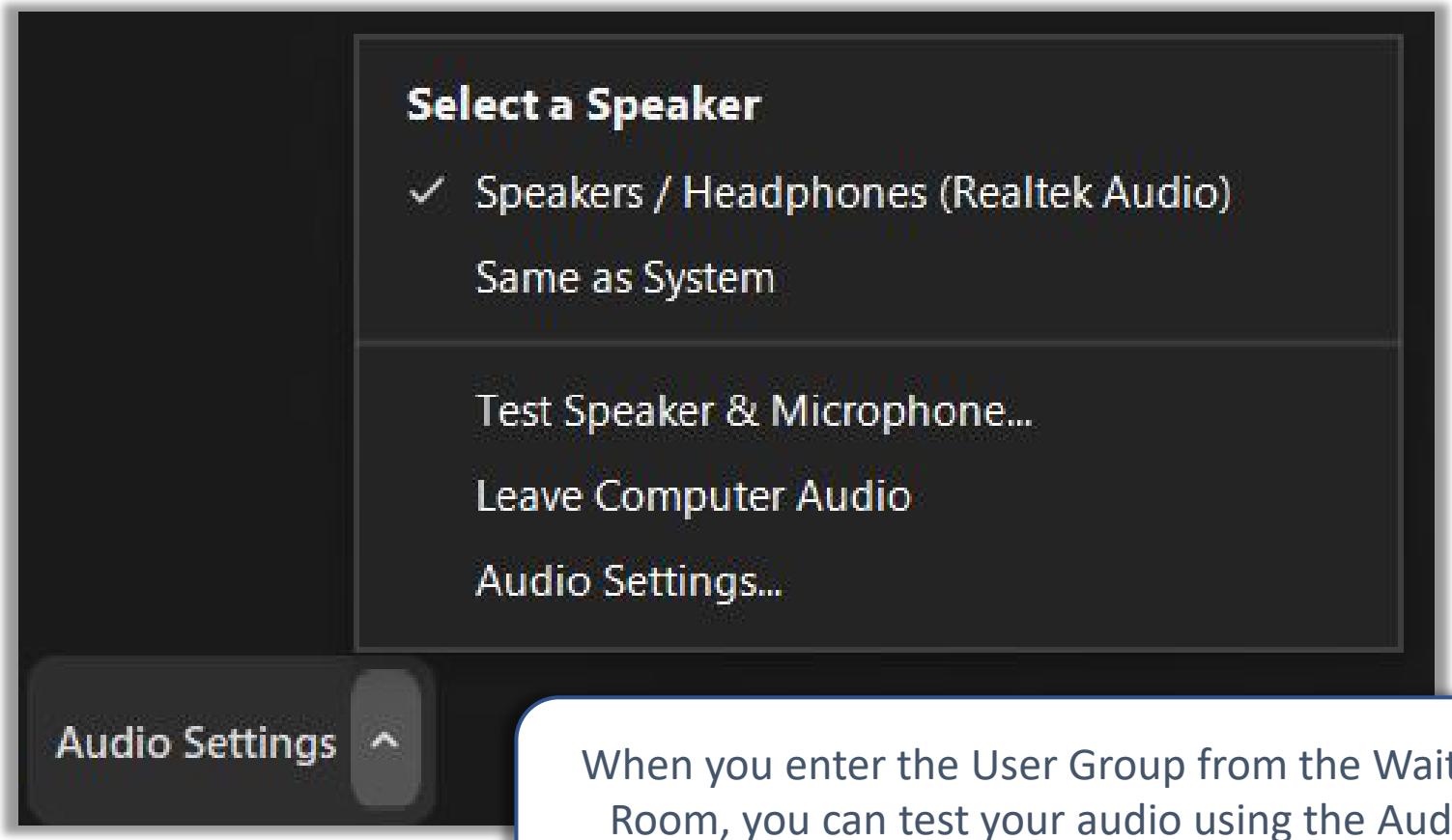
Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records

09/26/2024 | 2:00-3:00 p.m. ET

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Joining Audio



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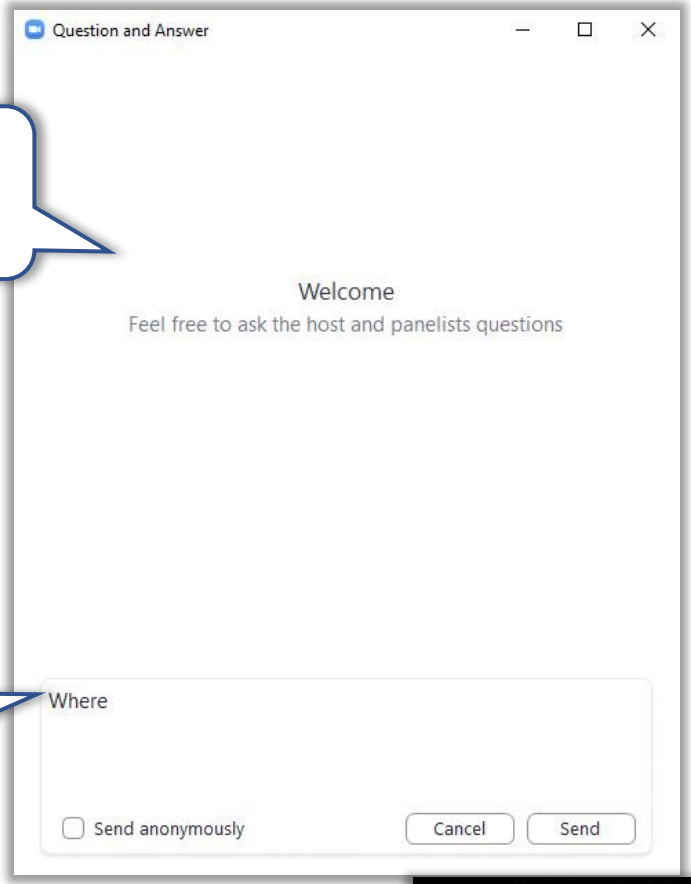

Type your question in the Q&A box and press the Send button.

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Objectives

1. To provide an overview of recent instructions related to submission of supplemental benefits data on encounter data records (EDRs)
2. To answer frequently asked questions regarding the instructions for the submission of supplemental benefits data on EDRs

Agenda

1. Overview: Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records
2. Examples
3. Dental
4. Frequently Asked Questions
5. Question and Answer Session
6. Resources

Overview: Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records

HPMS Memo: February 21, 2024

- CMS requires organizations providing services or items to Medicare beneficiaries to **submit data that characterize the context and purpose of each item and service provided to a Medicare beneficiary**, as described in regulation at 42 CFR 422.310.
- These requirements apply not only to Medicare-covered items and services, but also extend to **supplemental benefits** offered by MA organizations.
- While MA organizations have always been able to submit some supplemental benefits to the Encounter Data System, not all MA organizations have regularly submitted the supplemental benefits that could be submitted. Further, a number of these benefits could not be submitted because many supplemental benefits are non-medical in nature and, therefore, were difficult to report in the medical claims format used to collect encounter data.

Two Challenges Identified in Submitting Supplemental Benefit Data to EDS - #1

Challenge #1: For certain types of supplemental benefits, MA organizations may lack information necessary to populate required EDR fields, such as National Provider Identifiers (NPIs), procedure codes, diagnosis codes, and/or revenue codes.

February 21, 2024, HPMS Memo: For all supplemental benefits for which there does not exist sufficient data to populate an X12 837 Version 5010 professional or institutional record, CMS has developed **default codes**, provided in the technical instructions, which may be used to populate the required data fields.

These default codes are **only to be used for submitting supplemental benefits data to the EDS when diagnosis, procedure, or revenue code data do not exist** for a given item or service (e.g., reporting over-the-counter (OTC) benefit utilization that does not have an associated diagnosis code). In all other circumstances, CMS expects MA organizations to obtain the specific codes necessary for submission from the provider or vendor.

Two Challenges Identified in Submitting Supplemental Benefit Data to EDS - #2

Challenge #2: Benefits are not provided in a manner that allows for standard reporting procedures. For instance, non-medical benefits may have very different patterns of utilization than medical benefits, or benefits (medical or non-medical) may be paid on a capitated or periodic basis (e.g., annual gym memberships and pre-funded allowance cards).

February 21, 2024, HPMS Memo: When considering how utilization of supplemental benefits should be reported on an EDR, MA organizations should use the guiding principle that a **record of utilization should be submitted for every individual instance when an enrollee actually uses the benefit**.

In certain circumstances in which per-utilization reporting is not practicable (e.g., each time an enrollee uses a physical fitness membership to visit a fitness center or an OTC pre-funded card is used at a participating retailer), MA organizations should instead **report when the enrollee first has access to the benefit and is able to use it or at the end of the benefit period with the amount of the allowance used.**

MA organizations should apply these general principles when submitting supplemental benefits beyond the examples provided in these instructions.

Identification of Supplemental Benefits in the EDS

CMS has developed a Supplemental Benefits Indicator to identify supplemental benefits on encounter data submissions using existing segments on the 837 format for professional and institutional, specifically the Paperwork (PWK) segments.

The use of the Supplemental Benefits Indicator will enable CMS to distinguish between items and services covered under Medicare Part A or Part B and those that are supplemental benefits.

In addition, to standardize reporting across various supplemental benefits data collection efforts, the Supplemental Benefits Indicator will include a Supplemental Benefit Services Category (SBSC) Code, which aligns with supplemental benefit categories used in PBP submissions (see Appendix 2.12 B).

Medicare Advantage General Supplemental Services Submission Guide, Section 2.12.3.1

Identification of Supplemental Benefits – PWK Segments

The Supplemental Benefits Indicator was created to identify all professional and institutional supplemental benefits offered by an MA organization. The Supplemental Benefits Indicator comprises the following four data elements within the 2400 Loop (line level) with the following values:

PWK01 = **IR**
PWK02 = **EM**
PWK05 = **AC**
PWK06 (Identification Code) = **SBSC Code**

The first three values are static values, and the last value (PWK06) is to be populated with appropriate SBSC code from Appendix 2.12 B, which aligns with supplemental benefit categories used in PBP submissions.

For example: Routine Foot Care

PWK01 = **IR**
PWK02 = **EM**
PWK05 = **AC**
PWK06 = **7f**

Medicare Advantage General Supplemental Services Submission Guide, Section 2.12.3.1

Examples

Example #1: Over-the-Counter (OTC) Debit Card

In this example, an MA plan offers an OTC benefit on a pre-funded card with a $200 quarterly allowance to be used at participating retail locations. Any unused portion of the allowance does not rollover to the subsequent period. The enrollee is mailed the card at the beginning of the plan year; in the first quarter of the year, they use the card to purchase $190 of covered OTC items. The OTC card vendor does not require diagnosis, procedure, or revenue codes as part of their billing process. At the end of the first quarter, the MA organization would report the first quarter OTC utilization on an EDR as outlined below.

- NPI (default) = 1999999984
- Procedure code (default) = SBSP1
- Diagnosis code (default) = SBSD1
- Revenue code (default) = 1111
- “From” date of service = 01/01/2024
- “Through” date of service = 03/31/2024
- PWK06 = 13b
- Line Item Charge Amount = $200.00
- Service Line Paid Amount = $190.00

Medicare Advantage General Supplemental Services Submission Guide, Section 2.12.4.5

Example #2: Physical Fitness Benefit

In this example, an MA plan offers a physical fitness benefit that consists of a monthly gym membership. The vendor does not collect or report diagnosis, procedure, or revenue codes as part of their billing process. The enrollee activates the membership in January. For benefits like this, CMS understands that a plan will not necessarily know each time the member visits the gym; instead, the plan should report when the membership was accessed or initiated.

The MA organization would report this utilization as follows:

- NPI (default) = 1999999984
- Procedure code (default) = SBSP1
- Diagnosis code (default) = SBSD1
- Revenue code (default) = 1111
- “From” date of service = 01/01/2024
- “Through” date of service = 01/31/2024
- PWK06 = 14c4-1

Medicare Advantage General Supplemental Services Submission Guide, Section 2.12.4.7

Example #3: Additional Days for Inpatient Hospital - Acute

In this example, in addition to Medicare-covered hospital stays, the MA plan offers unlimited additional acute inpatient days. An enrollee has an extended hospital stay and uses 7 days beyond the base Medicare-covered stay.

Additional days do not need to be reported as a separate EDR from Medicare-covered days; however, they should be reported as a **separate line** on the EDR and use the appropriate Supplemental Benefits Indicator segments within the 2400 Loop (line level).

The MA organization would report the additional inpatient days as follows:

- The actual NPI, diagnosis code, procedure code(s), and revenue code should all be populated just as they would for a stay that is part of the basic Medicare benefits in accordance with information received from the provider
- To specify additional days are being submitted, populate the Unit or Basis for Measurement Code (Professional Loop 2400 – SV103, Institutional Loop 2400 – SV204) with DA
- The actual count of additional days should be populated in the Quantity (Professional Loop 2400 – SV104, Institutional Loop 2400 – SV205)
- PWK06 = 1a1

Medicare Advantage General Supplemental Services Submission Guide, Section 2.12.4.1

Dental

August 22, 2024, Dental Guidance

- Supplemental dental benefits **cover preventive and comprehensive dental services outside of Medicare-covered dental services**; the context and purpose of these benefits are best captured via a dental-specific format.
- As such, supplemental dental benefits are to be **reported using the X12 837D Version 5010 claims format.**
  - Medicare-covered dental services must continue to be submitted using the 837P for dental services that are Part B benefits or the 837I for dental services that are Part A benefits.
- CMS notified submitters via the August 22, 2024, HPMS memo "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records – Dental Services Submission Instructions and Other Supplemental Service Updates," that 837D submissions would be accepted beginning September 13, 2024.

August 22, 2024, Dental Guidance (continued)

- CMS is phasing in the provision of response reports for supplemental dental services submissions in the 837D format.
- **Phase One** began on September 13, 2024, when the EDS began accepting 837D files.
  - In this phase, MA organizations submit supplemental dental services in the 837D format and receive only front-end edit reports (TA1, 999, and Dental Validation Report).
- In **Phase Two** of the implementation, MA organizations will be provided with additional response reports. CMS will inform MA organizations via a subsequent HPMS memo before Phase Two begins.
- Additional technical guidelines can be found in the Medicare Advantage Supplemental Dental Services Submission Guide, released on August 22, 2024.

Key Considerations for 837D Submissions

- MA organizations should be submitting supplemental dental services for dates of services beginning January 1, 2024.
- MA organizations that are already certified to submit 837-5010 are not required to complete a separate 837D certification.
- Supplemental dental services submitted using the 837D do not require the use of Supplemental Benefit Services Category (SBSC) codes or the PWK segments. CMS will instead be able to use the Current Dental Terminology (CDT) codes from files submitted in the 837D format to crosswalk services to the appropriate category.

Frequently Asked Questions

Frequently Asked Question 1

Where are the guidance documents located?

The guidance documents can all be found on the CSSC Operations website (csscoperations.com), under Encounter & Risk Adjustment Program > Supplemental Benefit Services Submission Guidance.

Frequently Asked Question 2

Is there a deadline for MA organizations to transition to submitting encounter data records for supplemental benefits with the new Supplemental Benefits Indicator?

As noted in the February 21, 2024, HPMS memo ("Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records"), we encourage MA organizations to start submitting supplemental benefit encounter data records (EDRs) as soon as possible and to submit on an ongoing basis (just as your organization would do for other EDRs).

While there is not a set implementation deadline, CMS will be monitoring submissions and will reach out to MA organizations that may not be submitting many supplemental benefits of the types expected based on their bids. (Continued)

Frequently Asked Question 2 (Continued)

Established deadlines for submission of risk adjustment data do not apply to the submission of supplemental benefits encounter data records, since they are for the submission of data for payment purposes. Further, as noted in the February 2024 HPMS memo, the EDS filtering logic for risk score calculations remains unchanged. Generally speaking, diagnoses associated with supplemental benefits are not risk adjustment eligible. Diagnoses on EDRs that contain supplemental items or services along with a service with an allowable procedure code will be risk adjustment-eligible.

Frequently Asked Question 3

If an organization already submitted supplemental benefits on EDRs (without the Supplemental Benefits Indicator), do they need to resubmit those EDRs once the Supplemental Benefits Indicator is operational?

As noted in the February 21, 2024, HPMS memo, MA organizations that are already successfully submitting EDRs for any supplemental benefits should continue their current practices as they develop the capability to submit data on additional supplemental benefits, as discussed in the technical instructions.

These MA organizations are **not expected to resubmit** encounter data records for supplemental benefits, assuming these records have been successfully accepted into the EDS.

Frequently Asked Question 4

Is there a cross-walk or mapping for items and services (and/or HCPCS codes) to the appropriate Supplemental Benefit Services Category (SBSC) Code?

Please refer to section 2.12.4 of the Medicare Advantage General Supplemental Services Submission Guide for examples intended to help MA organizations submit complete and accurate EDRs for supplemental benefits. As noted in that guide, the SBSC must align with supplemental benefit categories used in PBP submissions (see Appendix 2.12 B).

MA organizations are expected to have internal processes for mapping provided supplemental benefits to their corresponding SBSC.

Frequently Asked Question 5

My organization does not receive information on the provider bill to determine when the three (3) pint deductible was waived for blood transfusions. Is CMS asking MA organizations to require that providers bill these indicators?

CMS is aware of reporting challenges for a subset of supplemental benefits that are related to extensions of Medicare-covered services (including additional days for inpatient acute and psychiatric stays, waivers of hospital stays prior to a SNF admission, and waivers of the three (3) pint blood deductible).

We intend to provide additional information related to reporting these categories in future guidance.

Frequently Asked Question 6

Do the requirements for submitting supplemental benefits on EDRs apply to both mandatory and optional supplemental benefits?

Yes. CMS requires that EDRs be submitted for all items and services provided to Medicare Advantage enrollees, including both mandatory and optional supplemental benefits.

Frequently Asked Question 7

If a supplemental service is provided as part of an encounter along with Medicare-covered services, do the services need to be submitted on separate EDRs?

As noted above in the Medicare Advantage General Supplemental Services Submission Guide, the Supplemental Benefits Indicator is a line level indicator that identifies an item or service as a supplemental benefit. These benefits do not need to be submitted as a separate encounter data record if they were provided as part of a single encounter with other services.

Medicare Advantage General Supplemental Services Submission Guide, Section 2.12.3.1

Frequently Asked Question 8

How should payment be reported for combined services, such as a combined vision and hearing benefit?

When allowance amounts on pre-funded cards span multiple categories of supplemental benefits (e.g., a single allowance for vision and hearing), MA organizations must separate out spending by service category and submit an EDR for each category in which there was utilization.

Frequently Asked Question 9

How will MA organizations know if 837D submissions are accepted?

As stated in the August 22, 2024, HPMS memo, supplemental dental services submission in the 837D 5010 format will have a phased implementation. Phase One began September 13, 2024. In this phase, MA organizations began submitting supplemental dental services in the 837D format and **receive only encounter dental data front-end edit reports (TA1, 999, and Dental Validation Report).** The TA1 report enables the receiver to notify the sender when there are problems with the interchange control structure. The sender will only receive a TA1 if there are syntax errors in the file. Errors found in this stage will cause the entire X12 interchange to be rejected with no further processing.

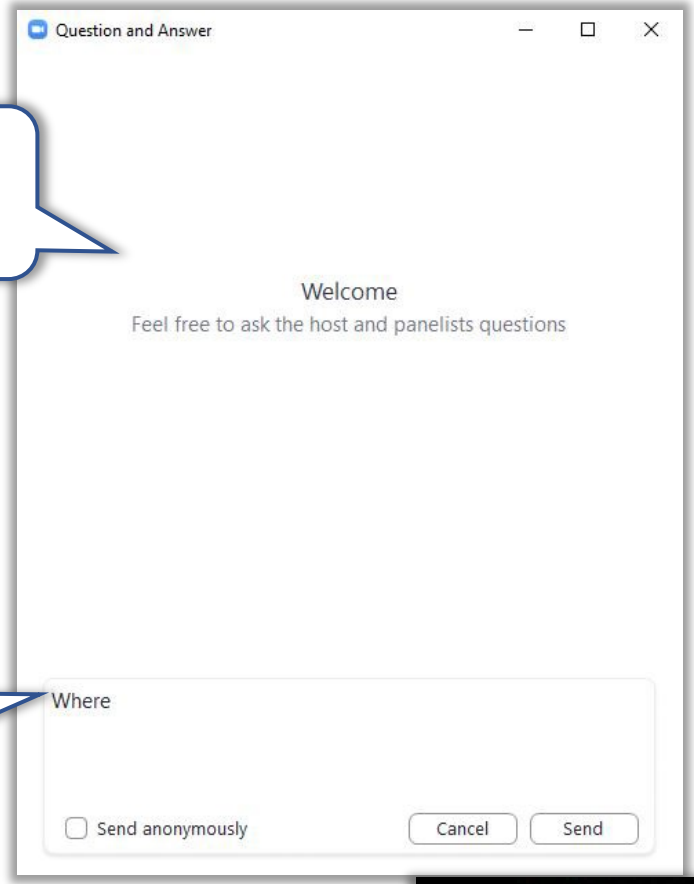
In Phase Two of the implementation, MA organizations will be provided with additional response reports.

Refer to the Medicare Advantage Supplemental Dental Services Submission Guide, Sections 6.1-6.3 for additional information on reports. CMS will inform the MA organizations before Phase Two begins.

Question and Answer Session

Ask Questions During the Q&A Session

Your questions and any answered questions will appear here.



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Resources

Questions

Operational & Policy Questions

Encounter Data and Risk Adjustment Operational Communications/Inquiry Mailbox:
RiskAdjustmentOperations@cms.hhs.gov

Technical Support

CSSC Operations Help Desk
1-877-534-2772
csscoperations@palmettogba.com

Additional Resources

Location	Resource
CSSC Operations	User Group Slide Decks
CSSC Operations	Medicare Advantage General Supplemental Services Submission Guide
CSSC Operations	Appendix B Supplemental Benefit Services Category Codes
CSSC Operations	Appendix C Supplemental Benefits Minimum Data Elements and Default Data
CSSC Operations	Medicare Advantage Supplemental Dental Services Submission Guide
CSSC Operations	Encounter Data Submission and Processing Guide
HPMS Memo/ CMS.gov	Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records, February 21, 2024
HPMS Memo/ CMS.gov	Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records – Dental Services Submission Instructions and Other Supplemental Service Updates, August 22, 2024
HPMS Memo/ CMS.gov	Encounter Data Software Release Updates: February 2024 Release