitters must be consistent with the CMS filtering logic. In other words, diagnoses that are disallowed for risk adjustment should *not* be submitted with HCPCS codes that would cause these diagnoses to be allowed for payment purposes. For example, a diagnosis code resulting from a lab test that the professional filtering logic would have excluded, because the CPT/HCPCS code for the lab visit was not included on the list of allowable CPT/HCPC codes for the service year, <u>*should not*</u> be submitted on a CRR with an allowable default CPT/HCPCS code. Similarly, other data elements, such as the dates of service, should preserve the integrity of the associated encounter and medical record from which the CRR was created.

Note: CMS guidance has used the term *default data* when discussing CPT/HCPCS codes on CRRs. Here, we clarify that CMS does not provide default data values for populating CPT/HCPCS codes on CRRs. Rather, MAOs and other submitters are responsible for identifying appropriate CPS/HCPCS codes for populating their CRRs, in accordance with the guidance stated in this guide.

3.9. Populating "Other Payer Paid" Fields

For the submission and processing of encounter data, CMS implements a payer-to-payer model of benefit coordination within the X12 837 5010 (instead of the provider-to-payer-to-provider-to-secondary payer model of benefit coordination). Under the payer-to-payer approach, CMS is treated as the secondary destination payer, and MAOs and other submitters must submit all payments they made for an encounter in the "Other Payer Paid" fields of the EDR. Specifically, MAOs need to populate:

Loop ID-2320 AMT02 = Other Payer Paid header

Loop ID-2430 SVD02 = Other Payer Paid line

For capitated or staff model arrangements submitting encounter data, MAOs and other entities must submit zero dollars (0.00) *only if* billed and/or payment amount information is not available. If billed and/or payment information is available, it should be submitted. EDPS will accept a zero dollar amount for the billed and paid amounts for capitated encounter submissions (Loop 2300 CN101 = '05').

3.10. DME Guidance

Currently, two types of DME submissions are acceptable for encounter data submissions:

1. DME services that are incident to a provider
2. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier services

A provider of service may include an institution or physician. A supplier is an entity other than a provider that furnishes health care services under Medicare. A provider of supplies that enrolls as a DMEPOS supplier is considered a DMEPOS supplier for encounter data submission. DME incident and DMEPOS supplier EDRs will be validated according to the NPI and Payer ID only.

3.10.1. DME Services Incident to Submissions

If the DME service is incident to a physician or institutional service, it should be submitted on the 837-P or 837-I, using the appropriate Payer ID:

- 80881/80888[1]—for DME encounters incident to an institutional service
- 80882/80889[2]—for DME encounters incident to a professional service

The NPI on the EDR must be for a provider, physician, or institution and not for a DMEPOS Supplier.

When considered incident to a health care provider's services, the following are part of the provider's, physician's, or institution's encounter: implanted DME, implanted prosthetic devices, replacement parts, accessories, and supplies for the implanted DME.

3.10.2. DMEPOS Supplier Services Submissions

DMEPOS supplier services must be submitted on an 837-P. MAOs and other entities should use the following values on the EDR for a DMEPOS supplier service provided to a beneficiary:

- ISA08 (Interchange Receiver ID) = 80887/80890[3]
- GS03 (Application Receiver's Code) = 80887/80890
- Loop 1000B, NM109 (Receiver's Identifier) = 80887/80890
- Loop 2010BB, NM109 (Payer's Identifier) = 80887/80890

If an encounter is submitted with Payer ID 80887/80890 along with a DMEPOS supplier NPI, the HCPCS from DMEPOS fee schedule must be used. If the submitted HCPCS does not exist in DMEPOS fee schedule, but is found in the Medicare physician fee schedule, an informational edit '32070—Non-DME HCPCS Code' will be posted on the DME encounter.

3.11. Ambulance Encounter Processing

MAOs and other entities must submit professional ambulance data on the 837-P. Loop 2310E (Ambulance Pick-Up Location) and 2310F (Ambulance Drop-Off Location) to have these encounters appropriately processed.

The EDPS has unique logic for processing ambulance services. Ambulance services are identified by the Billing Provider Specialty Code of 59 (Ambulance Service Provider) and procedure code(s) A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, A0436, or A0888. The EDPS validates ambulance

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[1] Medicare-Medicaid Demonstration contracts use Payer ID 80888 for an institutional service.

[2] Medicare-Medicaid Demonstration contracts use Payer ID 80889 for a professional service.

[3] Medicare-Medicaid Demonstration contracts use Payer ID 80890 for a DMEPOS supplier service.

services data on submitted encounters against reference files in the EDPS database. The EDPS databases contain the ZIP Code 5 to Carrier Locality Table and the ZIP Code 9 to Carrier Locality Table. When the EDPS receives an encounter, it reads the date of service, and the ZIP code from the Ambulance Pick-Up Location address (Loop 2310E) to process the EDR.

If the true ambulance pick-up and drop-off locations are available from the provider, MAOs and other entities must include the address line(s), city, state, and ZIP code in Loops 2310E and 2310F. If the true ambulance pick-up and drop-off locations are not available from the provider, MAOs and other entities must abide by the following operational guidance:

- If the pick-up address is unavailable, populate the address, including the address line(s), city, state, and ZIP code and populate this information in Loops 2310E and 2310F using the subscriber's address information.

- If the rendering provider differs from the billing provider, populate the rendering provider's complete address, including the address line(s), city, state, and ZIP code and populate this information in Loops 2310E and 2310F.

- Use the billing provider's complete address, including the address line(s), city, state, and ZIP code and populate this information in Loops 2310E and 2310F.

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Chapter 4. EDFES Processing

The purpose of the Encounter Data Front-End System (EDFES) is to collect Medicare Advantage encounter data records (EDRs) from Medicare Advantage Organizations (MAOs) and to ensure the integrity of EDR files and records. The submitter prepares and submits files containing EDRs and chart review records (CRRs) to the EDFES in the X12 837 5010 format. For information regarding segments and enveloping structure of the 5010 format, see Chapter 3, Section 3.2. Also see Figure 4.2 in Chapter 4 for a graphical overview of how the EDFES is positioned in relation to other Encounter Data Processing System components.

This chapter provides operational submission guidance for 5010 records and information on the reports the EDFES returns to submitters.

4.1. Connecting and Transferring Files

MAOs and other submitters must first establish connectivity to CMS' systems. For information on connecting to CMS systems and accessing the EDFES and the Front-End Risk Adjustment System (FERAS) to upload files with EDRs and RAPS records, and to download transmittals from CMS, please see the new file "MA & Part D Communications Handbook," found at https://www.csscoperations.com/. Note that this file is a consolidation of three files previously found on the CSSC Operations website: EDFES User Guide, FERAS User Guide, and PDFS User Guides.

4.2.   File Size and File Format Guidance

First, there are two basic definitions:

- **File size.** A file begins at the ISA segment and ends at the IEA segment, and file size refers to the number of ISA-IEA envelopes (also known as ISA-IEA transaction sets).[1] The ISA-IEA envelope contains at least one ST/SE transaction set.

- **ST/SE transaction set size.** For all connectivity methods, the TR3 guides recommend a limit for each ST/SE envelope of no more than 5,000 claims. CMS adopts this recommendation, allowing a maximum of 5,000 records (EDRs and CRRs) per ST/SE transaction set.

See Chapter 3 for a discussion of ISA-IEA envelope(s) and ST-SE transaction set(s).

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[1] *Transaction set* is a general term referring to a set of encounter data interchange (EDI) standards or instructions about how to structure information to be exchanged between trading partners, according to the relevant ANSI X12 format.

4.2.1. File Size Rules

For CMS, the number of records per file is dependent upon the connectivity method of the submitter. Submitters should count both EDRs and CRRs when assessing counts. The following submission practices will help prevent delays in the generation and distribution of EDFES Acknowledgement Reports.

As shown in Table 4.1, FTP/Connect:Direct users cannot exceed 85,000 professional EDRs and CRRs per file, and 5,000 institutional EDRs and CRRs per file. Gentran users cannot exceed 5,000 EDRs and CRRs per file.

Due to system processing overhead associated with smaller numbers of EDRs and CRRs within the ST/SE envelope, CMS highly recommends that MAOs submit at or close to the maximum number of EDRs and CRRs within the ST/SE transaction set, not to exceed 5,000 records.

Table 4.1. File Size* Limitations for Encounter Data Record and Chart Review Record Submissions

Connectivity	Maximum Number of 837-P Professional EDRs Per File	Maximum Number of 837-I Institutional EDRs Per File	Maximum Number of EDRs Per ST-SE Transaction Set
FTP/C:D**	85,000	5,000	5,000
Gentran	5,000	5,000	5,000

*File size refers to the number of EDRs within a transaction set (ST/SE).

**C:D is Connect:Direct

4.2.2. File Format

Connect:Direct and Gentran submitters must format all submitted files in an 80-byte fixed block format. This means MAOs must upload every line in a file with a length of 80 bytes/characters. Segments must consist of one continuous stream of information that continues to the next line every 80 characters.

- Submitters should create files with segments stacked, using only 80 characters per line.
- At position 81 of each segment, MAOs must create a new line. On the new line, starting in position 1, continue for 80 characters, and repeat creating a new line in position 81 until the file is complete.
- If the last line in the file does not fill to 80 characters, the submitter should space the line out to position 80 and then save the file.

Note: If MAOs are using a text editor to create the file, pressing the Enter key will create a new line. If MAOs are using an automated system to create the file, create a new line by using a carriage return line feed or a line feed.

Figure 4.1. Sample ISA Interchange Control Header Code

For example, the ISA Interchange Control Header is 106 characters long:

The first line of the file will contain the first 80 characters of the ISA segment; the last 26 characters of the ISA segment will continue on the second line. The next segment will start in the 27th position and continue until column 80.

   ISA*00*   *00*   *ZZ*ENH9999   *ZZ*80882   *120430*114 4*^*00501*000000031*1*P*:~

Note to Connect:Direct users: If a submitter has not established a sufficient number of Generated Data Groups (GDGs) to accommodate the number of files returned from the EDFES, the EDFES will not store all of the Acknowledgement Reports in the submitter's system. To prevent this situation, Connect:Direct submitters should establish a limit of 255 GDGs in their internal processing systems.

4.3. Submission Frequency Requirements

MAOs are required to submit encounter data to the EDPS on a frequency based on the contract's enrollment size, as shown in Table 4.2.

Table 4.2. Submission Frequency Requirements

Number of Medicare Enrollees in a Contract	Minimum Submission Frequency
Greater than 100,000	Weekly
50,000–100,000	Bi-weekly
Less than 50,000	Monthly

"Bi-weekly" means every two weeks.

The level of contract enrollment that CMS uses for this EDR submission frequency standard for a contract year is the number of contract enrollees in February (as reported in the Health Plan Management System (HPMS) enrollment file). MAOs and other entities may determine the cycle for submission of encounter data, as long as the schedule adheres to the standards outlined by CMS for the MAO's enrollment size. As a best practice, MAOs are encouraged to submit EDRs daily.

4.3.1. Timing of Sequential Uploads

CMS recommends that FTP submitters' scripts upload no more than one file per five-minute interval. Zipped files should contain one file per transmission. MAOs should refrain from submitting multiple files within the same transmission. Connect:Direct and Gentran users may submit a maximum of 255 files per day. Adhering to these guidelines will support maximum performance by the CMS' encounter data systems.

4.3.2. End-of-Year Submission Load

CMS is concerned that some MAOs and organizations offering cost plans are submitting a substantial percentage of their EDRs for a service year in the January right before the final risk adjustment data submission deadline (that is, during the 13th month after the end of the service year). As CMS discussed in the July 26, 2016 HPMS memo "Encounter Data Submission Timing Guidance- Reminder and Update," this generates a considerable load on CMS' systems. Further, although the frequency requirements discussed earlier in this section do not address volume, their intent is to have EDR and CRR submissions spread evenly throughout the year.

To this end, CMS will identify contracts that submit 30 percent or more of the contract's total EDRs for a service year to CMS in the January prior to the final risk adjustment data submission deadline, and will contact those organizations that have one or more contracts that do not meet this 30 percent monitoring standard (with the exception of Programs of All-Inclusive Care for the Elderly (PACE) organizations and Medicare-Medicaid Plans (MMPs)). The 30 percent rate will be calculated as follows, using calendar year 2014 as an example: the number of EDRs for a contract with 2014 dates of service submitted to CMS by the organization in January 2016 divided by the total number of EDRs for the contract with 2014 dates of service.

We recognize that there may be valid reasons for submitting a large proportion of EDRs in the month before the risk adjustment deadline, and we believe the threshold of 30 percent reflects this recognition. However, to the extent that organizations can plan their annual submissions process to meet this threshold (for example, the timing of internal quality reviews of diagnosis data and other validation checks), CMS expects them to do so.

4.4. Overview of Encounter Data Front-End System Processing and Reporting

The Encounter Data Front-End System (EDFES) performs several phases of successive edits when processing encounter data files and records. These phases are shown in Figure 4.2 and are discussed in the following sections:

- Section 4.5: Pre-screening validation (applicable to files submitted by entities using Connect:Direct)
- Sections 4.6 and 4.7: Translator edits
- Section 4.8: Combined Common Edits & Enhancements Module (CCEM)
- Section 4.9: Strategic National Implementation Process (SNIP) edits (occurs in the EDFES translator and the CCEM)
- Section 4.10 Post-screening validation – edits specific to the Medicare Advantage program

Figure 4.2. EDFES Processing Phases
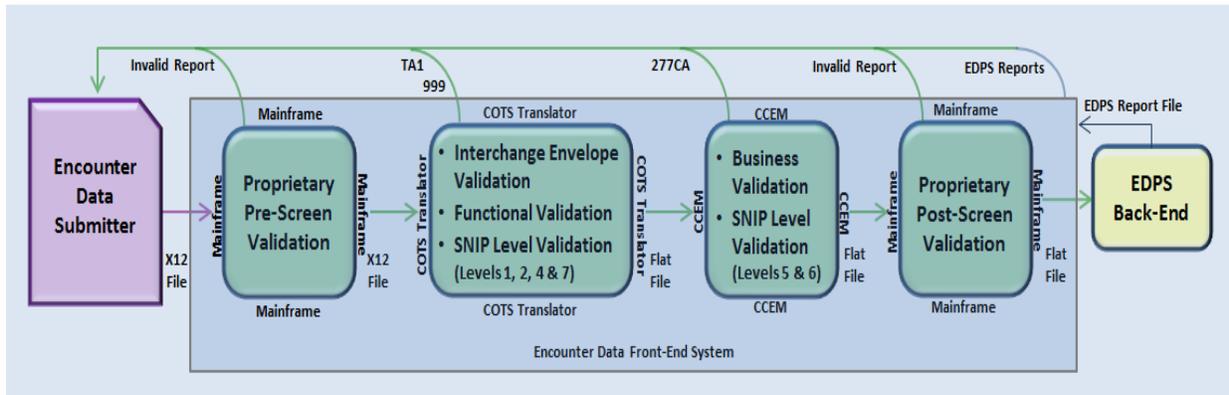
COTS = Commercial Off-the-Shelf; SNIP = Strategic National Implementation Process; CCEM = Combined Common Edits Module; EDPS = Encounter Data Processing System.

Figure 4.3 provides another view of the EDFES processing flow.

Figure 4.3. Flow of Encounter Data through the EDFES
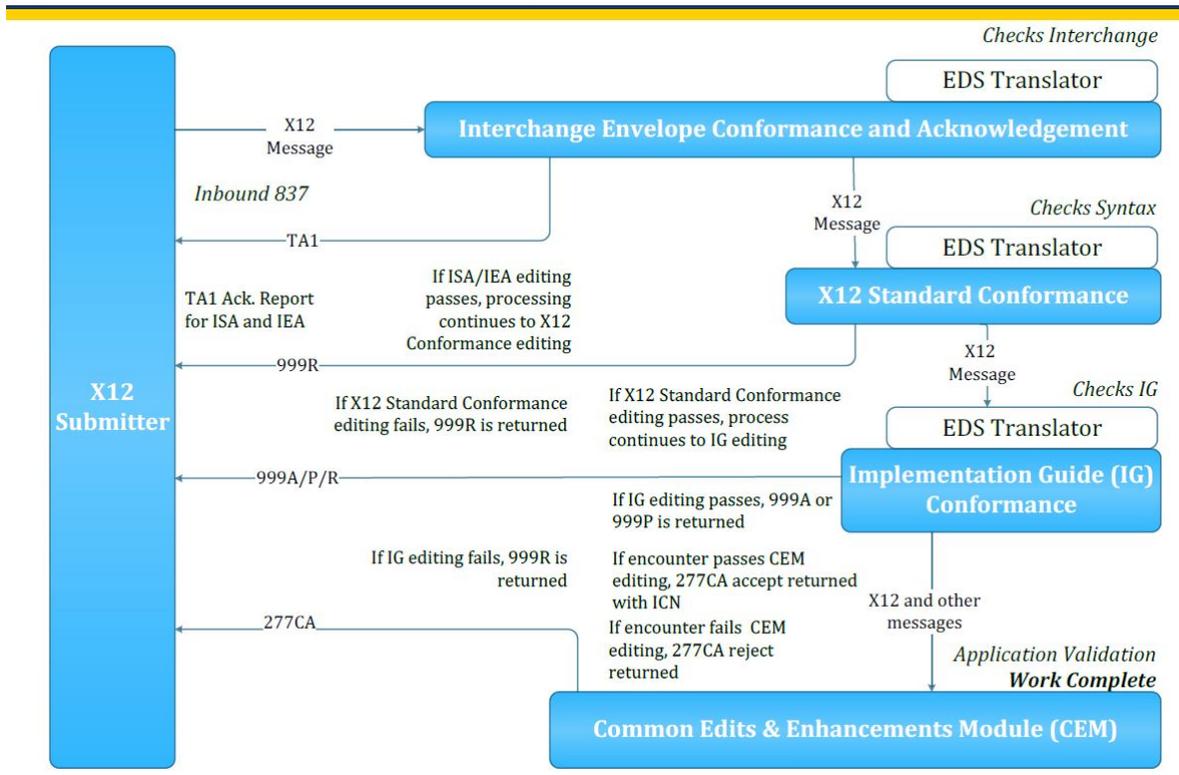
EDS = Encounter Data System.

Table 4.3 shows which validation edits are included in which EDFES Acknowledgement Report. Note that the edits contained in the CMS 5010 Edit spreadsheet include CCEM edits and Translator edits. Further, some Translator edits are passed on from the Translator and displayed in the 277CA Report.

Table 4.3. EDFES X12N 837 5010 Validation Processes and Acknowledgement Reports

Editing Environment	Type of Edits	Report
Pre-Screening Validation	Proprietary editing	Pre-screen Invalid Report for entities connecting via Connect:Direct
Commercial off-the-shelf (COTS) Translator	Syntax editing for Interchange Envelope conformance (ISA/IEA level)	TA1 Acknowledgement report, if the transaction is rejected
Commercial off-the-shelf (COTS) Translator	TR3 conformance editing for functional groups (GS/GE) and transactions sets (ST/SE)	Three possible reports: 999A = all Transaction Sets accepted 999P = Partially accepted (at least one Transaction Set was rejected) 999R = Rejected syntax errors were noted
Combined Common Edits Module (CCEM)	Medicare-specific edits at the record and line levels	277CA: provides record-level info and assigns an Internal Control Number for each **accepted** record
Post-screening Encounter Data Front-End System (EDFES) validation	Medicare Advantage-specific edits at the record and line levels; e.g., presence of contract ID	Post-screen Invalid Report (formerly known as EDFES Notification)

* Refer to column L in the CMS 5010 Edit spreadsheet to determine if the edit is reported on the 999 or 277CA acknowledgement report, found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/.

If a fatal error occurs in the ISA-IEA envelope, the entire file is rejected and the EDFES generates and returns the TA1 Interchange Acknowledgement report within 24 hours of the submission. Other acknowledgement reports are sent to MAOs within 48 hours of submission.

CMS provides a comprehensive list of edits in the CMS 5010 Edit Spreadsheets for Part A, Part B, and Durable Medical Equipment (DME), which can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/. These spreadsheets include all of the 5010 Translator and CCEM edits applied to EDR and CRRs during the phases of processing described above.

4.4.1. Naming Conventions for EDFES Acknowledgement Reports

File naming conventions were developed to allow MAOs identify Acknowledgement Reports. See the MA & Part D Communications Handbook for instructions on file naming.

4.4.2. Report Restoration

The 999 and 277CA Acknowledgement Reports will not be restored if the files are older than 20 business days. Restoration requests for more than 200 files, per single request, will not be accepted. Plan sponsors and submitters can send multiple requests for report restoration over a span of time. CMS recommends that MAOs monitor their files and submit requests appropriately. CMS reserves the right to deny requests that do not follow the guidelines.

4.5. Pre-screening Validation and Invalid Report

When an MAO sends files to the EDFES through Connect:Direct, CMS performs edits prior to TA1-level editing in the Translator, for institutional, professional, and DME EDRs and CRRs. These edits are referred to as "pre-screening" edits. When a file fails a pre-screening edit, the submitter receives an Invalid Report, Table 4.4 lists the pre-screening edits that are performed.

Note: Pre-screening edits will not always be one-to-one; for example, claim type mismatch.

If a file fails the pre-screening validation edits, the submitter receives a Pre-Screening Invalid Report with the following format:

1. File Name Record

    Positions 1–10 = File Name

    Position 11 = Blank Space

    Positions 12–55 = Saved File Name

    Positions 56–80 = Blank Spaces

2. File Message Record

    Positions 1–63 = "File cannot be processed at this time for the following reason"

    Positions 64–80 = Blank Spaces

3. Notification Message

    Positions 1–80 = Notification Message

    The report format example is as follows:

    FILE NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    FILE CANNOT BE PROCESSED AT THIS TIME FOR THE FOLLOWING REASON:

    INVALID FILE SIZE EXPECTED: 80 ACTUAL: 3700

Table 4.4 provides the list of pre-screening validation edits and examples of erroneous code.

Table 4.4. EDFES Pre-screening Validation Edits Applied to Files Submitted to the EDFES via Connect:Direct

Edit	Notification Message	Examples Triggering Edit
INVALID FILE SIZE	The file size is incorrect	EXPECTED: 80 ACTUAL: 3700
INVALID RECORD SIZE	The first record size is not equal to 80 characters	EXPECTED: 80 ACTUAL: 79
SUBMITTER ID MISMATCH ISA06	The Submitter ID in field ISA06 does not match the Submitter ID in the file name	ISA06: ENC9994 FILE NAME: ENC9996
SUBMITTER ID MISMATCH GS02	The Submitter ID in field GS02 does not match the Submitter ID in the file name	GS02: ENC9994 FILE NAME: ENC9996
SUBMITTER ID MISMATCH 1000A-NM109	The Submitter ID in field NM109 in the 1000A loop does not match the Submitter ID in the file name	1000A-NM109: ENC9994 FILE NAME: ENC9996
SUBMITTER ID MISMATCH GS02	The Submitter ID in field GS02 does not match the Submitter ID in field ISA06	GS02: ENC9994 ISA06: ENC9996
SUBMITTER ID MISMATCH 1000A-NM109	The Submitter ID in field NM109 in the 1000A loop does not match the Submitter ID in field ISA06	1000A-NM109: ENC9994 ISA06: ENC9996
SUBMITTER ID MISMATCH 1000A-NM109	The Submitter ID in field NM109 in the 1000A loop does not match the Submitter ID in field GS02	1000A-NM109: ENC9994 GS02: ENC9996
INVALID RECEIVER ID ISA08	The Receiver ID in ISA08 is not a valid Medicare Receiver	ISA08: 80888
RECEIVER ID MISMATCH GS03	The Receiver ID in field GS03 does not match the Receiver ID in field ISA08	GS03: 80881 ISA08: 80888
RECEIVER ID MISMATCH 1000B-NM109	The Receiver ID in field NM109 in the 1000B loop does not match the Receiver ID in field ISA08	1000B-NM109: 80881 ISA08: 80888
RECEIVER ID MISMATCH 1000B-NM109	The Receiver ID in field NM109 in the 1000B loop does not match the Receiver ID in field GS03	1000B-NM109: 80881 GS03: 80888
CLAIM TYPE MISMATCH ISA08	The Receiver ID in ISA08 does not match the Claim Type in field GS08	ISA08: 80881 CLAIM TYPE: X222
CLAIM TYPE MISMATCH GS03	The Receiver ID in GS03 does not match the Claim Type in field GS08	GS03: 80881 CLAIM TYPE: X222
CLAIM TYPE MISMATCH 1000B-NM109	The Receiver ID in field NM109 in the 1000B loop does not match the Claim Type in field GS08	1000B-NM109: 80881 CLAIM TYPE: X222

Edit	Notification Message	**Examples** Triggering Edit
CLAIM TYPE MISMATCH GS08	The Claim Type in field GS08 does not match the Claim Type in field ST03	GS08: 005010X223A2 ST03: 005010X222A1
INELIGIBLE SUBMISSION ISA08	The Submitter ID in field ISA06 is not authorized to submit Medicare encounters	ISA08: 80888 NOT AUTHORIZED FOR ENCOUNTER
INELIGIBLE SUBMISSION ISA08	The Submitter ID in field ISA08 is not authorized to submit Medicaid encounters	ISA08: 80882 NOT AUTHORIZED FOR MMP
SUBMITTER NOT CERTIFIED ISA06	The Submitter ID in field ISA06 is not authorized to submit encounters	ISA06: ENC9994
FILE DOES NOT CONTAIN VALID X12 VERSION 5010 DATA	It could not be determined from the data that the file contains X12 Version 5010 data	Not Applicable
INVALID SEGMENT FORMAT	The ISA was less than the required 106 characters and an invalid delimiter was detected	Not Applicable
MISSING SEGMENTS LOOP	Missing segments in the 2000A loop	Not Applicable

4.6. Interchange Edits and the TA1 Acknowledgement Report

The next phase of edits for institutional, professional, and DME EDRs and CRRs is performed in the EDFES Translator. The Translator analyzes the Interchange Control Structure (ISA-IEA envelope) for syntactical accuracy. Errors detected by the Translator in the ISA/IEA interchange will cause the X12 837 file to be rejected. If the file is rejected, there is no further processing. MAOs must correct and resubmit any file that is rejected.

The purpose of the TA1 Acknowledgement Report is to provide information about a file's rejected Interchange header (ISA) and trailer (IEA). See Appendix 4A for the full layout of the TA1 Acknowledgement Report segments and their associated descriptions.

Note the following details regarding Interchange edits and the TA1 report:

- The submitter will only receive a TA1 report if there are syntax errors in the file, causing the file to be rejected. One TA1 Report is generated per file submission.
- The TA1 is a single segment and is unique in that it is transmitted without the GS/GE envelope structure.
- The notice of the file rejection and the specific error is within the TA1 segment.
- The TA1 report includes the Interchange Control Number, Interchange Date and Time, Interchange Acknowledgement Code, and Interchange Note Code.

The Interchange Control Number, Date, and Time are identical to those populated on the original 837-I or 837-P ISA line, which allows MAOs to associate the TA1 with a specific file previously submitted.

Interchange Acknowledgement Code TA104 indicates if the interchange (ISA/IEA) rejected due to syntactical errors. An "R" will be the value in the TA104 data element if the interchange rejected due to syntactical errors.

Interchange Acknowledgement Code TA105 notifies MAOs of the specific error.

4.6.1. Example: Reading the TA1 Acknowledgement Report

The string provided on line 2 in Figure 4.4 is a TA1 acknowledgement report. This string will allow MAOs to identify the interchange error.

Figure 4.4. TA1 Acknowledgement Report Example

```
1       ISA*00*   *00*    *ZZ*80881    *ZZ*ENC9999 *110916*1632*^*00501*000000013*0*T*:~
2      TA1*000000003*110825*1217*R*001~
3       IEA*0*000000003~
```

Based on the data string provided on lines 1 and 3, the Institutional 837 file (value = 80881) with an Interchange Control Number of **000000013** was rejected because the Interchange header (ISA) and trailer (IEA) control numbers do not match:

Interchange Date: August 25, 2011

Interchange Time: 12:17 p.m.

Interchange Acknowledgement Code: R = Rejected

Interchange Note Code: 001 = Interchange Control Number in the Header and Trailer Do Not Match. The value from the header is used in the acknowledgement

4.6.2. Steps for Resolving the TA1 Error in Figure 4.4

The following steps should be taken to resolve error 001 in the example above.

1. Locate the error on the TA1 Acknowledgement Report: **001** (Interchange Control Number in the header and trailer do not match) is found in TA1 segment TA105.
2. Look in the appropriate edit spreadsheet, (837-I CMS 5010 & CCEM Edits Spreadsheet) for the error.
3. Locate the error on the edit spreadsheet: Search "001" in the Disposition/Error Code column.

   Result: the 2nd row is the error.

Table 4.5. Example of TA105 Error Lookup

Disposition / Error Code	5010 Edits
TA105 = 001: "The Interchange Control Number in the Header and Trailer Do Not Match"	IEA02 must be present
TA105 = 001: "The Interchange Control Number in the Header and Trailer Do Not Match"	IEA02 must = ISA13

1. Access the 837 file with the Interchange Control Number of 000000003.

2. View the value populated in the data elements ISA13 and IEA02 (they must be identical).

3. Correct the value populated in ISA13 and IEA02 by populating both data elements with an identical unused value (not used within 12 months).

4. Resubmit the 837 file.

If no errors are found during TA1-level editing process, the EDFES begins validation of EDRs and CRRs for TR3 standards conformance editing (next section).

4.7. Functional Group and Transaction Set Edits and the 999 Acknowledgement Reports

After the Interchange passes the TA1 edits, the next stage of editing for institutional, professional, and DME EDRs and CRRs is to verify the syntactical accuracy of the functional group(s) (GS/GE enveloping segments). Functional groups allow for the organization of like data within an Interchange. A file may be populated with more than one functional group containing multiple EDRs and CRRs within the functional group. If a file has multiple GS/GE segments and errors occurred at any point within one of the syntactical and/or TR3 edit validations, the GS/GE segment will reject, and **processing will continue to the next GS/GE segment**. For instance, if a file is submitted with three functional groups and there are errors in the second functional group, the first functional group will accept, the second functional group will reject, and processing will continue to the third functional group.

In addition to checking the syntactical accuracy of functional groups, this phase of editing also checks the detail segments and data fields within a transaction set.

A 999 Acknowledgement Report is generated for every file submission and is used to inform MAOs of the processing status of the functional group and transaction sets included in the file. The report provides MAOs with information on whether the functional groups were accepted or rejected, and whether the functional groups adhere to TR3 (IG)-level edits and CMS standard syntax errors as depicted in the CMS 5010 Edits spreadsheets for Part A, Part B, and DME (see Section 4.8.). The CMS 5010 Edits spreadsheet provides failure reasons that appear in 999 Reports.

The three possible acknowledgement values in 999 Reports are as follows:

"A" – Accepted: File is accepted and will continue processing

"R" – Rejected: Functional group(s) rejected and the file will not continue for processing

"P" – Partially Accepted: at least one transaction set was rejected

Note: When the 999R (rejected) or 999P (partial) Acknowledgement Report is received, MAOs must correct and resubmit the file.

The 999 Acknowledgement Report is composed of segments nine key segments, listed in Table 4.6.

Table 4.6. Key Segments of the 999 Acknowledgement Report

Key Segments	Description of Key Segment
AK1	Functional Group Response Header
AK2	Transaction Set Response Header
IK3	Error Identification (Represents the Segment in Error)
CTX Segment Context	Related to IK3
CTX Business Unit Identifier	Related to IK3
IK4	TR3 Data Element Note (for the Data Element in Error within the Segment noted in the IK3 loop)
CTX Element Context	Related to IK4
IK5	Transaction Set Response Trailer
AK9	Functional Group Response Trailer

See Appendix 4B for the full layout of the 999 Acknowledgement Report segments and their associated descriptions. Below we provide information on the key segments in Table 4.6.

IK3 and IK4 Segments

Segments such as the IK3 error identification are present only when there is a need to report a segment error. The CTX context segment appears after the IK3 segment to describe the context within the segment.

- The first element in the IK3 and IK4 indicates the segment and element that contain the error.
- The second element in the IK3 and IK4 indicates the segment position in a transaction set.
- The third element in the IK3 segment identifies the loop that contains the error.
- The IK4 data element segment is present when there is a need to report an error at the data element level. If required, there is a CTX context segment after the IK4 to describe the context within the segment. The third element in the IK4 segment indicates the reason code for the error.

IK5 and AK9 Segments

The IK5 and AK9 segments are always present, noting the transaction set and and/or the functional group's accept or reject status.

If an "A" is displayed in the IK5 and AK9 segments, the claim file is accepted and will continue processing.

If an "R" is displayed in the IK5 and AK9 segments, an IK3 and an IK4 segment will be displayed. These segments indicate what loops and segments contain the error that requires correction so the interchange can be resubmitted.

If a "P" is displayed in the IK5 and AK9 segments, this means only part of the file passed editing and at least one transaction set was rejected. Only the passing data will continue to the next phase of processing.

4.7.1. Example: Reading the 999 Acknowledgement Report for an Accepted Transaction Set

The string provided in Figure 4.5, on lines 4 to 7, comprises a 999-A Acknowledgement Report.

Figure 4.5. 999-A Acknowledgement Report example


```
1   ISA*00*     *00*     *ZZ*80882     *ZZ*ENC9999 → *120410*0802*^*00501*003125081*0*T*:~
2   GS*FA*80882*ENC9999*20120410*08021518*3112795*X*005010X231A1~
3   ST*999*112795001*005010X231A1~·
4   AK1*HC*135*005010X222A1~·
5   AK2*837*000000135*005010X222A1~¶
6   IK5*A~·
7   AK9*A*1*1*1~·
8   SE*6*112795001~·
9   GE*1*3112795~·
10  IEA*1*003125081~¶
```

A Professional 837 file (value = 80882) with a Functional Group Control Number of 135 was submitted containing one transaction set (ST/SE) with a control number of 000000135. Both the functional group and transaction set passed 999 editing and were accepted. Fields in the 999 report segments are as follows:

AK1	999 Segment Identifier, Functional Group Response Header
HC	Functional Identifier Code (GS01)
135	837 Functional Group Control Number (GS06)
005010X222A1	TR3 Guide ID Health Care Claim: Professional (GS08)
AK2	999 Segment Identifier Transaction Set Response Header
837	Claim Transaction Set Identifier Code (ST01)
000000135	Transaction Set Control Number (ST02)
005010X222A1	TR3 Guide ID Health Care Claim: Professional (ST03)
IK5	999 segment Identifier, Transaction Set Response Trailer

A	Transaction Set Acknowledgment Code: Accepted – "A" in the IK501 segment indicates there were no errors in the **Transaction Set**
AK9	999 Segment Identifier, Functional Group Response Trailer
A	Functional Group Acknowledgement Code: "A" in the AK9 segment indicates there were no errors in the **Functional Group**
1	Number of Transaction Sets Included
1	Number of Received Transaction Sets
1	Number of Accepted Transaction Sets

4.7.2. Example: Reconciling the 999 Acknowledgement Report for a Rejected Transaction Set

Figure 4.6 and Table 4.7 present an example of a 999-R Acknowledgement Report. While lines 4, 5, and 17 in Figure 4.6 are part of the 999 Report (segments AK1 and AK2), the black boxes around lines 6 to 16 and 18 to 23 highlight segments IK3 and IK4, which identify X12 837 segments and data fields in error, respectively. It is these lines that are explained in Table 4.7. This example includes two transaction sets, where the first set has with two EDRs (IDs 2012020399900522TC11 and 2012030799900224TC11); and the second transaction set has one EDR (ID P2752560).

Figure 4.6. Example of 999R Acknowledgement Report

```
1→ ISA*00*  →  *00*  →  *ZZ*80882 →  *ZZ*ENC9999 →  *120406*0804*^*00501*003038950*0*T*:~¶
2→ GS*FA*80882*ENC9999*20120406*08043574*3026654*X*005010X231A1~¶
3→ ST*999*26654001*005010X231A1~¶
4→ AK1*HC*133*005010X222A1~¶
5→ AK2*837*000000133*005010X222A1~¶
6→ IK3*SBR*689*2430*7~¶
7→ CTX*CLM01:2012020399900522TC11~¶
8→ IK3*AMT*698*2320*8~¶
9→ CTX*CLM01:2012020399900522TC11~¶
10→ IK4*2**7*000000000021~¶
11→ IK3*SBR*735*2430*7~¶
12→ CTX*CLM01:2012030799900224TC11~¶
13→ IK3*AMT*744*2320*8~¶
14→ CTX*CLM01:2012030799900224TC11~¶
15→ IK4*2**7*000000000015~¶
16→ IK5*R*I5~¶
17→ AK2*837*000020860*005010X222A1~¶
18→ IK3*SVD*31*2430*8~¶
19→ CTX*CLM01:P2752560~¶
20→ IK4*1**2*H9999~¶
21→ CTX*SITUATIONAL· TRIGGER***2330~¶
22→ IK5*R*I5~¶
23→ AK9*R*2*1*0~¶
24→ SE*16*26654001~¶
25→ GE*1*3026654~¶
26→ IEA*1*003038950~¶
```

Table 4.7. Reference Table for Figure 4.6 999R, Acknowledgement Report Example

Data String Line # in Figure 4.6	Data Element	Description
6	IK3	999 segment Identifier, Error Identification
6	SBR	ID of segment containing the syntax error (SBR segment)
6	689	Position of the segment in error relative to the start of the transaction set (SBR is the 689th segment from the "ST" segment, which is counted as 1)
6	2430	Loop identifier Code
6	7	Syntax Error Code; 7 = Segment Not in Proper Sequence
7	CTX	999 segment Identifier, Segment Context
7	CLM01:2012020399900522TC11	Context Identification Context Name: Context Reference Number
8	IK3	999 segment Identifier, Error Identification
8	AMT	ID of segment containing the syntax error (AMT segment)
8	698	Position of the segment in error relative to the start of the transaction set (AMT is the 698th segment from the "ST" segment, which is counted as 1)
8	2320	Loop identifier Code
8	8	Syntax Error Code, 8 = Segment has data element errors
9	CTX	999 segment Identifier, Segment Context
9	CLM01:2012020399900522TC11	Context Identification Context Name: Context Reference Number
10	IK4	999 segment Identifier, TR3 Data Element Note
10	2	Position of the element in error inside of the segment IK301(AMT) + IK401(2) = (AMT02)
10	7	Syntax error code, 7 = Invalid code value
10	000000000021	Copy of Data Element in error
11	IK3	999 segment Identifier, Error Identification
11	SBR	ID of segment containing the syntax error (SBR segment)
11	735	Position of the segment in error relative to the start of the transaction set (SBR is the 735th segment from the "ST" segment, which is counted as 1)
11	2430	Loop identifier Code
11	7	Syntax Error Code, 7 = Segment not in proper sequence
12	CTX	999 segment Identifier, Segment Context
12	CLM01:2012030799900224TC11	Context Identification Context Name: Context Reference Number

Data String Line # in Figure 4.6	Data Element	Description
13	IK3	999 segment Identifier, Error Identification
13	AMT	ID of segment containing the syntax error (AMT segment)
13	744	Position of the segment in error relative to the start of the transaction set (AMT is the 744th segment from the "ST" segment which is counted as 1)
13	2320	Loop identifier Code
13	8	Syntax Error Code, 8 = Segment has data element errors
14	CTX	999 segment Identifier, Segment Context
14	CLM01:2012030799900224TC11	Context Identification Context Name: Context Reference Number
15	IK4	999 segment Identifier, TR3 Data Element Note
15	2	Position of the element in error inside of the segment IK301(AMT) + IK401(2) = (AMT02)
15	7	Syntax error code, 7 = Invalid code value
15	000000000015	Copy of Data Element in error
16	IK5	999 segment Identifier, Transaction Set Response Trailer
16	R	Acknowledgement Code R = rejected
16	I5	Transaction Set Syntax Error Code I5 = Implementation One or More Segments in Error
18	IK3	999 segment Identifier, Error Identification
18	SVD	ID of segment containing the syntax error (SVD segment)
18	31	Position of the segment in error relative to the start of the transaction set (SBR is the 31st segment from the "ST" segment, which is counted as 1)
18	2430	Loop identifier Code
18	8	Syntax Error Code, 8 = Segment has data element errors
19	CTX	999 segment Identifier, Segment Context
19	CLM01:P2752560	Context Identification Context Name: Context Reference Number
20	IK4	999 segment Identifier, TR3 Data Element Note
20	1	Position of the element in error inside of the segment IK301(SVD) + IK401(1) = (SVD01)
20	2	Syntax error code, 2 = Conditional required data element missing
20	H9999	Copy of Data Element in error
21	CTX	999 segment Identifier, Segment Context
21	SITUATIONAL TRIGGER	Context Identification

Data String Line # in Figure 4.6	Data Element	Description
21	2330	Loop Identifier Code, the loop ID number for this data element
22	IK5	999 segment Identifier, Transaction Set Response Trailer
22	R	Acknowledgement Code R = rejected
22	I5	Transaction Set Syntax Error Code I5 = Implementation One or More
23	AK9	999 Segment Identifier, Functional Group Response Trailer
23	R	Acknowledgement Code R = rejected
23	2	Number of Transaction Sets Included
23	1	Number of Received Transaction Sets
23	0	Number of Accepted Transaction Sets

To properly reconcile the 999R Acknowledgement Report, using the example in Figure 4.6 and Table 4.7, MAOs must locate and resolve the errors in the file. In the example, there are two transaction sets: 000000133 and 000020860.

Transaction set 000000133 has two EDRs, IDs 2012020399900522TC11 and 2012030799900224TC110, and each EDR has two errors, for a total of four errors in this transaction set.

Transaction set 000020860 has one EDR, with one error.

In the transaction set 000000133, locate the four errors in the 999 Acknowledgement lines, and then look in the appropriate edit spreadsheet (999 TR3-P and CMS 5010 Edit Spreadsheet, professional) for the explanation of the error in the Disposition/Error Code column.

Errors in first transaction set 000000133, EDR # 2012020399900522TC11

Error 1: EDR Identifier Number 2012020399900522TC11, Error IK304 = 7, "**Segment Not in Proper Sequence.**" was found in the 999 TR3, not the CMS CEM Edits Spreadsheet. As noted in Table 4.7, in the 2430 Loop, the SBR segment found in the 689th location from the "ST" segment is not in the proper sequence.

Resolution 1: Move the 2430 Loop, SBR segment to the correct sequence/location in the data string.

Error 2: EDR Identifier Number 2012020399900522TC11, Error IK304 = 8, "**Segment has data element errors**." As noted in Appendix 4B on the 999 Acknowledgement Report layout, the IK4 segment is required when the error described in IK3 applies to a data element. Thus, line 10 has an IK403 value of 7, meaning "**Invalid Code Value**", which line 8 of the Acknowledgement Report indicates is found in the AMT segment loop 2320.

Error IK403 = 7, "**Invalid Code Value**" for the AMT segment was found in the 999 TR3, not in the CMS 5010 Edits Spreadsheet. As noted in Table 4.7, in the 2320 Loop, the AMT segment found in the 698th location from the "ST" segment has data element errors.

Resolution 2: Data element AMT02 has an invalid code value because the code value for the AMT02 is found in data element AMT01; the value should be "D", not "000000000021".

Errors in first transaction set 000000133, EDR # 2012030799900224TC11

Error 3: EDR Identifier Number 2012030799900224TC11, error IK304 = 7, "**Segment Not in Proper Sequence.**" was found in the 999 TR3, not the CMS CEM Edits Spreadsheet. As noted in Table 4.7, the position of the segment is in error relative to the start of the transaction set (SBR is the 735th segment from the "ST" segment, which is counted as 1)

Resolution 3: Move the 2430 Loop, SBR segment to the correct sequence/location in the data string.

Error 4: IK403=8 EDR Identifier Number 2012030799900224TC11, Error IK304 = 8, "**Segment has data element errors.**" As noted in Appendix 4B on the 999 Acknowledgement Report layout, the IK4 segment is required when the error described in IK3 applies to a data element. Thus, line 15 has an IK403 value of 7, meaning "**Invalid Code Value**", which line 13 of the Acknowledgement Report indicates is found in the AMT segment loop 2320. In the 2320 Loop, the AMT segment is found in the 744th location from the "ST" segment.

Resolution 4: Look at the value in Loop 2320, data element AMT01. Correct the value in AMT01; it must be "D". The code value for the AMT02 data element is found in data element AMT01, but the value should be "D" not "000000000021".

Error in second transaction set 000020860, EDR # P2752560

The example presents one error, affecting EDR P2752560.

Error 5: EDR Identifier Number P2752560, Error IK304 = 8, "**Segment has data element errors"** and IK403-I12 "**Implementation pattern match failure.**" As noted in Table 4.7, the position of the element in error inside segment IK is in the 31st location from the "ST" segment on the 837X file, and the syntax error code 2 indicates a missing conditional required data element.

Error IK304 = 8 was found in the 999 TR3 = "**Segment has data element errors**", and Error IK403 = I12 was found on the CMS CEM Edits Spreadsheet = "**Implementation Pattern Match Failure**".

Resolution 5: The values in the following data elements must match: 2430 Loop, data element SVD01 and 2330B Loop, data element NM109.

After all encounters in the transaction set are corrected, MAOs must resubmit both transaction sets.

4.8. CCEM Transaction Set Edits and the 277CA Acknowledgment Reports

After the file is accepted at the Interchange and functional group levels that is, passes 999 editing), the third level of editing occurs at the transaction set level within the CCEM (header and line edits). The CCEM checks the validity of the values within the data elements. The result of this editing is reported in the 277CA Acknowledgment Report. For example, data element N403 must be a valid nine-digit ZIP code. If a non-existent ZIP code is populated, the CEM will reject the encounter.

4.8.1. CMS 5010 Edits Spreadsheets

CMS provides 5010 file format technical edit spreadsheets for the X12 837-I, 837-P, and 837-DME modules on the CMS website, referred to as the CMS 5010 edits spreadsheets. The edits included in the spreadsheets include those reported in TA1, 999, and 277CA reports. CMS provides this spreadsheet to clarify the TR3 guide instructions and to add Medicare-specific requirements, and it can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/.

To determine the implementation date of the edits contained in the spreadsheet, MAOs and other submitters should initially refer to the spreadsheet version identifier. The version identifier is composed of 10 characters, as follows:

- Positions 1–2 indicate the line of business:
    - EA – Part A (837-I)
    - EB – Part B (837-P)
    - CE – DME/Part B Drugs
- Positions 3–6 indicate the year (for example, 2015)
    - Position 7 indicates the release quarter month
    - 1 – January release
    - 2 – April release
    - 3 – July release
    - 4 – October release
- Positions 8–10 indicate the spreadsheet version iteration number (for example, V01-first iteration, V02-second iteration)

The effective date of the spreadsheet is the first calendar day of the release quarter month. The implementation date is the first business Monday of the release quarter month. Federal holidays that potentially occur on the first business Monday are considered when determining the implementation date.

4.8.2. Edits Deactivated for Requirements Unique to the Medicare Advantage Program

Several edits currently active in the CMS 5010 Edits spreadsheet are deactivated in the EDFES in recognition of several unique requirements of the Medicare Advantage program. Deactivation of these edits ensures that syntactically correct EDRs and CRRs pass front-edit editing. See **Appendix 4D** for a list of deactivated edits. Appendix Table 4D.1 is organized as follows:

- The Edit Reference column provides the exact reference for the deactivated edits.
- The Edit Description column provides the Claim Status Category Code, the Claim Status Code, and the Entity Identifier Code, when applicable.
- The Notes column provides a description of the edit reason.
- Columns "I", "P", and "D" indicate if the edit is deactivated for Institutional, Professional, or DME encounters, respectively.

MAOs and other entities should reference the WPC website at https://www.wpc-edi.com for a complete listing of all Claim Status Category Codes and Claim Status Codes.

4.8.3. 277CA Acknowledgement Report

The 277CA is an unsolicited Acknowledgement Report from CMS to MAOs and other entities. The 277CA Acknowledgement Report provides the status of each EDR or CRR as either accepted or rejected due to CCEM edits. See **Appendix 4C** for the 277CA Acknowledgement Report Key Segments.

The 277CA is used to acknowledge the acceptance or rejection of encounters submitted using a hierarchical level (HL) structure. There are four hierarchical levels:

1) Information Source (HL Code = 20); Sender of the 277CA (for example, Palmetto GBA)
2) Information Receiver (HL Code = 21); Submitter of data to CMS
3) Provider of Service (HL Code = 19); Billing Provider
4) Patient (HL Code = PT); Beneficiary

Acceptance or rejection at this level is based on the TR3 guides, and the CMS 5010 Edits spreadsheets. Edits received at any hierarchical level will stop, and no further editing will take place. For example, if there is a problem with the Billing Provider of Service submitted on the EDR, individual patient edits will not be performed.

When the EDR is rejected at any hierarchical level, the entire EDR will reject and the submitter will be required to correct and resubmit the encounter until it is accepted. For example, if there is a problem with the Billing Provider of Service submitted on the 837, individual patient edits will not be performed.

The STC03 data element value will indicate the status of the HL:

- "WQ" if the HL was accepted
- "U" if the HL was rejected

If an EDR is accepted, the 277CA will provide the Internal Control Number (ICN) assigned to that encounter. The ICN segment for the accepted encounter will be located in 2200D REF segment, REF01=IK and REF02=ICN. The ICN is a unique 13-digit number.

4.8.4. Example: 277CA Acknowledgement Report

Figure 4.7 and Table 4.8 present an example of a 277CA Acknowledgement Report.

Figure 4.7. Example of 277CA Report
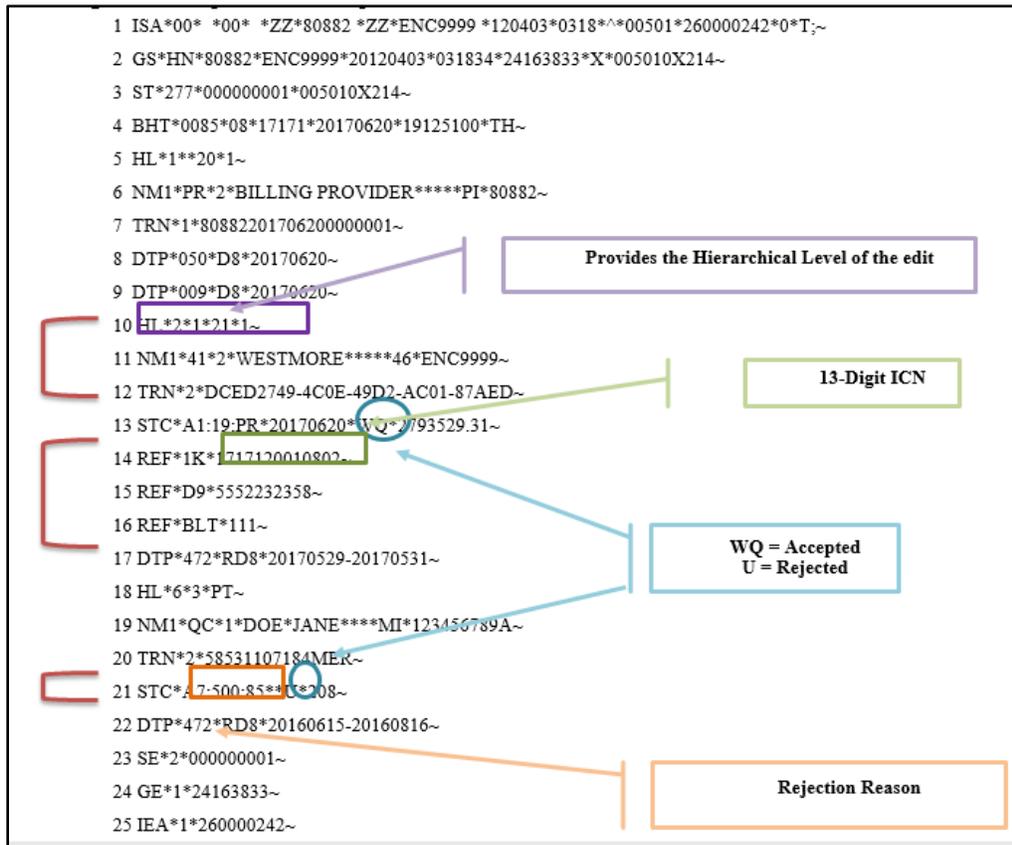
Table 4.8. Reference Table for Figure 4.7 277CA Acknowledgement Report example

Data String Line From Figure 4.7	Data Element	Data Element Position	Description
10	HL		277CA segment identifier
10	HL	2	Identifies this level as the 2nd level within this ST/SE segment
10	HL	1	Identifies this level as a subordinate to level "1" (HL 1 is parent to this level)
10	HL	21	Identifies this level as 21, which means Information Receiver

Data String Line From Figure 4.7	Data Element	Data Element Position	Description
10	HL	1	Identifies that there is at least one additional subordinate level beyond this level (a child level follows)
11	NM1		277CA segment identifier
11	NM1	41	Entity code, 41 = Submitter
11	NM1	2	Entity type qualifier, 2 = Non-person entity
11	NM1	WESTMORE	Information Receiver Name (Submitter Name entered in Loop 1000A, data element NM103 on the 837)
11	NM1	46	Entity qualifier, 46 = Entity's ID Electronic Transmitter Identification Number (ETIN)
11	NM1	ENC9999	Identifies the entity's contract number
12	TRN		277CA segment identifier
12	TRN	2	Trace Type Code
12	TRN	DCED2749-4COE-49D2-AC01-87AED	Provider of service information – Trace identifier
14	REF		277CA segment identifier
14	REF	1K	Reference Identification Qualifier
14	REF	1717120010802	Internal Control Number assigned to the claim by the payer
15	REF		277CA segment identifier
15	REF	D9	Reference Identification Qualifier
15	REF	5552232358	MAO claim identifier number to identify the transmission
16	REF		277CA segment identifier
16	REF	BLT	Billing Type
16	REF	111	Reference identification
17	DTP		277CA segment identifier
17	DTP	472	Date/Time qualifier
17	DTP	RD8	Identifies the format of the date/time period format qualifier
17	DTP	20170529-20170531	Service Date
21	STC		277CA segment identifier
21	STC	A7:500:85	Rejection reason code
21	STC	U	Status code indicator
21	STC	208	Monetary amount

4.9. Strategic National Implementation Process (SNIP) Edits in the Translator and CCEM

The Workgroup for Electronic Data Interchange (WEDI) was established in 1991 to coordinate within the healthcare industry to identify practical strategies for reducing administrative costs in healthcare through the implementation of EDI. WEDI helped secure the passage of the Health Insurance Portability and Accountability Act

of 1996 (HIPAA) and was acknowledged as the facilitator of industry consensus on the implementation and fulfillment of the HIPAA mandate. In 2003, WEDI proposed expansion of EDI testing to include seven unique types of testing. Table 4.9 provides the definition of the SNIP types and location within the EDS. Figure 4.8 illustrates the SNIP types and their link to the EDS.

Table 4.9. Strategic National Implementation Process Types of Testing

SNIP Type	SNIP Type of Testing	SNIP Type Definition	SNIP Type EDS Location
Type 1	Integrity Testing	Tests for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 syntax and compliance with X12 rules.	Translator
Type 2	Requirement Testing	Tests for HIPAA IG specific requirements, such as repeat counts, used and not used codes, elements and segments, required or intra-segment situational data elements (nonmedical code sets as laid out in the IG), and values noted by an X12 code list or table.	Translator
Type 3	Balancing Testing Note: Does not apply to Medicare Advantage encounter data	Tests the transaction for balanced field totals, record or segment counts, financial balancing of claims, and balancing of summary fields.	Translator
Type 4	Situation Testing	Tests the specific inter-segment situations described in the HIPAA IGs such that: if 'A' occurs, then 'B' must be populated. This is considered to include the validation of situational fields given values or situations present elsewhere in the file.	Translator
Type 5	Code Set Testing	Tests for valid IG specific code set values.	CEM
Type 6	Line of Business Testing	Specialized testing required by certain product types/types of service such as chiropractic, ambulance, durable medical equipment, etc.	CEM
Type 7	Trading Partner-Specific Testing	Tests edits in the HIPAA IG that are unique and specific to a payer/receiver.	Translator

EDS = Encounter Data System; HIPAA = Health Insurance Portability and Accountability Act of 1996; IG = Implementation Guide; CEM = Common Edits and Enhancements Module.

Figure 4.8. Strategic National Implementation Process Types and the EDS
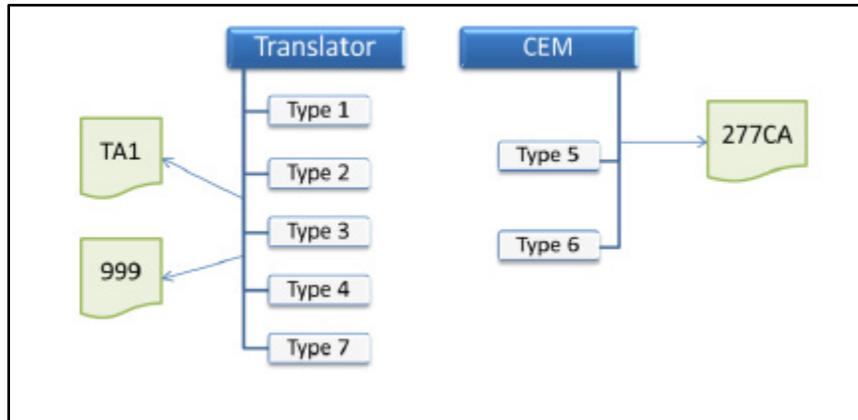
Note: All rejected lines must be removed from the EDR or CRR prior to submission. After receipt of corrected data, the MAO or other entity may submit an adjustment encounter to the FERAS for processing.

4.10. Post-screening Validation and the Invalid Report

Finally, the last stage of EDFES editing pertains to requirements for the Medicare Advantage program that are not addressed in the other phases of editing described above (for example, checking the Plan-to-Submitter security access credentials).

The EDFES distributes a Post-Screening Invalid Report, formerly known as the EDFES Notification Report, to notify MAOs when a file failed. When a Post-Screening Invalid Report is generated, the file will not proceed for further processing.

The Post-Screening Invalid Report has an 80 character record length and contains the following record layout:

1. File Name Record

    Positions 1–7 = Blank Spaces

    Positions 8–18 = File Name:

    Positions 19–62 = Name of the Saved File

    Positions 63–80 = Blank Spaces

2. File Control Record

    Positions 1–4 = Blank Spaces

    Positions 5–18 = File Control:

    Positions 19–27 = File Control Number

    Positions 28–80 = Blank Spaces

3.   File Count Record

Positions 1–18 = Number of Claims:

Positions 19–24 = File Claim Count

Positions 25–80 = Blank Spaces

File Separator Record

Positions 1–80 = Separator (----------)

File Message Record

Positions 1–80 = FILE WILL NOT PROCEED FOR FURTHER PROCESSING FOR THE FOLLOWING REASON(S)

The report format example is as follows:

FILE NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

FILE CONTROL: XXXXXXXX NUMBER OF CLAIMS: 99,999

FILE WILL NOT PROCEED FOR FURTHER PROCESSING FOR THE FOLLOWING REASON(S)

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Table 4.10 provides the Post-Screening Invalid Report file type, notification message, message description, and indicator of applicability to institutional, professional, and DME CRRs. The messages do not occur in any other Acknowledgement Reports.

Table 4.10. Post-Screening Invalid Report for Institutional, Professional, and DME Encounter Data Records and Chart Review Records

Applies To	Notification Message	Notification Message Description	INST	PROF	DME
All files submitted	File ID (XXXXXXXXX) is a duplicate of a file id sent within the last 12 months	The file ID must be unique for a 12 month period	Y	Y	Y
All files submitted	Submitter not authorized to send EDRs for this contract (Contract ID)	The submitter is not authorized to send EDRs for this contract	Y	Y	Y
All files submitted	Contract ID cannot be the same as the submitter id	The Contract ID cannot be the same as the Submitter ID	Y	Y	Y
All files submitted	At least one EDR is missing a contract ID in the 2010BB-REF02 segment	The Contract ID is missing	Y	Y	Y

Applies To	Notification Message	Notification Message Description	INST	PROF	DME
Production files submitted	Submitter not certified for production	The submitter must be certified to send EDRs for production	Y	Y	Y
All files submitted	See service type columns	The maximum number of EDRs allowed in a file	File cannot exceed 5,000 EDRs	File cannot exceed 85,000 EDRs	File cannot exceed 85,000 EDRs
All files submitted	Transaction set (ST/SE) (xxxxxxxx) cannot exceed 5,000 claims	There can only be 5,000 claims in each ST/SE Loop	Y	Y	Y
All files submitted	Date of service cannot be before 2011	Files cannot be submitted with a date of service before 2011	Y	Y	Y
All files submitted	CAS adjustment amount must not be 0	The CAS Adjustment Amount cannot be zero (0).	Y	Y	Y
All files submitted	Billing provider loop is missing	The Billing Provider Loop must be present.	Y	Y	Y
End-to-End Testing - File 1	File cannot contain both unlinked and linked test cases	The test cases from File 1 and File 2 cannot be in the same file		Y	
End-to-End Testing - File 1	Cannot send linked test cases until all unlinked test cases have been accepted	The test cases for File 2 cannot be sent before all File 1 test cases are accepted		Y	
Tier 2 files submitted	The interchange usage indicator must equal 'T'	The Institutional Tier 2 file is being sent with a 'P' in the ISA15 field	Y	Y	Y
Tier 2 files submitted	The contract ID has (x,xxx) claims in this file. Only 2,000 are allowed	The number of encounters for a Contract ID cannot be greater than 2,000	Y	Y	Y
End-to-End Testing	See service type columns	See service type columns	File cannot contain more than 6 EDRs	File cannot contain more than 6 EDRs	File cannot contain more than 4 EDRs
End-to-End Testing	Patient control number is more than 20 characters long the TC# was truncated	The Claim Control Number, including the Test Case Number, must not exceed 20 characters	Y	Y	Y
End-to-End Testing	File contains (x) test case (x) encounter(s)	The file must contain two (2) of each test case	Y	Y	Y

Applies To	Notification Message	Notification Message Description	INST	PROF	DME
Test	No test cases found in this file	This file was processed with the Interchange Usage Indicator = 'T' and the Submitter is not yet Certified	Y	Y	
End-to-End Testing	Additional files cannot be validated until an MAO-002 report has been received	The MAO-002 report must be received before additional files can be submitted	Y	Y	Y

EDR = encounter data record; CAS = Claim Adjustment Segments; MAO = Medicare Advantage Organization.

When EDRs and CRRs have been processed and accepted by the FERAS, they are passed to the back-end EDPS, as described in Chapter 5.

Chapter 5. EDPS Processing

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5.1.   Terminology

(1) In various publications, the term Encounter Data System (EDS) is used to describe both the Encounter Data Front-End System (EDFES) and the back-end Encounter Data Processing System (EDPS). In this guide, we have separate chapters distinguishing the EDFES and the EDPS.

(2) To reduce the number of acronyms, CMS is retiring the following names and acronyms for processes within the EDPS:

- Retired: Encounter Data Professional Processing and Pricing System (EDPPPS)
- Retired: Encounter Data Institutional Processing And Pricing System (EDIPPS)
- Retired: Encounter Data Durable Medical Equipment (DME) Processing and Pricing System (EDDPPS)

5.2.   Overview of EDPS Processing

Once an encounter data record (EDR) or chart review record (CRR) has successfully passed through the front-end EDFES edits (accepted on the 277CA acknowledgement report and assigned an Internal Control Number (ICN), and moved through post-screening without triggering an Invalid Report), the record is then transferred to the back-end EDPS for additional processing. During EDPS processing, EDRs and CRRs are subjected to additional record- and line-level edits that result in records and/or lines being rejected or accepted. Many of the edits apply to institutional records and professional/DME records, whereas other edits are specific to the record type (institutional or professional/DME).

There are two possible edit dispositions for edits applied in the EDPS: Informational and Reject.

- Informational edits: Informational edits are indicated by an "I" before the edit description; for example, the description for edit 25000 would read '25000 I:CCI Error' with the 'I' indicating that this is an informational edit. An Informational edit results in an accepted record or line and will not cause processing to cease.
- Reject edits indicate that the submitter must resubmit the record through the EDFES. The resubmitted encounter must then pass editing at the translator and Combined Common Edits Module (CEM) levels before being transferred again to the EDPS.
    - If there is a reject edit at the header level, the encounter will reject.
    - If there is no reject edit at the header level but all lines reject, the record will reject.
    - If there is no reject edit at the header level and at least one of the lines is accepted, then the record will be accepted.

A full list of edits that occur in the EDPS can be located in the "EDPS Edit Code Look-up Tool," which is available at https://www.csscoperations.com.

Two reports, the MAO-001 and the MAO-002, are generated that reflect the outcome of the EDPS editing process. These reports are discussed in the following section.

5.3.   EDPS Reports to Submitters

The EDPS generates two reports on the outcome of the editing process: MAO-001, MAO-002 reports. These data processing reports are delivered to submitters in a fixed-length format and distributed by two methods: flat file and formatted. Flat file reports are categorized by header record, detail record, and trailer record.

Table 5.1 describes these production EDPS reports, which become available within five business days of receipt from the EDFES (testing reports should be available within seven business days of receipt from the EDFES).

Table 5.1. EDPS Processing Status Reports

EDPS Report Type	Description
MAO-001 Encounter Data Duplicates	Lists all encounters that received duplicate errors (98300, 98325, 98320, and 98315) *Medicare Advantage Organizations and other entities will not receive the MAO-001 report if there are no duplicate errors received on submitted encounters
MAO-002 Encounter Data Processing Status	Lists the accepted and rejected status of all encounters at the claim (header) and line levels, along with edit codes and brief edit descriptions.

5.3.1.   MAO-001 Encounter Data Duplicates Report

The EDPS will generate and return the MAO-001 Encounter Data Duplicates Report. Medicare Advantage Organizations (MAOs) and other entities will not receive the MAO-001 report if no duplicate errors are received on submitted encounters. When the MAO-001 Encounter Data Duplicates Report is returned to an MAO or other entity, it contains one or more of the following edits:

98300 – Exact Inpatient Duplicate Encounter

98315 – Linked Chart Review Duplicate

98320 – Chart Review Duplicate or

98325 – Service Line(s) Duplicated

Details on the MAO-001 report include the encounter ICN and service line that is rejected, along with record type, the previously submitted and accepted encounter ICN and service line, plan id, date of service, error code, and beneficiary ID.

The MAO-001 report is a fixed-length report available in flat file and formatted report layouts.

See **Appendix 5A** for a complete flat file layout of an MAO-001 report.

Figure 5.1. MAO-001 Record Data Duplicates Report

Figure 5.2. MAO-001 Report – Key Data Elements

5.3.2.   MAO-002 Encounter Data Processing Status Report

The MAO-002 Encounter Data Processing Status Report provides information on the disposition status (accepted and rejected) and edit codes for all records and lines for each file submitted. Please refer to **Appendix 5B** for a complete flat file layout of an MAO-002 report.

The MAO-002 Report reflects two disposition statuses at the record and service line levels: "accepted" or "rejected." Lines with a status of "accept" but containing an error code and a message in the Error Description column have triggered informational edits. MAOs and other entities are not required to take further action on informational edits; however, they are encouraged to review submissions to ensure accuracy of internal claims processing data.

The "000" line on the MAO-002 report identifies the header level. If the header is rejected, the entire record is considered rejected and MAOs and other entities must correct and resubmit the record. If the "000" header line is accepted and at least one other line (that is, 001 002 003 004) is accepted, then the record is accepted. If all the lines within the record are rejected, the "000" header line is rejected without error code and description.

To reconcile a rejected record identified on an MAO-002 report, the MAO must submit a new record after applying corrections. If the record is accepted and the service line(s) is rejected, the MAO must submit a correct/replace record, where CLM05-3 equals "7". The final disposition of the record is determined based on the submitter's receipt of the MAO-002 report, with the assigned ICN.

00265 – Correct/Replace or Void ICN Not in EODS (Encounter Operational Data Store): If a submitter attempts to submit an adjustment for a previously submitted record **before** receiving the MAO-002 report and the EDPS has not completed processing of that previously submitted record, the submitter may receive the error 00265.

00760 – Adjusted Encounter Already Void/Adjusted (Reject): If a submitter submits an initial adjustment EDR (ICN2) for a previously submitted EDR (ICN1) and then attempts to submit a subsequent adjustment EDR (ICN3) with the same parent ICN (ICN1) before receiving the MAO-002 report for an initial adjustment EDR (ICN2), the submitter may receive the error 00760.

00755 – Void Encounter Already Void/Adjusted (Reject): If a submitter submits an initial void EDR (ICN2) for a previously submitted EDR (ICN1) and then attempts to submit a subsequent void EDR (ICN3) with the same parent ICN (ICN1) before receiving the MAO-002 report for an initial void EDR (ICN2), the submitter may receive the error 00755.

Figure 5.3. MAO-002 Encounter Data Processing Status Report
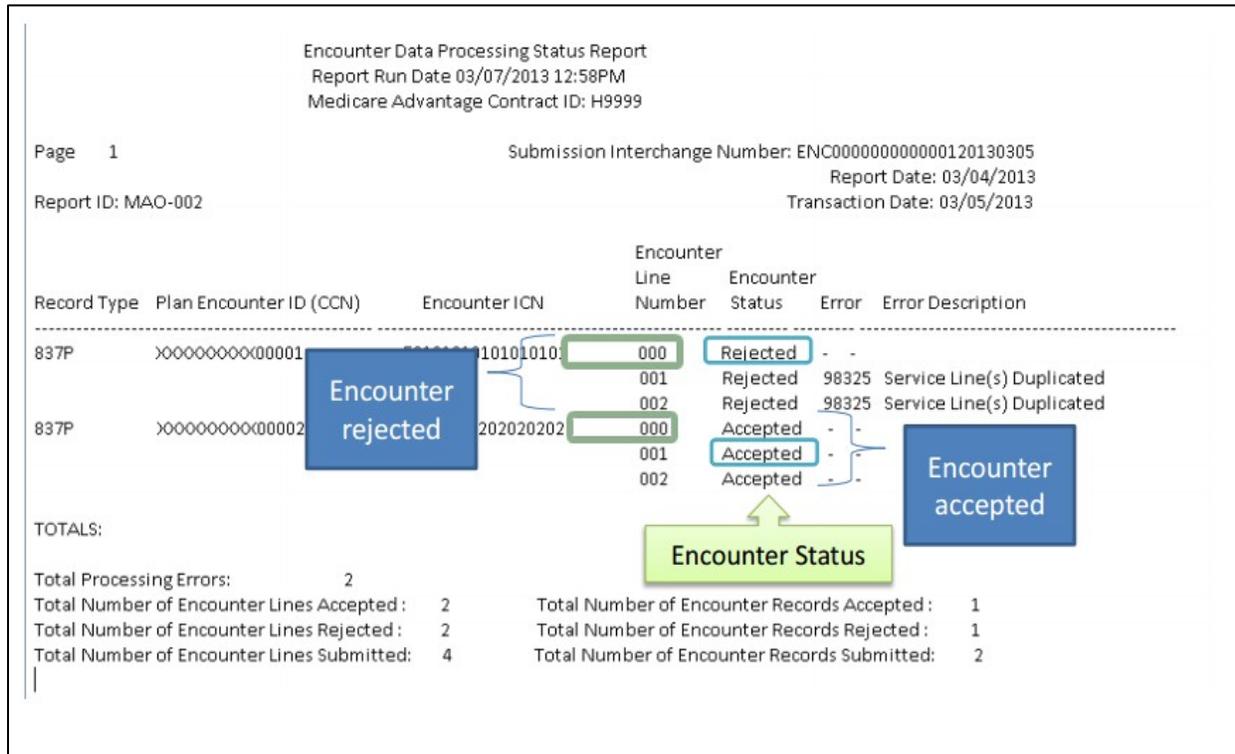
MAOs should wait for receipt of MAO-002 reports to properly reconcile any submissions before submitting replacement records. MAOs should only submit adjudicated records with changes in data from the original record data submission. Avoiding duplicate record submissions will allow the EDS to process all records more efficiently and cost-effectively so that timely and accurate reporting can continue.

5.4. Report Restoration

The MAO-001 and MAO-002 reports are stored in the CMS repository for a limited time. Under certain circumstances, MAOs may need to request that reports be restored. For example, reports not retrieved from the MAO's mailbox within 14 days are deleted from the MAO's mailbox. CMS will restore reports based on the date the report was originally distributed to an MAO or other entity. EDPS reports will not be restored if the requested files are older than 60 business days from the original distribution date. Requests to restore more than 200 files will not be accepted.

CMS recommends that MAOs and other entities monitor their files and submit requests appropriately, and CMS reserves the right to deny requests that manipulate the guidelines. If MAOs/ Medicare-Medicaid Plans are uncertain if an MAO report has been generated, please do not resubmit the file. Contact the Customer Service and Support Center Operations Help Desk for assistance.

Chapter 6. Prevention and Resolution Tips for ED Submission Errors

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6.1.   Overview of Edit Codes

Edit codes are used throughout encounter data processing to indicate invalid or unacceptable data submitted in an encounter data set. Note: In some places in this Guide, the term *error code* is also used, for example, in the MAO-002 Report record layout and in Chapters 4 and 5.

Information on Encounter Data Front-End System (EDFES) edits can be found in the following locations:

- **Chapter 4, Table 4.4:** EDFES Pre-Screening Validation Edits. These edits are text only, not numerical codes. These edits only apply to Connect:Direct files

- **EDFES Edit Code Look-up Tool:** This tool, available at https://www.csscoperations.com, includes edit codes found in CMS' 5010 Edits Spreadsheets – that is, Translator edits (837 5010 Interchange envelope and Functional Group edits) and CCEM edits (837 5010 Transaction Set edits.)

- **Appendix 4D:** Edits in CMS' 5010 Edits Spreadsheets that have been deactivated.

- **Chapter 4, Table 4.10:** Post-Screening Invalid Report. These edits are text only, not numerical codes.

Information on Encounter Data Processing System (EDPS) edits can be found in the EDPS Edit Code Look-up Tool at https://www.csscoperations.com. In addition, online and downloadable listings of all EDPS edit codes are available on the same website.

Both the EDFES and EDPS Edit Code Look-Up Tools are updated regularly, and it is the responsibility of the Medicare Advantage Organization (MAO) to ensure its submissions comply with all editing and validation steps.

Currently, this chapter focuses on tips for a subset of the most frequently occurring edits in the EDPS. CMS expects to add a section on tips regarding frequently occurring edits in the EDFES in future versions of this document.

6.2. Selected Header-Level Edit Codes – Detailed Information and Examples

6.2.1. Edit 00265 – Correct / Replace or Void ICN Not in EODS

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
00265	Correct/Replace or Void Internal Control Number ICN Not in EODS	R	ALL

Example scenarios

Example 1: Wednesday Health Services sent an original encounter to the (Encounter Data System) EDS and received accepted Internal Control Number (ICN) 123456789. Dr. John May corrected the associated claim and resubmitted to Wednesday Health Services. Wednesday Health Services submitted the replacement encounter to the EDS using ICN 234567890. The encounter was rejected because the ICN was invalid for the replacement encounter submission.

Example 2: Chance Medical Services submitted an encounter to the EDS and received an MAO-002 report with an accepted ICN of 123456789. The encounter required an adjustment (void or replacement). Chance Medical Services submitted a replacement encounter using ICN 234567899. The replacement encounter was rejected because there was no original record in the EDS for this ICN with the same Submitter ID.

Prevention/resolution strategy: Replacement or void encounter data record submitted with an invalid ICN. EDS does not store rejected ICNs. Verify the accuracy of the ICN on the returned MAO-002 report.

6.2.2. Edit 00760 – Adjusted Encounter Already Void/Adjusted

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
00760	Adjusted Encounter Already Void/Adjusted	R	ALL

Example scenarios:

Example 1: On 8/20/2012, Pragmatic Health submitted a replacement encounter for ICN 123456789 to correct a Current Procedural Terminology (CPT) code. However, Pragmatic Health had already submitted a void for the same ICN on 8/18/2012 but had not yet received the MAO- 002 report by 8/20/2012. Pragmatic Health received edit 00760 on a subsequent MAO-002 report because the EDPS had already processed the void encounter submitted on 8/18/2012.

Example 2: (Rejected records included ICNs for records that had been previously replaced): An original record submitted and accepted in 2015 (ICN: 15152XXXXXXXX).

A replacement record (ICN: 17188XXXXXXXX) submitted on 7/8/2017 and successfully replaced the original record. A second replacement record (ICN: 17192XXXXXXXX) submitted on 7/12/2017. The second replacement rejected with Edit 00760 because the original/parent (ICN = 15152XXXXXXXX) has already been replaced. The original/parent ICN should be 17188XXXXXXXX.

Example 3: (Rejected records included ICNs for records that had already been voided.): An original record was submitted and accepted in 2015 (ICN: 15177XXXXXXXX).

A Void record (ICN: 17072XXXXXXXX) with claim frequency "8" was submitted on 3/15/2017 and successfully voided the original record (ICN: 15177XXXXXXXX).

A replacement record (ICN: 17192XXXXXXXX) was submitted on 7/12/2017 with the ICN of the voided record (ICN: 17072XXXXXXXX). The replacement record was rejected with Edit 00760.

Edit features:

- Header-level edit
- Applicable to both encounter data and chart review replacement records (Claim Frequency Code = 7).
- Displayed on a replacement encounter data or chart review record (Claim Frequency Code = 7).
- Displayed when the original/parent record whose ICN was submitted on the replacement encounter data or chart review record has already been voided or replaced by a previous replacement or void encounter data record.

Prevention/resolution strategy: The submitter has previously voided an encounter data record and is attempting to replace the same voided encounter OR the submitter has previously replaced an encounter data record and is attempting to replace the same replaced encounter.

The submitter should review returned MAO-002 reports to confirm processing of the voided encounter data record or replacement encounter data record before resubmitting the replacement.

Ensure that replacement records are submitted with the correct reference ICN of the most recently submitted accepted record.

- An accepted encounter record can only be replaced or voided once.
- If a record has been successfully replaced by a replacement record and the submitter wants to send a subsequent replacement record to modify additional data elements, the second replacement record must be submitted with the ICN of the first accepted replacement record.

- Do not submit a replacement record with an ICN of a voided record. If a voided record was submitted in error, the submitter must resubmit the original encounter data record.

- This new encounter data record must be submitted with claim frequency "1", because the system will not allow any replacements of voided records.

6.2.3.   Edit 00780 – Adjustment Must Match Original

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
00780	Adjustment Must Match Original	R	ALL

Example scenario

Torchlight Healthcare submitted an encounter totaling $250 for services provided to Ciao Bella by Dr. Gavin and received ICN 5555555555557. Dr. Gavin's staff identified the need to adjust the payment amount and sent the corrected amount, $205, to Torchlight Healthcare under a different billing National Provider Identifier (NPI) than the billing NPI on the original encounter data record (EDR) (ICN 5555555555557). Torchlight Healthcare submitted the replacement encounter to the EDPS with the corrected payment information and the new billing NPI. The EDPS rejected the replacement encounter because the billing NPI on the adjustment record did not match the billing NPI of the EDR that it was intended to replace.

Edit features:

- Header-level edit

- Applicable to both encounter data and chart review replacement records (Claim Frequency Code = 7).

- Applicable to replacement records only

The seven key header-level data elements listed below from a replacement record must match the previously submitted and accepted record that the newly submitted record is intended to replace:

- Linked Internal Control Number

- Beneficiary HIC Number (or Member Beneficiary Identifier (MBI))

- Beneficiary Last Name (first five characters)

- Beneficiary First Name (first character)

- Place of Service (professional and DME records) / Type of Bill (institutional records)

- Billing Provider NPI

- Payer ID

CMS analysis: A CMS analysis demonstrated that the edit is posting accurately on replacement EDRs. Observations from the analysis indicated that in most cases there was a mismatch of the billing NPI submitted on the replacement record and in some instances there were mismatches with beneficiary last name or first name.

Prevention/resolution strategy: When submitting a replacement encounter, MAOs must match the ICN, Health Insurance Claim Number (HICN) or Member Beneficiary Identifier (MBI), Last Name, First Name, Billing Provider NPI, Payer ID, and Type of Bill (TOB) (INST only), POS (PROF/DME only), of the EDR that is to be replaced. Note: The EDPS will validate the beneficiary's demographic data (HICN or MBI , Last Name, First Name) according to the Medicare Beneficiary Database (MBD), as well as validate the beneficiary's Billing Provider NPI before posting edit 00780.

6.2.4.   Edit 00800 – Parent ICN Not Allowed for Original

EDPS Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
00800	Parent ICN Not Allowed for Original	R	ALL

Example scenario:

Southwest Health Plan submitted an original, non-chart review encounter for Samuel Anderson. The original, non-chart review encounter contained a reference to ICN 4561234561233. The EDPS rejected the encounter because an original non-chart review encounter should not contain an ICN.

The original encounter should be resubmitted without the ICN.

Prevention/resolution strategy: An original non-chart review EDR will be rejected if an ICN or any other data are populated in Loop 2300 REF02 along with REF01= F8. An original non-chart review encounter data record should not contain a linked ICN.

Note: Although some MAOs use the ICN field for their own purposes, there are also cases where MAOs intended to submit voids, replacements, or linked chart reviews, and did not submit the proper claim frequency code or indicate a chart review record. To avoid having records with an unclear intent, we will reject records that are not clearly original EDRs.

6.2.5.   Edit 02125 – Beneficiary DOB Mismatch

EDPS Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
02125	Beneficiary DOB Mismatch	R	ALL

Example scenario

Swan Health submitted an encounter to the EDS for Joe Blough that listed Mr. Blough's DOB as 12/13/1940. The CMS systems listed Mr. Blough's DOB as 12/13/1937. The EDS returned the MAO- 002 report to Swan Health with edit 02125 due to the year of birth exceeding the two-year variance.

Edit features:

- Header-level edit

- Applicable to EDRs and chart review records (CRRs)

CMS analysis: A 2017 CMS analysis demonstrated, for the sample reviewed, that the enrollee information submitted on the records differs significantly from the enrollee data in the EDPS reference tables. Specifically, in the sample reviewed, the DOB submitted on the records was different than the DOB in the EDPS reference tables. The day, the month, or both the day and month, of the DOB submitted did not match the day and month information in the EDPS reference tables. In all instances, the year of the enrollee's DOB submitted on a record was the same as the year of the enrollee's DOB in the EDPS reference tables.

Prevention/resolution strategy: This edit checks to make sure that the DOB submitted on the EDR matches the MBD data in CMS' encounter data system. CMS' analysis of a sample of records failing these checks shows that the DOB information submitted does not match the data in the MBD. CMS also checked to see if the MBD data had changed recently and found that the data in the MBD match the data in the Monthly Membership Report (MMR) and have not been changed for several years in most cases. MAOs have access to the correct data in their MMRs.

Verify that the DOB populated on the encounter matches the DOB listed in CMS' systems. The EDPS will accept these encounters within plus or minus two years from a beneficiary's birth year. Note: CMS anticipates that the change in this edit will be short term and expects plan sponsors to improve their submission of DOBs.

The edit will result in a rejection when the DOB on the record does not match the enrollee's DOB in the CMS enrollment reference data

Note: Currently, the day and month submitted on the EDR corresponding to the beneficiary/member's DOB must be an exact match to the day and month of the member's DOB within the CMS enrollment reference data. However, the year submitted for the member's DOB on the EDR may differ with the member's DOB year stored in the CMS enrollment reference data by plus or minus two years.

6.2.6. Edit 02240 – Beneficiary Not Enrolled in MAO for Dates of Services

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
02240	Beneficiary Not Enrolled in MAO for dates of services	R	ALL

Example scenario

Gabrielle Boyd was admitted to Faith Hospital for an appendectomy on 6/11/2012 and was discharged on 6/14/2012. Faith Hospital submitted the claim for the hospital admission to Adams Healthcare. Adams Healthcare adjudicated the claim and submitted an encounter to the EDS on 7/12/2012. Ms. Boyd's effective date with Adams

Healthcare was 7/1/2011. The EDS returned an MAO-002 report to Adams Health with edit 02240 because Ms. Boyd was not enrolled with the health plan for the DOS submitted by Faith Hospital.

Edit features:

- Header-level edit for Institutional, Professional and DME records

- Applicable to EDRs only. As of December 22, 2017, this edit is bypassed for chart review records. Please see Health Plan Management System (HPMS) Technical Release Memo dated December 15, 2017.

- The EDPS first validates if the contract ID submitted on the record for the enrollee matches the contract ID in the CMS enrollment reference data. If the contract ID does not match the data in the CMS enrollment reference data, the record will be rejected with edit 02240 posting.

- If the contract ID matches the data in the CMS enrollment reference data, then the system validates if the dates of service on the encounter are within the contract enrollment dates.

CMS analysis: A 2017 CMS analysis demonstrated, for the sample reviewed, the enrollee information submitted on the records differ significantly from the enrollee data in the EDPS reference tables. Specifically, in the sample reviewed, the enrollee was not enrolled in the contract for the dates of services (DOS) submitted on the record. Examples include the following:

- The enrollee has a date of death recorded in the EDPS reference table and is no longer enrolled in the contract for the DOS submitted on the record.

- In these instances, the DOS submitted are after the enrollee has been disenrolled from the contract.

- (Note: An enrollee is automatically disenrolled from a contract at the end of the month based on his or her date of death).

- The enrollee was not enrolled in the contract submitted on the record for the DOS on the record. In these instances, the enrollee was enrolled in a different contract for the DOS submitted. In some instances, the beneficiaries' enrollment in the contract ended.

The enrollee was not enrolled in a Medicare Advantage (MA) contract for the submitted DOS. In these instances, the DOS submitted on the record are prior to the enrollee being enrolled in an MA contract.

Prevention/resolution strategy: Verify that the beneficiary was enrolled in contract during DOS on the encounter. If the beneficiary was not enrolled in contract for the encounter DOS, do not submit the encounter. Encounters should only be submitted for DOS in which the beneficiary was enrolled in your contract. Verify the enrollees enrollment and demographic information using the reports distributed monthly through the Medicare Advantage Prescription Drug System (MARx). Populate the correct enrollment and demographic information accordingly on encounter data and chart review records.

Bypass conditions:

This edit is bypassed for chart review records.

For encounter data records, the bypass conditions are as follows:

Professional records: If the "from date" on the header is the same as or before the enrollee's disenrollment date in the contract AND the "through date" is after the enrollee's disenrollment date in the contract AND the Place of Service value on the record is 21, 31, 32, 51, 55, 56, or 61.

Institutional encounters: If the "from date" on the header is the same or before the enrollee's disenrollment date in the contract AND the "through date" is after the enrollee's disenrollment date in the contract AND the Type of Bill value on the record is 11X, 12X, 18X, 21X, 22X, 41X, OR 85X.

DME encounters: If the "from date" on the header is the same or before the enrollee's disenrollment date in the contract AND the "through date" is after the enrollee's disenrollment date in the contract.

6.2.7.   Edit 17330 – Request for Anticipated Payments (RAP) Not Allowed

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
17330	RAP Not Allowed	R	INST

Example scenario:

Magic Morning Health Plan submitted an encounter to the EDS for BackHome Health (a primary home health agency) with TOB 322. The encounter was rejected because the EDS does not accept Request for Anticipated Payment (RAP) encounters.

Prevention/resolution strategy: Requests for Anticipated Payment cannot be submitted for Home Health encounters TOBs 322 or 332 (with DOS before 10/1/13).

6.2.8.   Edit 22355 – Inpatient Service Line Error

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
22355	Inpatient Service Line Error	R	INST

Example scenario:

On 6/28/2015, Care Bear Health resubmitted an encounter to the EDS with bill type 21X and a billed amount of $240.00 on the Revenue Code 0022 service line. The EDS previously rejected the encounter and returned an MAO-002 Report containing error code 21979, "Charges for Rev Code 0022 Must Be Zero" because the Revenue Code service line billed amount and noncovered charge amounts must be either blank or equal to zero. The adjusted encounter received error code 22355 at the header level because it contained a reject error on the service line.

Prevention/resolution strategy: CMS is posting error code 22355 along with error description "Inpatient Service Line Error" to the Institutional inpatient encounter (TOB 11X, 18X, 21X, and 41X) header when a submitted encounter contains a reject error on any service line.

Anytime a reject error is posted because of an error on an inpatient encounter service line, edit 22355 will post on the header as necessary to reject the encounter. The whole encounter is rejected if any line on the encounter is rejected for any reason. The submitter should re-submit the whole encounter afer applying the corrections to the reject service line(s).

6.2.9.   Edit 22405 – Occurrence Code 55 & Date of Death Required

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
22405	Occurrence Code 55 & DOD Required	R/I	INST

Prevention/resolution strategy: The EDPS implemented Error Code 22405, "Occurrence Code 55 and DOD Required" to validate the presence of Occurrence Code 55 and date of death when a patient discharge status code of 20 (expired), 40 (expired at home), 41 (expired in a medical facility), or 42 (expired – place unknown) is populated on an encounter.

Informational: Without an Occurrence Code 55 and a date of death from date of service 10/1/12–12/31/12.

Reject: Without an Occurrence Code 55 and a date of death from date of service 01/01/13 – current DOS

6.2.10.   Edit 30261 – Referring Physician NPI Required

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
30261	Referring Physician NPI Required	I	DME

Edit features: Edit 30261 is currently being posted on DME encounters for the following conditions:

- The Referring Provider NPI is not submitted on the encounter.
- The Referring Provider NPI submitted on the encounter does not have a valid Medicare Enrollment.
  Update to edit logic:
- CMS will now validate the Referring Provider NPI received on DME encounters against National Plan and Provider Enumeration System (NPPES).
- The informational edit will now post if the Referring provider NPI is not submitted or not present in NPPES for the submitted date of service.

6.2.11.   Edit 98300 – Exact Inpatient Duplicate Encounter

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
98300	Exact Inpatient Duplicate Encounter	R	INST

Example scenario

On 8/3/2015, A Fine MAO submitted an encounter for Mayank Deshpande's stay at Mercy Hospital from 6/15/2015 through 6/23/2015. On 8/10/2015, A Fine MAO resubmitted the same encounter as an original to the EDPS with altered procedure modifiers. The EDPS rejected the encounter submitted on 8/10/2015 because the header level (Loop 2300) HICN, DOS, TOB, and Billing Provider NPI data values matched those of the previous encounter submitted on 8/3/2015. If the provider wishes to adjust the line level (Loop 2400) elements, they must submit a replacement encounter or void the original encounter, then resubmit.

Edit features: This edit looks for duplicate inpatient submissions by matching on four key fields: HICN, DOS (from and through), Billing Provider NPI, and TOB.

- Applicable to Type of Bills 11X, 18X, 21X and 41X
- Bypassed for CRRs

Figure 6.1. MAO-001 Report with Edit 98300
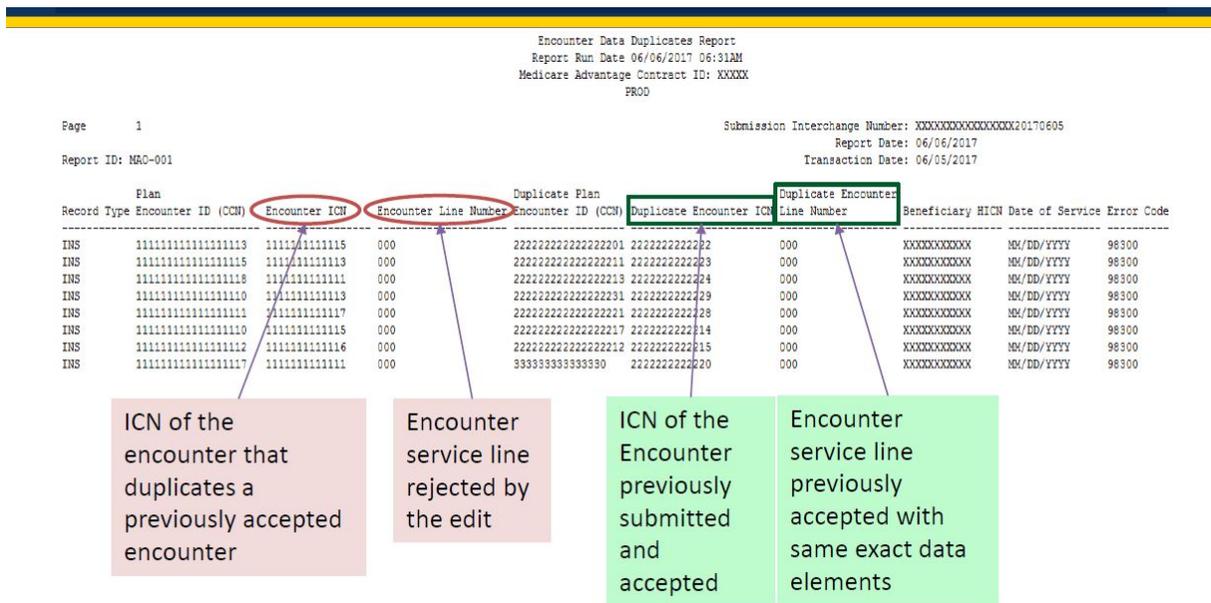
- Line Number '000' indicates the edit is posted at the Header Level

CMS analysis: The EDRs that were rejected as duplicates included several service lines compared to just one line found on the previously submitted and accepted EDR. The EDRs that were rejected were also missing data elements that were submitted on the previously accepted EDR – for example, Contract Information (2300 CN1), Other Diagnosis Codes (2300 HI), Attending Provider (2310A NM1). The EDRs that were rejected included additional data elements that were not submitted with the previously accepted EDR – for example, Remittance Date (2330B DTP).

Submitters have requested that we add additional fields to the logic for this edit. CMS conducted extensive analysis on this edit and found that when edit 98300 fired, the services reported on the more recently submitted record were in fact identical to the services reported on the previously submitted and accepted record, based on the four-key duplication logic. CMS understands that data elements other than the four considered for the 98300 duplicate check may differ. However, if CMS adds data elements to the logic, we will be accepting two records representing the same encounter. This situation compromises data integrity and shifts the responsibility of identifying the most accurate data from the submitter to CMS or even to other users of encounter data, who would need to make assumptions about the submitters' intent regarding which record of the service to use.

Prevention/resolution strategy: MAOs must submit adjustment or void encounters when altering Inpatient encounters. The EDPS will reject TOBs 11X, 18X, 21X, or 41X that contain duplicate header level (Loop 2300) data elements for HICN, DOS (from and through), TOB, and Billing Provider NPI of an accepted encounter.

MAOs may wait to submit an inpatient EDR until an inpatient hospital stay has been fully adjudicated in the MAOs' systems.

If an MAO has submitted an inpatient EDR and would like to make changes to any of the data elements on the record, the MAO can do one of two things:

1. Void the original EDR by submitting with a claim frequency code of 8 AND submitting a new record
2. Submit a replacement EDR with a claim frequency code of 7.

There are two options a submitter can use to make changes to the diagnosis codes on a previously submitted and accepted inpatient EDR, but not other aspects of the data related to the encounter:

1. The MAO may follow the guidance above regarding changing data elements on the record.
2. The MAO may use a CRR to add diagnoses to the EDR or use a chart review delete record that is linked to the EDR to delete diagnoses from the EDR.

Because an EDR is by definition a report to CMS from the MAO and not a provider claim, the MAO should use the appropriate value for the claim frequency code on the EDR, even if it differs from the claim frequency code of the claim submitted to the MAO by the provider.

6.2.12.   Edit 98315 – Linked Chart Review Duplicate

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
98315	Linked Chart Review Duplicate	R	ALL

Example scenario:

Sequoia Health Plan conducted an audit of Langhorne Hospital and discovered that an encounter previously submitted to the EDS contained an unnecessary diagnosis code. On 4/01/2014, Sequoia Health Plan submitted a linked chart review encounter to the EDS containing the associated ICN of the original encounter to identify the unnecessary diagnosis code. On 5/01/2014, Sequoia Health Plan inadvertently submitted the exact same linked chart review encounter to the EDS. The EDS rejected the second submission of the linked chart review encounter because no changes were detected between the two linked chart review encounters.

Edit features:

- Header-level edit
- Chart Review Replacement Records only

Table 6.1. Data Elements Compared for Duplicate

Professional & DME Encounters	Institutional Encounters
Health Insurance Claim Number or Medicare Beneficiary Identifier	Health Insurance Claim Number or Medicare Beneficiary Identifier
Dates of Service – Header	Dates of Service – Header
Diagnosis Codes	Diagnosis Codes
Referenced Internal Control Number	Referenced Internal Control Number
Not Applicable	Type of Bill

Figure 6.2. MAO-001 Report with Edit 98315

- Line Number '000' indicates the edit is posted at the Header Level

- Most recent encounter is a duplicate of the encounter referenced
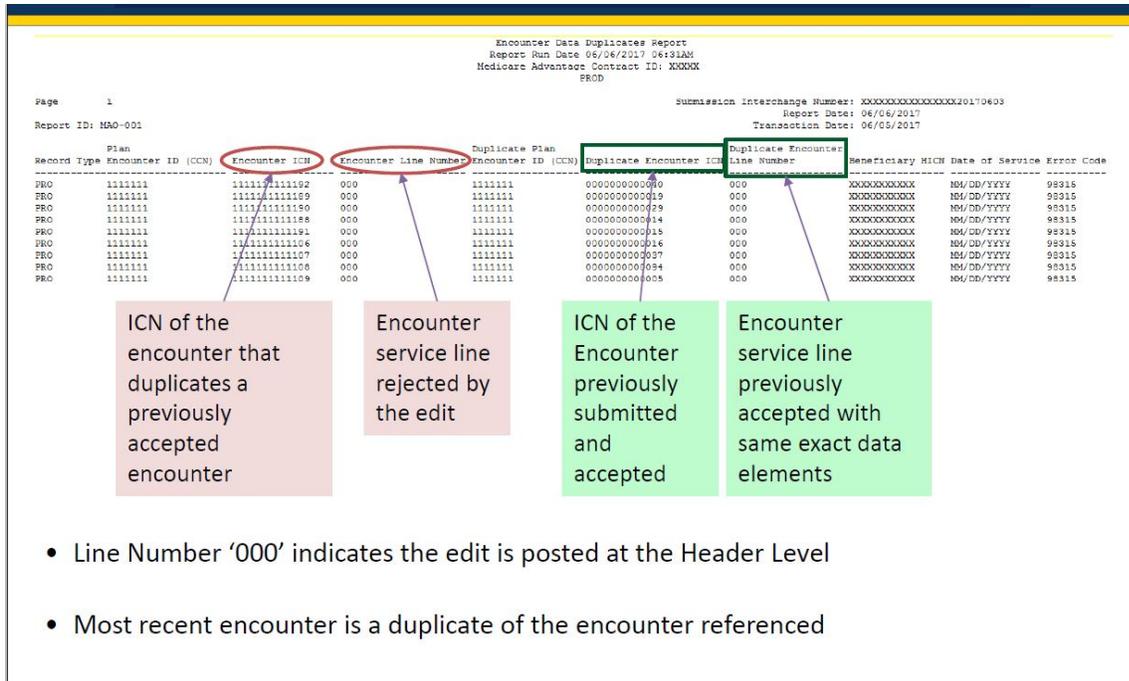
CMS analysis: All of the data elements on the EDR that was rejected as a duplicate and the previously accepted EDR were identical except for Service Line noncovered charges (2400 SV207) and Line Check or Remittance Date (2430 DTP).

Prevention/resolution strategy: Linked Chart Review encounters cannot be submitted where the HICN, Associated ICN, header DOS, diagnosis code(s) and TOB (TOB applicable to Institutional only) contain the exact same values as another chart review encounter already present within the EODS. Submitters should use a replacement CRR to replace diagnosis codes only on previously accepted chart review records. If you need to correct data elements *other than diagnoses codes* on a previously accepted CRR, void the previously accepted chart review record and resubmit a new record with the corrections.

6.2.13.   Edit 98320 – Duplicate Chart Review

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies to: (Institutional, Professional, DME, ALL)
98320	Duplicate Chart Review	R	ALL

Example scenario:

Ohio Health Plan conducted an audit of Cincinnati City Hospital and discovered that an encounter not previously submitted to the EDS required an additional diagnosis code. On 3/15/2014, Ohio Health Plan submitted

an unlinked chart review encounter to the EDS to include the additional diagnosis code. On 6/01/2014, Ohio Health Plan submitted the same unlinked chart review encounter to the EDS due to a clerical error. The EDS rejected the second submission of the unlinked chart review encounter because the EDS detected no changes between the two unlinked chart review encounters.

Edit features: Edit 98320 is posted when a duplicate chart review record (linked or unlinked with claim frequency other than 7 or 8) is received on the Professional, Institutional or DME.

- Header-level edit

- Original chart review records only (Linked and Unlinked)

- Applicable to Professional, DME, and Institutional

A CRR is identified as a duplicate if it has the same values as an existing, accepted chart review record for the fields in Table 6.2. The edit logic for Edit 98320 was updated on September 29, 2017, to include the Reference ICN in the matching criteria to identify duplicate CRRs. Please see the HPMS Technical Release Memo dated August 8, 2017.

Table 6.2. Edit 98320 Institutional Matching Criteria Effective September 29th, 2017

Current 98320 Logic	Updated 98320 Logic
Health Insurance Claim Number or Member Beneficiary Identifier	Health Insurance Claim Number or Member Beneficiary Identifier
Header Dates of Service	Header Dates of Service
Diagnosis code	Diagnosis code
Type of Bill	Type of Bill
Not Applicable	Reference Internal Control Number

Table 6.3. Edit 98320 Professional and DME Matching Criteria as of October 1, 2017

Current 98320 Logic	Updated 98320 Logic
Health Insurance Claim Number or Member Beneficiary Identifier	Health Insurance Claim Number or Member Beneficiary Identifier
Header Date of Service	Header Date of Service
Diagnosis code	Diagnosis code
Not Applicable	Reference Internal Control Number

Figure 6.3. MAO-001 Report with Edit 98320

• Line Number '000' indicates the edit is posted at the Header Level
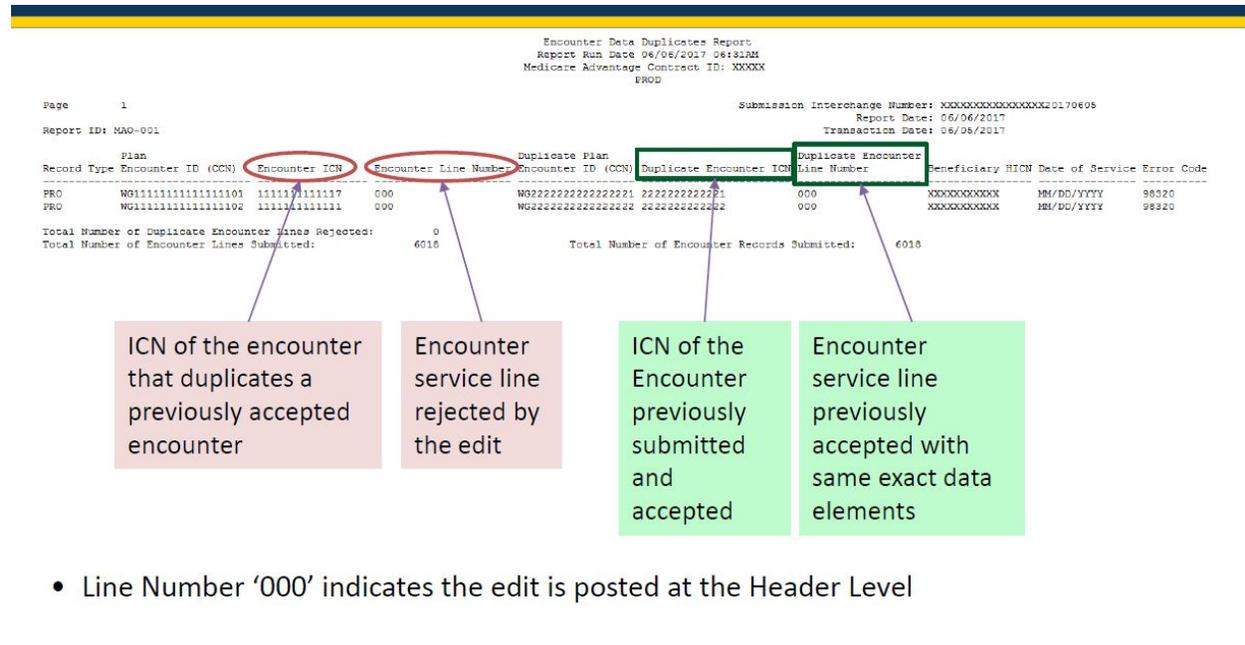
CMS analysis: In most cases for professional EDRs, the EDR that was rejected as a duplicate is an unlinked CRR and the previously accepted EDR is a linked CRR with a parent ICN. For institutional EDRs, the rejected and the previously accepted EDRs were both unlinked CRRs. Other than the linking ICN, all of the data elements on the rejected EDR and the previously accepted EDR were identical except for Patient Control Number (2300 CLM01), Other Payer Claim Check or Remittance Date (2330B DTP), and Claim Identifier for transmission intermediaries (2300 REF02 with D9 Qualifier).

Prevention/resolution strategy: Submitters should use a CRR only to add and delete diagnosis codes, but not to change other data elements. If a submitter needs to correct a data element other than a diagnosis code on a previously accepted CRR, the submitter should void the previously accepted CRR and resubmit a new CRR with the corrected data elements.

6.3. Selected Line-Level Edit Codes – Detailed Information and Examples

6.3.1. Edit 02256 – Beneficiary Not Part C Eligible for DOS

Encounter Data Processing System Edit Code	Edit code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
02256	Beneficiary Not Part C Eligible for DOS	R	ALL

Example scenario

On July 4, 2012, Gail Williams had severe chest pains and went to the emergency room for a chest X-ray at Underwood Memorial Hospital. At the time of the emergency room visit, Ms. Williams did not have Part C Medicare coverage because her Part C coverage was not effective until 8/1/2012. Underwood Memorial submitted the claim to AmeriHealth. AmeriHealth submitted an encounter to CMS and received error code 02256 because Ms. Williams is not covered under Part C Medicare for the DOS.

Edit features:

- Header-level edit for Institutional records
- Line level edit for Professional and DME records
- Applicable to EDRs and CRRs

Notwithstanding the bypass logic (described below), this edit will result in a rejection when both the "from" and "through" dates on a record are not within the enrollee's active enrollment dates in Medicare Advantage.

CMS analysis: A 2017 CMS analysis demonstrated, for the sample reviewed, the enrollee did not have active enrollment in Medicare Advantage for the DOS submitted on the record as shown in the following examples:

- The enrollee has a date of death recorded in the EDPS reference table and is no longer enrolled in any MA contract for the DOS submitted on the record. In these cases, the DOS submitted are after the enrollee has been disenrolled from MA.
- The enrollee did not have an active Medicare Advantage enrollment for the DOS submitted on the record.
    - In these instances, the enrollee was enrolled in a Part D-only contract for the DOS submitted.
    - In some instances, the enrollee was disenrolled from an MA contract prior to the DOS submitted on the record.
- The beneficiary was not enrolled in MA for the submitted DOS. In these instances, the DOS submitted on the record is before the enrollee's participation in MA.

Prevention/resolution strategy: Verify that beneficiary was enrolled in Part C for DOS listed on the encounter. Encounters should not be submitted for beneficiaries not enrolled with the contract for the DOS on the received claim. Encounters should only be submitted for DOS for which the beneficiary is actually enrolled with the contract. Submitters should make sure that the begin and end dates of the service fall within the Part C eligibility begin and end dates. Verify the enrollee's enrollment and demographic information using the reports distributed monthly through MARx. Populate the correct enrollment and demographic information accordingly on EDRs and CRRs.

Bypass conditions:

Professional records: If the "from" date on a service line is the same as or before the enrollee's disenrollment date in the contract AND the "through" date is after the enrollee's disenrollment date in the contract AND the Place of Service value on the record is 21, 31, 32, 51, 55, 56, or 61.

Institutional encounters: If the "from" date on the header is the same or before the enrollee's disenrollment date in the contract AND the "through" date is after the enrollee's disenrollment date in the contract AND the TOB value on the record is 11X, 12X, 18X, 21X, 22X, 41X, OR 85X.

DME encounters: If the "from" date on the service line is the same or prior to the enrollee's disenrollment date in the contract AND the "through" date is after the enrollee's disenrollment date in the contract.

6.3.2.   Edit 17310 – Rev Code 036X Requires Surg Proc Code

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
17310	Rev Code 036X Requires Surg Proc Code	R	INST

Example scenario:

Life and Health Associates submitted an encounter for Galaxy Suburb Hospital for a prostate cryosurgery performed on 5/15/2012. They reported the Revenue Code of 036X but did not include the surgical CPT code of 55873 (Cryosurgical ablation of the prostate).

Edit features:

- Line-level edit
- Applicable to EDRs and CRRs
- Applicable to Institutional Records with TOB 11X, 18X, or 21X
- Edit 17310 will be posted if the following conditions are satisfied:
  - Revenue Code (2400 SV201) 036X is present on any of the service lines of an EDR or a CRR
    AND

    – ICD-9 or ICD-10 Principal (2300 HI01-2, where 2300 HI01-1 is BR/BBR) or Other Procedure Code (2300 HI01-2, where 2300 HI01-1 is BQ/BBQ) is not submitted on the EDR.

- **Note:** This edit will be bypassed if

    – The EDR contains ICD-9 diagnosis code(s) (2300 HI01-2, where 2300 HI01-1 is BK or BJ or BF) V641, V642, or V643

        OR

    – The EDR contains ICD-10 diagnosis code(s) (2300 HI01-2, where 2300 HI01-1 is ABK or ABJ or ABF) Z5301, Z5309, Z531, Z5320, Z5321, Z5329, Z538, Z539, Z9911, Z9981 or Z993.

    CMS analysis: CMS conducted an analysis of this edit code activity in 2017 and confirmed it posts correctly.

    Prevention/resolution strategy: Ensure Institutional Inpatient EDRs (TOB 11X, 18X, or 21X) containing Revenue code 036X are submitted at a minimum with one Principal or other Procedure Code. If the Principal or Other Procedure Code is not available, the EDR should contain at least one diagnosis code that is included in the bypass logic.

Table 6.4. Submission of ICD-10 Procedure Codes on 837-I 5010 EDRs

Scenario	Code
Principal Procedure Code X12 format for EDRs with DOS prior to ICD-10 implementation dates (10/01/2015)	HI*BR:3121:D8:20051119~
Other Procedure Code X12 format for EDRs with DOS prior to ICD-10 implementation date (10/01/2015)	HI*BQ:3121:D8:20051119~
Principal Procedure Code X12 format for EDRs with DOS on or after ICD-10 implementation date (10/01/2015)	HI*BBR:0B110F5:D8:20151001~
Other Procedure Code X12 format for EDRs with DOS on or after ICD-10 implementation date (10/01/2015)	HI*BBQ:02139Y3:D8:20151001~

Figure 6.4. Example of a Valid Submission Common Edits and Enhancements Module (CEM)

```
.
.
2300  0001CLM XXXXXXXXXXXXX XXXXXXXXXX11X XXXX
2300  0001HI 0001ABKZ5111
2300  0001HI 0002ABJC9000
2300  0001HI 0001BBR30233R1
2300  0001HI 0002BBQ3E04305

  .

  .
2400  0003LX 0001000003
2400  0003SV2 00010360
NNNNNNNNNNNXXNNNNNNNN NNNNNNNNNN
.
.
```

6.3.3.   Edit 98325 – Service Line(s) Duplicated

Encounter Data Processing System Edit Code	Edit Code Description	Disposition of Edit	Scenario Applies To: (Institutional, Professional, DME, ALL)
98325	Service Line(s) Duplicated	R	ALL

Example scenario:

Sanford Health Systems submitted an encounter on 6/15/2015 for a claim received from Dr. Skye for an office visit. Dr. Skye resubmitted the claim to correct the office point of contact. Sanford Health submitted a replacement encounter to CMS and received error code 98325 because none of the data elements validated by the EDPS duplicate logic were changed from the previously submitted encounter. To correct the office point of contact only, Sanford Health Systems would need to void the previously submitted encounter and submit a new original encounter or submit a replacement encounter data record against the original encounter data record to correct the inaccurate or missing data elements.

Edit features: Edit 98325 is a line-level edit that identifies service lines that are duplicates of an existing accepted encounter service line in history (previously submitted) or another service line within the same EDR. The edit is not applicable for CRRs, Void EDRs, or adjustment EDRs against the previously submitted and accepted EDRs.

For institutional outpatient encounters, the dates of service at the service line level are optional if header from and through dates are the same. Therefore, EDPS uses the **header-level** statement "from" and "through" dates

for validation if the line-level DOS are missing. If the line-level DOS are submitted, the EDPS uses line-level DOS for validation.

Table 6.5. Institutional Outpatient Fields Used for Duplicate Checking

Institutional – Outpatient
Health Insurance Claim Number or Medicare Beneficiary ID
Dates of Service
Procedure Code and up to 4 modifiers
Paid Amount (2320 AMT02/2430 SVD02)
Billed Amount
Type of Bill
Billing Provider NPI
Revenue Code

For professional/DME encounters: Use the service-line Rendering Provider NPI. If the Rendering Provider NPI is not submitted on the service line, use the header-level Rendering Provider NPI. If the header-level Rendering Provider NPI is not submitted, use the header-level Billing Provider NPI.

Table 6.6. Professional/DME Fields used for Duplicate Checking

Professional/DME
Health Insurance Claim Number or Medicare Beneficiary ID
Dates of Service
Procedure Code and up to 4 modifiers
Paid Amount (2320 AMT02/2430 SVD02)
Billed Amount
Place of Service
Rendering Provider NPI

Prevention/resolution strategy: When the original encounter data record is in "Accepted" status with all accepted service lines and the MAO needs to correct a data element that is **not part of duplicate check**:

- Void the Original encounter data record and resubmit a new encounter data record with the corrections
     OR
- Submit a "replacement" (Claim Frequency Code of 7) EDR against the original EDR to correct the inaccurate or missing data elements.

When the original encounter data record is in "Accepted" status with accepted and rejected service lines and the MAO needs to **correct rejected lines only**:

- Void the Original EDR and resubmit a new EDR with both the previously accepted service lines, and with corrections to the previously rejected service lines

    OR

- Submit an "Original" (Claim Frequency Code other than 7 or 8) EDR with the corrections and include only the service lines that were previously rejected.

    For repeated Procedure/Service, or a Distinct Procedural Service, include appropriate modifiers.

    When an MAO-001 Report is returned with encounter service lines rejected with edit 98325:

- **Do** make corrections to your rejected lines and resubmit them (see the two allowed approaches above).
- **Do not** resubmit a new encounter file until the MAO Reports for previously submitted files have been received and reconciled by your system.
- **Do** incorporate duplicate line checks within your internal processing systems prior to submission.

    Bypass conditions: The duplicate check is bypassed for encounters submitted with the following modifiers:

Table 6.7. Modifiers that will Trigger Edit 98325 Bypass

Institutional – Outpatient	Professional
59 - Distinct Procedural Service	59 - Distinct Procedural Service
62 - Two Surgeons	(Not applicable)
66 - Surgical Team	(Not applicable)
76 - Repeat Procedure by Same Physician	76 - Repeat Procedure by Same Physician
77 - Repeat Procedure by Another Physician	77 - Repeat Procedure by Another Physician
91 - Repeat Clinical Diagnostic Laboratory Test	91 - Repeat Clinical Diagnostic Laboratory Test

Edit 98325 is also bypassed for specific modifiers and specific Ambulatory Surgery Centers (ASC) procedures. Ambulatory Surgical Center (ASC) Encounters. Specifically, Professional and Institutional ASC encounter service lines having procedure code with Multiple Procedure Discount Indicator of 1 on the ASC Fee Schedule.

6.4.   Informational Edit Codes and Resolutions: Edit 00845 and Edit 00850

CMS created two new informational edits, effective September 29, 2017, to identify non-CRRs that replace or void a CRR. This violates CMS operational policy, whereby only CRRs can replace CRRs, and only EDRs can replace EDRs. See Chapter 2, Section 2.3. CMS is implementing these edits because we cannot determine the submitter's intent in these situations.

    Notes:

1. The new informational edits will be posted only when the previously submitted chart review record is in accepted status.

2. If the data elements on the previously submitted chart review record do not match the data received on the replacement or void EDR, the record will be rejected with edit 00699 or 00780.

Table 6.8. Informational Edits for CRRs, Effective September 29, 2017

Edit Code	Disposition	Description	Applies To
00845	Informational	Adjustment Must Be a Chart Review Record	ALL
00850	Informational	Void Must be a Chart Review Record	ALL