Medicare-Medicaid Encounter Data System

Addendum to Encounter Data System Companion Guide and State assigned Medicaid Companion Guides

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

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Preface

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The Medicare-Medicaid Encounter Data System (MMEDS) Addendum contains information to assist Medicare Medicaid Plans (MMPs) and other entities in the submission of Medicare-Medicaid Encounter data. Information in this MMEDS addendum reflects current decisions and may be subject to change. Each version of the MMEDS addendum is identified with a version number, which is located in the version control log on the last page of the document. Users should verify that they are using the most current version.

Questions regarding the contents of the MMEDS addendum should be directed to csscoperations@palmettogba.com.

Contents

1.0 Introduction

The purpose of this addendum is to provide MMPs and other entities with unique requirements of the MMEDS to be used in conjunction with the 837I Encounter Data System Companion Guide and your State assigned Medicaid Companion Guides.

2.0 Website/Email Resources

Contact CSSC Operations at 1-877-534-2772 or csscoperations@palmettogba.com for any MMP support related questions. You may also visit our website at www.csscoperations.com.

3.0 Connectivity

MMPs may use FTP, NDM/Connect:Direct or Gentran/TIBCO for connectivity to the MMEDS. Please refer to section 3.0 of the 837I Encounter Data System Companion Guide for information regarding file size limitations and structure.

4.0 Testing Requirements

MMPs will be required to submit test files to ensure the submitter's systems are properly configured for data submission. Before exchanging production transactions, each plan must complete testing to become certified. This process allows MMPs to confirm that the CMS operational guidance has been properly programmed in their systems. A test file will need to be submitted containing 25 encounters and must pass 100% of the front end edits. In the event more than 25 encounters are submitted, the file must receive an accepted or partially accepted 999, and 277CA with a minimum of an 80% acceptance rate. (Note: MMPs must first enroll to submit MMP data before any testing occurs.)

5.0 File Submission

The Gentran/TIBCO/MFT file naming convention for files from the plan to Palmetto should be constructed as follows:

Medicare	
Test	guid.racf.MEDS.freq.cccc.<Sub Id>.T
Production	guid.racf.MEDS.freq.cccc.<Sub Id>.P
Medicaid	
Test	guid.racf.MMCD.freq.ccccc. <Sub Id>.T
Production	guid.racf.MMCD.freq.ccccc. <Sub Id>.P

6.0 Control Segments/Envelopes

The control segments/envelopes in Section 4 of the 837I Encounter Data System Companion Guide will apply with the following exceptions:

LEGEND
SHADED rows represent segments in the X12N Implementation Guide
NON-SHADED rows represent data elements in the X12N Implementation Guide

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
ISA		Interchange Control Header		
	ISA06	Interchange Sender ID		Submitter ID assigned by Palmetto GBA
	ISA08	Interchange Receiver ID	80888	Medicare
			80891	Medicaid

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
GS		Functional Group Header		
	GS02	Application Sender's Code		Submitter ID assigned by Palmetto GBA This value must match the value in ISA06
	GS03	Application Receiver's Code	80888	Medicare
			80891	Medicaid

7.0 837 Institutional Data Elements

The data elements in Section 5 of the 837I Encounter Data System Companion Guide will apply with the following exceptions:

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Submitter ID assigned by Palmetto GBA
1000B	NM1	Receiver Name		
	NM103	Receiver Name		MMEDSCMS
	NM109	Receiver ID	80888	Medicare
			80891	Medicaid
2000B	SBR	Subscriber Information		
	SBR01	Payer Responsibility Number Code	S	MMEDSCMS is considered the destination (secondary) payer
	SBR09	Claim Filing Indicator Code	MA	Medicare Part A
			MC	Medicaid
2010BA	NM1	Subscriber Name		
	NM108	Subscriber ID Qualifier	MI	Must be populated with a value of MI – Member Identification Number
	NM109	Subscriber Primary Identifier		This is the subscriber's Health Insurance Claim (HIC) number. Must match the value in Loop 2330A, NM109)
2010BB	NM1	Payer Name		
	NM103	Payer Name		MMEDSCMS
	NM109	Payer Identification	80888	Medicare
			80891	Medicaid
2010BB	REF	Billing Provider Secondary Identification		
	REF01	Medicaid Subscriber ID Identifier	G2	
	REF02	Medicaid Subscriber ID Number		Medicaid State Assigned Identification Number
2300	REF	Payer Claim Control Number		
	REF01	Original Reference Number	F8	
	REF02	Payer Claim Control Number		Identifies ICN from original encounter when submitting adjustments
2320	AMT	Payer Paid Amount		
	AMT01	Amount Qualifier	D	Must be populated with a value of D – Payer Amount Paid
	AMT02	Payer Paid Amount		Medicare-Medicaid Plan paid amount

8.0 Loop 2330B – REF01 Segment

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2330B	REF	Other Payer Secondary Identifier		
	REF01	Reference identification Qualifier	FY	If the MMP populates data in the 2330B Loop/REF02 segment, when the REF01 = FY, Palmetto GBA will overlay the data populated in the REF02 segment with the Palmetto GBA assigned ICN.

The Palmetto GBA assigned ICN will be populated in the 2330B Loop REF02 segment with an FY qualifier. This ICN will be passed to the State Agency in an 837 delimited file. If the MMP populates data in the 2330B Loop REF02 segment when the REF01 = FY, Palmetto GBA will overlay the data populated in the REF02 segment with the Palmetto GBA assigned ICN. PLEASE NOTE, currently this only applies to the State of California and its MMPs. No other MMPs are affected.

9.0 Acknowledgements and/or Reports

The acknowledgement and/or reports in Section 6 of the 837I Encounter Data System Companion Guide will apply with the following exceptions:

- Encounters designated as Medicaid will receive a 277CA report.
- Additionally, Encounters designated as Medicaid will not receive the MAO-001 or MAO-002 reports.

10.0 Report File Naming Conventions

Medicare Gentran/TIBCO/MFT references can be found in Sections 6.6.1; Tables 5 and 6, and 6.6.2; Tables 8 and 9 of the 837I Encounter Data System Companion Guide.

Medicaid Gentran/TIBCO/MFT references are as follows:

GENTRAN/TIBCO/MFT Report Name
P.xxxxx.MCD_RESPONSE.pn
P.xxxxx.MCD_REJT_IC_ISAIEA.pn
P.xxxxx.MCD_REJT_FUNCT_TRANS.pn
P.xxxxx.MCD_ACCPT_FUNCT_TRANS.pn
P.xxxxx.MCD_RESP_CLAIM_NUM.pn

11.0 EDFES Notifications

This table replaces Table 10 found in Section 6.7 of the 837I Encounter Data System Companion Guide.

APPLIES TO	ENCOUNTER TYPE	NOTIFICATION MESSAGE	NOTIFICATION MESSAGE DESCRIPTION
All files submitted	All	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
All files submitted	All	SUBMITTER NOT AUTHORIZED TO SEND CLAIMS FOR PLAN (CONTRACT ID)	The submitter is not authorized to send for this plan
All files submitted	All	PLAN ID CANNOT BE THE SAME AS THE SUBMITTER ID	The Contract ID cannot be the same as the Submitter ID
All files submitted	All	AT LEAST ONE ENCOUNTER IS MISSING A CONTRACT ID IN THE 2010BB-REF02 SEGMENT	The Contract ID is missing
Production files submitted	All	SUBMITTER NOT CERTIFIED FOR PRODUCTION	The submitter must be certified to send encounters for production
All files submitted	All	FILE CANNOT EXCEED 5,000 ENCOUNTERS	The maximum number of encounters allowed in a file
All files submitted	All	TRANSACTION SET (ST/SE) (XXXXXXXXX) CANNOT EXCEED 5,000 CLAIMS	There can only be 5,000 claims in each ST/SE Loop

12.0 Medicaid Edits

High level file integrity checks are performed on MMP Medicaid encounters. The encounters are interrogated by a commercial off the shelf (COTS) EDI translator. CMS provides a list of edits used to process encounters submitted to the MMEDS found in the CMS 5010 Edits Spreadsheets. For a list of current edits, MMPs should refer to the spreadsheet version identifier in cell A1. The version identifier is comprised of ten characters, broken down as follows:

- Positions 1-2 indicate the line of business
  - EA – Part A
  - EB – Part B
- Positions 3-6 indicate the year (i.e., 2014)
- 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 (i.e., V01-first iteration, V03-third iteration)

The CMS 5010 Edits Spreadsheets provide documentation regarding edit rules that explain how to identify an edit and the associated logic. The CMS 5010 Edits Spreadsheets are accessible on the CMS website. In addition, a link to this page can be found on the CSSC Operations website under Edits. Only 999R, 999E and 277T edits are applicable and are identified in the columns labeled "TA1/999/Validation" and "Accept/Reject".

13.0 Business Scenarios

The Submitter ID, Payer Code, and Receiver Name (EDSCMS) contained in the business scenarios in Section 9 of the 837I Encounter Data System Companion Guide will not apply to MMP Medicare or Medicaid data submissions. (**Note:** MMP submitters should use Receiver Name MMEDSCMS)

14.0 Medicaid Data Elements

Refer to your State assigned companion guide for data element specifications with the exception of the data elements specified in Sections 6.0 and 7.0 of this addendum.

REVISION HISTORY

VERSION	DATE	DESCRIPTION OF REVISION
1.0	11/14/2013	Baseline Version
2.0	12/12/2013	Updated table in Section 5.0 – Changed segment from NM103 to NM108 in the 2010BA loop
		Removed EDFES notifications from table in Section 7.0
		Changed MMEDSCMS acronym to EDSCMS acronym in Section 8.0
3.0	07/02/2014	Updated Testing Requirements, Section 10.0 to include requirements when a file contains more than 25 files
4.0	09/08/2014	Added the 2010BB REF segment to the 837 Institutional Data Elements table; Section 5.0
		Updated Testing Requirements, Section 10.0 to exclude the 837 type (i.e. 837I)
5.0	11/05/2014	Corrected the term “validation” to “277CA” in Section 6.0; page 5
6.0	12/09/2014	Inserted Medicaid Edits (section 9.0). Moved the two existing sections below this point to 10.0 and 11.0. Updated the Table of Contents to reflect this change
7.0	01/20/2015	Under EDFES Notifications (section 8.0), removed "Date of service cannot be before 2011. Files cannot be submitted with a date of service before 2011."
8.0	02/04/2015	Updated the hyperlink within section 1.0
		Added 2320 AMT information to table in section 6.0
9.0	03/31/2015	Added 2300 Payer Claim Control Number information to table in section 6.0
10.0	05/06/2015	Updated the fourth sentence of section 4.0 by removing “for Institutional data” from the sentence.
11.0	07/06/2015	Updated sections 3.0 and 7.1 to show that Gentran/TIBCO is valid for use
12.0	08/19/2015	Added Gentran/TIBCO/MFT naming conventions to sections 5.0 and 9.0
		Corrected reference in section 3.0 by removing “DME”
13.0	09/04/2015	Updated the hyperlink in Section 11.0
14.0	11/03/2015	Removed the Tier-II testing exception from Section 4.0
15.0	04/22/2016	Inserted section 8.0 to note the special handling of Loop 2330B - Other Payer Secondary Identifier and REF01/REF02 segments.