ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
1	12/01/10	**Q: Item three (3) of the CMS encounter data newsletter states that MAOs should submit only "adjudicated" claims for encounter data. What is CMS' definition of an adjudicated claim?** **A:** MAOs are required to submit only adjudicated claims for the new Encounter Data System (EDS). An adjudicated claim is one that has been finalized in the claims processing system. For the purposes of Encounter Data Processing, only adjudicated claims that are paid or denied are acceptable for submission. Plans should not submit claims in a pending status.
2	12/08/2010	**Q: What is Encounter Data? Does it include any claims data submitted from providers to plans?** **A:** Encounter Data comprises any claims data information entered in the 5010 format. Currently, CMS is asking MAOs to submit only adjudicated claims.
3	12/08/2010	**Q: Are plans required to submit pricing information?** **A:** MAOs must submit adjudicated claims data. CMS does not intend to compare the amount actually paid by the plan to the amount CMS would pay. Pricing information will be stored in the Encounter Data repository and used in the future to recalibrate the risk adjustment model, once CMS can be certain that the plan payments will not be impacted by the transition to collection of encounter data.
4	12/08/2010	**Q: What does adjudicated mean?** **A:** Adjudicated claims are those that are approved/accepted or denied claims. CMS only seeks data on paid and denied services and it is important that the MAOs conduct as little manipulation as possible to ensure all data is collected.
5	12/08/2010	**Q: What type of certification process will be required for Third Party submitters currently not submitting on behalf of a health plan but that anticipate doing so in the future? What are the anticipated requirements and timelines to obtain certification as a Third Party submitter?** **A:** As of right now, plans would need to certify their organization using true data. Unless a Third Party submitter has a plan to certify data on behalf of, the Third Party cannot submit data for certification at this time.
6	12/09/2010	**Q: When the regulations say that plans will be required to submit only adjudicated claims, does that mean the claims must be error free?** **A:** Plans should submit encounters after they have been completely adjudicated in the plan's claims system. This means that that they should be clean claims when they are submitted to CMS. CMS will apply edits and if there are errors, plans will receive notification via reports.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
7	**12/15/2010**	**Q: Does one (1) claim equal one (1) encounter?** **A:** As of now, yes, one claim equals one encounter.
8	**12/15/2010**	**Q: Is CMS going to be requiring many more data fields than what is required on a basic claim?** **A:** No, there will not be more required data fields than what is required on a basic claim (5010).
9	**12/16/10**	**Q: In preparation for submitting encounter data, can you verify the Commercial Off the Shelf (COTS) software solution currently utilized by CMS?** **A:** In Encounter Data processing, there are several different COTS translators that are recommended for use with the 5010 format. One example of this is Edifecs. If you are interested in more information about the CEM edits that CMS will perform for encounter data, then please reference this site, http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp, for further information on the institutional and professional edits.
10	**12/22/2010**	**Q: What is the process for applying for an encounter data submitter ID? Is there an anticipated timeframe from application completion to issuance? Is the expectation that MAO's need to apply or is it possible the Third Party submitter can apply on their behalf?** **A:** We anticipate that new submitter packages will be available prior to the testing start date. Due to the attestation requirements, we expect MAOs to apply. If the MAO plans to use a Third Party submitter, they will need to submit a letter allowing the Third Party submitter to submit on their behalf. Basically, the process will work just as it does for RAPS and PDE data submission.
11	**01/12/2011**	**Q: When will plans receive the published encounter data submitters' package?** **A:** The submitter's package will be published on the www.csscoperations.com website by March 15, 2011. Submitters will need to complete and return the forms by March 30, 2011.
12	**01/12/2011**	**Q: What is the definition for "denied" claims? It was stated that plans should only submit paid or denied claims, but not claims rejected by the plan for invalid claim submission.** **A:** A "denied" claim is a claim that the plan did not pay and payment to the provider was denied.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
13	**01/12/2011**	**Q: Is there a web link available for obtaining all of the required fields for submission of encounter data?** **A:** The information can be found at: http://store.x12.org/ https://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp.
14	**01/12/2011**	**Q: When a claim is submitted, will it continue through all edits until all claim rejections are identified?** **A:** This depends on the type of error encountered. If there is enough data to continue the editing logic, then the claim will continue until it fails. Plans will receive the logic for edit errors.
15	**01/12/2011**	**Q: If one (1) encounter equals one (1) claim, will there be a limit on the number of lines for an encounter?** **A:** It is suggested that there be no more than 450 lines per encounter.
16	**01/13/2011**	**Q: Can you provide guidance on how to proceed with establishing connectivity for submission of encounter data?** **A:** The Submitter Package with instructions will be posted on http://www.csscoperations.com/ by March 15, 2011. This will include the detailed information for obtaining a new submitter ID to submit the 837 files to CMS for encounter data processing.
17	**01/19/2011**	**Q: Is the entire EDI Agreement process online or is part of the process through paper submission?** **A:** The EDI Agreement process is currently under development, and the industry will be notified as soon as the online version is prepared. The intention is to have the majority of this process online, but the EDI Agreement would remain a paper submission, as an original signature from the person in authority in each organization is required. The signed EDI Agreement, in paper form, will accompany the original document to be sent to CSSC to complete the EDI Agreement process.
18	**01/19/2011**	**Q: Are MAOs required to submit claims denied due to internal processing errors (i.e., incorrect member number or a provider ID issue)?** **A:** MAOs are required to submit only claims that were denied for payment purposes. Rejected claims should not be submitted.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
19	**01/19/2011**	**Q: Currently, a plan may scrub certain diagnosis codes prior to sending the RAPS file. For example, if a member has a history of breast cancer but the provider submits a diagnosis of breast cancer. Should plans continue to scrub diagnosis codes for the Encounter Data System (EDS)?** **A:** MAOs should submit encounters as they are received and should not conduct any additional filtering or scrubbing processes.
20	**01/19/2011**	**Q: Will paid encounters be re-priced by CMS for payment calibration?** **A:** Submitted encounters will go through CMS' processing and pricing system. Claims will be repriced according to the Fee-For-Service fee schedules and pricers.
21	**01/19/2011**	**Q: Are Medicare Cost Plans required to submit encounter data?** **A:** Details regarding Cost Plans requirements are currently under development.
22	**01/19/2011**	**Q: If one (1) encounter is equal to one (1) claim, is this driven by the date of service (Meaning one (1)date of service is equal to one (1) encounter)?** **A:** A claim is a submission for the purpose of reimbursement (i.e., from fee-for-service providers) and an encounter is a submission that is not linked to payment (i.e., from capitated providers). Both terms refer to evidence that a medical service was provided on a given date of service.
23	**01/19/2011**	**Q: What is the timeline for submission of supplemental data from chart reviews?** **A:** All Encounter Data, including those submitted from chart reviews, must be submitted according to the Patient Protection and Affordable Care Act Section 6404 and within the 12-month timely filing rules (http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf).
24	**01/19/2011**	**Q: How should encounters from atypical providers be submitted?** **A:** The industry will receive further guidance on the submission of encounter data from atypical providers during the Encounter Data Work Groups in the second quarter of 2011.
25	**01/19/2011**	**Q: Are plans required to submit all data with the exception of claims routed incorrectly and denied for a member not being on file?** **A:** MAOs should submit all data that has been paid or denied from all types of service to CMS for the collection of Encounter Data. Data that is rejected should not be submitted.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
26	**01/19/2011**	**Q: Should encounters denied for being medically inappropriate be submitted?** **A:** Encounters that are rejected due to being medically inappropriate (i.e., invalid gender with diagnosis code) should not be submitted.
27	**01/19/2011**	**Q: Are plans required to filter out rejected claims prior to submission (i.e., missing data, duplicate claims, and member enrollment issues)?** **A:** MAOs should submit all data that has been paid or denied from all types of service to CMS for the collection of Encounter Data. Data that is rejected should not be submitted.
28	**01/19/2011**	**Q: Many plans use self-defined modifiers for services to capture 'Pay for Performance' quality measures. Will these modifiers need to be filtered out prior to encounter data submission?** **A:** Plans should not filter their data. CMS will conduct all filtering on the collected encounter data and will share this filtering logic with MAOs so that they can replicate it when reconciling data.
29	**01/19/2011**	**Q: Must all fields in each 'GS' functional group be populated prior to submitting claim level information ('ST' level)?** **A:** Yes.
30	**01/19/2011**	**Q: Will plans be submitting claims with dates of service after January 1, 2012 only?** **A:** Yes, after the 'go-live' date for encounter data, MAOs will only send claims with dates of service after January 1, 2012.
31	**01/19/2011**	**Q: Will Chart Review data have to be submitted within the 12-month timely filing requirement?** **A:** CMS is currently developing the final policy regarding the 12-month timely filing requirement as it relates to Encounter Data.
32	**01/19/2011**	**Q: Section 6404 of the PPACA gives CMS the authority to specify exceptions for a one (1) year limit. Will CMS create an exception for submission of data discovered during medical record reviews more than one year after the date of service? If not, why?** **A:** CMS is currently developing the final policy regarding the 12-month timely filing requirement as it relates to encounter data.
33	**01/19/2011**	**Q: Does the 12-month filing requirement (requirement 5) apply to adjustment claims that were originally submitted within the acceptable timely filing timeframe?** **A:** CMS expects adjustment claims to be submitted within 12 months. Final policy regarding the 12-month timely filing requirements is under development.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
34	**01/19/2011**	**Q: Will encounters still have the year-end sweeps every two (2) years with the 12-month submission timeline on all encounters?** **A:** This policy is under development.
35	**02/11/2011**	**Q: Are plans required to complete the EDI Agreement before March 30, 2011? For example, if a plan has to pull together resources to establish this connection, and the connection cannot be made until April 5, 2011 will this be a violation?** **A:** Plans have between March 30 and June 30, 2011 to submit test files. For example, if you submit test data on April 5th you are still in compliance with the front-end testing timeframe.
36	**02/14/2011**	**Q: How do plans and/or Third Party submitters register for a new submitter ID for submission of encounter data? In addition, by what date does the application need to be completed?** **A:** The submitter package will be posted by March 15, 2011. To apply, new and existing submitters must download the package and submit it to www.csscoperations.com. Plans must submit test data at some point during the Encounter Data Front-End Testing from March 30 - June 30, 2011. The new submitter ID must be assigned prior to completing front-end testing.
37	**02/17/2011**	**Q: Will revenue codes be a required field for encounter submissions?** **A:** Yes, revenue codes will be a required field of the 5010 837 format.
38	**02/22/2011**	**Q: What will the file size limitations be for the new Encounter Data Processing System (EDPS)?** **A:** Gentran and SFTP users must limit the number of claims submitted per file to 2,500 and NDM users must limit the number of claims submitted per file to 15,000 claims.
39	**02/23/2011**	**Q: Should E-Codes be submitted as part of the 25 diagnoses allowed on an institutional claim (837-I) or 15 diagnoses allowed on a professional claim (837-P)?** **A:** All information associated with an encounter should be submitted to CMS. If there is additional data, including E-codes or V-codes that do not fit on the original claim submitted, they can be submitted as an adjustment using the 'CO' option (add only) in the CAS segment of the 5010.
40	**02/23/2011**	**Q: Should diagnoses not related to the risk adjustment model be submitted to CMS?** **A:** Yes, all data that is collected should be submitted for encounter data. The goal is to obtain as much data related to an encounter as possible.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
41	**03/01/2011**	**Q: Will HCPP 1833 Cost Plans be exempt from the encounter data reporting requirements?** **A:** HCPPs will be required to submit encounter data as stated in the 2012 advance notice. Details regarding Cost Plan requirements for submission are currently under development.
42	**03/02/2011**	**Q: Should only claims denied for payment purposes be submitted for encounter data and not including rejected claims?** **A:** Only adjudicated claims should be submitted to the Encounter Data System, both paid and denied. If the claim is rejected by a plan for invalid/missing data or pending (i.e., not released for payment or denied due to errors in your system) it should not be submitted for encounter data.
43	**03/02/2011**	**Q: How should plans handle claim lags?** **A:** CMS is currently evaluating the timely filing requirements for encounter data. Once the timely filing requirements are finalized CMS will evaluate how to operationalize the requirement.
44	**03/04/2011**	**Q: Where should plans pull the NPI from for the submission of 837 files, from provider claims or from the plans billing system? Will be NPPES available for plan use?** **A:** CMS has determined that the taxonomy code will not be required for encounter data 5010 file submissions.
45	**03/04/2011**	**Q: Are plans required to follow the specific CMS limitation of 450 lines per encounter?** **A:** CMS is requesting that MAOs follow these guidelines. The limit on amount of lines for 837-I is 449. The limit on the amount of lines for the 837-P is 50.
46	**03/04/2011**	**Q: Are plans required to submit COB information for encounter data?** **A:** Yes, plans should populate Coordination of Benefits (COB) fields on the 837-I and 837-P as described in the Washington Publishing Company (WPC) guidelines. If COB information applies to the data submitted, then these fields should be populated.
47	**03/04/2011**	**Q: Are plans required to submit encounter data weekly or monthly?** **A:** Currently, plans are required to submit encounter data monthly. However, we strongly recommend that plans submit more frequently.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
48	**03/14/2011**	**Q: There is a process in place for Third Party submitters to be selected by plans to submit their RAPS and/or enrollment data. This includes Third Party submitters filling out the online form that is provided for this and showing on that form the plans for whom they will be submitting data. The involved plans go into HPMS and fill out an online form saying that a third party submitter will be sending in their data and they would also print off an online form that is in HPMS and sign that and fax it into CMS' Help Desk. Is this the process that will be used when a Third Party submitter will be submitting encounter data to CMS on behalf of one or more plans?** **A:** CMS is currently modifying the HPMS Plan Connectivity module to support the Encounter Data System requirements.
49	**03/16/2011**	**Q: Currently, plans are sending Medicare diagnosis data to CMS using a list of diagnoses specified by CMS. Do we use that same list of diagnoses for encounter data? Are there certain diagnoses that CMS is expecting to receive for encounter data?** **A:** All data that is collected should be submitted for encounter data, including diagnoses not in the Diagnosis Code Files that shows valid diagnoses for the risk adjustment model. Plans should not filter any data. However, it is important to remember that payment for risk adjustment will continue to be based on the valid diagnoses submitted for RAPS. Therefore, plans will need to use the Diagnosis Code File for RAPS submissions. The goal for encounter data is to obtain as much data related to an encounter as possible in order to accurately price the claim.
50	**03/21/2011**	**Q: Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) cover Medicare and Medicaid benefits under one plan. That means, among other benefits, Medicaid-covered dental services, home care, DME etc. Not all Medicaid-covered services are included in the plan's bid, but are included in benefit package. Does CMS expect FIDE SNPs to submit services that are covered under the Medicaid package or only those included in the bid?** **A:** CMS is currently investigating encounter data submission requirements for SNPs. Currently, all data for all types of services should be submitted for encounter data including Medicaid benefits not included in the original bid.
51	**03/29/2011**	**Q: For FTP file submissions the maximum number of records is 2,500 and for NDM the maximum number of records is 15,000 records for encounter data. Do these file submission limits specified for encounter data have any implications to the testing activities taking place prior to the 01/01/2012 implementation date? If so, can you please provide additional information regarding such activities?** **A:** No, these requirements do not apply to testing phases prior to the 'go live' date of January 3, 2012. In front-end testing, send test files (one 837-I and one 837-P) containing between 50 and 100 claims.

ENCOUNTER DATA SUBMISSION REQUIREMENTS		
FAQ Number	**Submission Date**	**Question and Response**
52	**04/06/2011**	**Q: Once the EDPS system goes live on 01/01/2012 and the first file is submitted, should the file only contain dates of service beginning 01/01/2012 or can plans include dates of service that occur in 2011?** **A:** Yes, on January 3, 2012, MAOs should only send claims with dates of service after January 1, 2012.
53	**04/07/2011**	**Q: Is there any process for CMS to accept encounter diagnosis data for encounters that fail CMS edits for reasons not related to diagnosis?** **A:** Fundamentally, all encounters must process through the Encounter Data Processing System edits before diagnoses will be stored for risk adjustment. Specific details will be forthcoming.
54	**04/07/2011**	**Q: Does CMS have a list of approved or preferred vendors for encounter data submission?** **A:** We do not have a list of approved or preferred vendors and cannot provide one.
55	**04/07/2011**	**Q: Has CMS established, and if so published, any fines associated with failing to submit encounter data timely?** **A:** CMS is developing the guidelines and compliance measures associated with timely submission of encounter data. The industry will be notified of final policies and corresponding corrective actions as soon as possible.
56	**04/07/2011**	**Q: Does the requirement to submit encounters within 12 months of date of service refer to initial submission, or final? Can a plan submit a replacement for a previously accepted encounter more than 12 months after the date of service?** **A:** CMS is currently evaluating the timely filing requirements for encounter data. Once the timely filing requirements are finalized CMS will evaluate how to operationalize the requirement.
57	**04/08/2011**	**Q: Will HCPP 1833 Cost plans be required to submit encounter data?** **A:** HCPPs will be required to submit encounter data as stated in the 2012 Advance Notice and Announcement.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
58	**12/15/2010**	**Q: Using the 5010 837 format means there are certain fields that will not be available. What data is needed for risk adjustment?** **A:** CMS has not made a decision about how missing fields will be submitted. CMS must first obtain feedback from the health plans and then recommendations for submission of these fields will be developed as a group.
59	**01/06/2011**	**Q: Are the 5010 standards that should be used for the March 2011 test file be those named in the original regulation of January 2009, or the standards named in the notification of adoption of errata named in the regulation of October 2010? Will the version required change during the course of 2011? (See https://www.cms.gov/Versions5010andD0/70_Medicare_Fee-For-Service_Systems.asp for Medicare fee for service timeline for adoption of the errata).** **A:** We will require the latest version of the 5010. Testing of the 5010 begins March 30 – June 30.
60	**01/06/2011**	**Q: Does CMS expect that paper claims data (i.e., HCFA 1500, UB04) will be submitted in the 837-I and 837-P format? If so, will CMS allow for different edits for paper claims data versus electronic claims data?** **A:** We expect that data from claims received in paper format will be sent in the 837-I and 837-P. We are exploring application of edits for this data. CMS will release additional information regarding the edits as soon as decisions are made.
61	**01/12/2011**	**Q: Will there be both required and informational fields on the 5010?** **A:** Yes.
62	**01/12/2011**	**Q: Is the ICN the plan's number or is CMS assigning this number?** **A:** The ICN can be the pay-to-plan number as long as the 2010AC Loop is populated with the pay-to-plan information.
63	**01/12/2011**	**Q: For the 5010, should all required fields be populated?** **A:** Yes, all required fields should be populated.
64	**01/12/2011**	**Q: Will the Medicare provider ID be accepted in addition to the National Provider Identification (NPI) number for encounter data claims submissions?** **A:** Only NPI will be accepted. All providers should have an NPI.
65	**01/12/2011**	**Q: For providers that are not required to have an NPI, what do plans use for identification/acceptability?** **A:** CMS is currently in the process of developing alternative codes for these providers.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
66	**01/19/2011**	**Q: Is the 276 transaction an optional file submission that MAOs may use?** **A:** The 276 is an optional transaction that MAOs may use to communicate with CMS and to determine the status of a particular claim. It is a benefit to the plan, but it is not mandated for use.
67	**01/19/2011**	**Q: When 837 transactions are submitted, will a 277 transaction automatically be generated?** **A:** When an 837 transaction is received, a 277CA will automatically be returned to the MAO identifying whether claims were accepted or rejected.
68	**01/19/2011**	**Q: In cases where the 277CA is not complete as compared to the files submitted, should MAOs send a 276 transaction for records that do not have responses?** **A:** There is currently not enough information to determine preferences in using the 276 transaction. The workflow for 276 transactions is under development and the industry will receive information on submission of the 276 as soon as final determinations are made.
69	**01/19/2011**	**Q: Are Dental (837-D) encounters included in all requirements regarding professional (837-P) and institutional (837-I) claims?** **A:** Details regarding 837-D encounters are still under development. CMS will notify plans of the decisions regarding this process in the near future.
70	**01/19/2011**	**Q: Is there a separate testing/Go Live schedule for dental encounters (837-D)?** **A:** Details regarding 837-D encounters are still under development. CMS will notify plans of the decisions regarding this process in the near future.
71	**01/19/2011**	**Q: In addition to the 837-I and 837-P transactions, there is now an 837-D as well. For the testing phase, are MAOs required to submit the 837-I, 837-P, and the 837-D?** **A:** The initial systems testing emphasis will be on making sure that we have the processing systems in place to support Institutional (837-I) and Professional (837-P) claims. CMS is looking to receive as many examples of the 837-I and 837-P as possible. CMS is currently evaluating the use of the 837-D.
72	**01/19/2011**	**Q: What is the 837-D?** **A:** The 837-D represents Dental encounters.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
73	**01/19/2011**	**Q: Are dental claims received from providers on the CMS-1500 form submitted through the 837-P?** **A:** We are currently investigating how CMS-1500 dental claim forms will be submitted. We will notify the industry as soon as a determination is made.
74	**01/19/2011**	**Q: Will there be a standard format for 277 transactions?** **A:** The standard Washington Publishing Company (WPC) 5010 format will be used for 277 transactions. The format is located on the WPC website at http://www.wpc-edi.com/content/view/817/1.
75	**01/19/2011**	**Q: If a 276 transaction is submitted, will a 277 be returned?** **A:** Yes, a 277 will be returned to the MAO when a 276 transaction is submitted.
76	**01/19/2011**	**Q: For 2011 dates of service, what file format should plans use for the final submission deadline on 1/31/2013?** **A:** The Risk Adjustment and Encounter Data Systems will run parallel until CMS can validate accuracy of data and calibrate the model. It is too soon to determine the accuracy of the encounter data collected and if the model will have been recalibrated for the 2012 payment year (covering 2011 dates of service). Further information regarding the file format to be used in final submission for reconciliation of Risk Adjustment data by 1/31/2013 will be announced at a later time.
77	**01/19/2011**	**Q: Will an 837 file be limited to 5,000 encounters?** **A:** It is recommended that the size of the transaction is limited to a maximum of 2,500 CLM segments per ST-SE.
78	**01/19/2011**	**Q: Will the 835 format be used to report EDPS results back to the plans?** **A:** The ANSI reports that will be returned to the plans are TA1, 999, and 277CA. If CMS determines that the remittance advice will be used, it will be in the 835 format. All other reports will be customized for encounter data purposes.
79	**01/19/2011**	**Q: How should plans handle multiple reasons for a line denial? Does the current 837 format support this scenario?** **A:** CEM will edit the claim line using the 277CA edits. If an error is encountered, the entire claim will be rejected and the 277CA acknowledgment will report where the edit was found within the claim. Editing is at the CEM level, the entire claim is error free or it is rejected.
80	**01/19/2011**	**Q: How should plans handle a provider who has multiple taxonomy entries per NPPES?** **A:** For Medicare Advantage Encounter Data, only the NPI is required.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
81	**01/19/2011**	**Q: Will CMS provide processing rules and guidelines to support 4010 to 5010 conversions?** **A:** CMS will provide a companion guide for MAOs for the 5010 format only. However, there are resources on the CMS website that currently depict the difference between the formats at http://www.cms.gov/MFFS5010D0/Downloads/Remittance4010A1to5010.pdf.
82	**01/19/2011**	**Q: For a 4010 claim submitted prior to 01/01/2012 that is denied and then resubmitted after 12/31/2011; what is the required format of the resubmitted claim? Please confirm that the resubmission would be in the 5010 format based on the resubmission being after 12/31/2011.** **A:** The CMS Encounter Data System will only accept the 5010 format.
83	**01/19/2011**	**Q: Will the new format require all encounters to be submitted with an NPI for all provider types? How should we handle providers that have been assigned multiple NPIs (i.e., Acute Hospitals)?** **A:** We are investigating the issue for handling multiple NPIs at this time.
84	**01/24/2011**	**Q: Do 837-D claims need to be tested in the same way as Institutional and Professional claims during the Front-End Testing? If so, what is the testing schedule for the 837-D claims?** **A:** CMS is currently evaluating the use of the dental claim. When a final decision has been made, we will inform you.
85	**01/26/2011**	**Q: If the 837 is used, will the number of diagnosis codes be limited after RAPS system is no longer in place?** **A:** The total number of diagnosis codes submitted will not be limited. The 5010 will allow 12 diagnosis codes for professional encounters and 25 diagnosis codes for institutional encounters to be documented; however, if more codes need to be added, plans may just submit the additional codes on a separate claim.
86	**02/09/2011**	**Q: Are Tax ID and Taxonomy Codes equivalent?** **A:** No, Tax ID does not reference the Health Care Provider Taxonomy Code. They are not equivalent.
87	**02/09/2011**	**Q: Will the National Provider Identification (NPI) number be required for claims submission?** **A:** Yes, NPI will be required.
88	**02/09/2011**	**Q: If the NPI will be required on the 5010, why is the Tax ID necessary?** **A:** The Tax ID is being evaluated and may not be a required field on the 5010, but NPI will definitely be required.
89	**02/09/2011**	**Q: If the diagnosis code is not valid for pricing, do we still get risk adjustment credit for diagnosis codes?** **A:** A diagnosis code must be valid and pass all edits, before the diagnosis will be stored. The stored diagnosis will be used for risk adjustment purposes, assuming the diagnosis is included in the risk adjustment model.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
90	**02/09/2011**	**Q: If Diagnosis Pointers are omitted from the 5010, will the encounter reject or will the diagnosis codes apply to all procedures?** **A:** Yes, the claim will reject. No, the pointers will not apply to all procedures. Diagnosis pointers will be a required field on the 5010 and will be edited on.
91	**02/24/2011**	**Q: Could you provide guidance on where the CMS Contract Number and HICN are going to be captured on the 5010 837 format?** **A:** For the purposes of encounter data, the HICN will be placed in Loop 2010BA segment NM108 with a value of "MI" and segment NM109 with a value of "HICN." The CMS contract number will be placed in Loop 2010BB segment NM108 with a value of "PI" and segment NM109 with a value of "CMS ID."
92	**03/02/2011**	**Q: Because paper claims do not have all of the data elements necessary to populate the 5010 file format, what fields need to be populated and what, if any, default values can be used?** **A:** CMS is still researching population methods of paper claim fields not accounted for on the 5010 format and seeking additional information on this issue. If possible, please send a list of paper claim fields that plans are unable to populate on the 5010 and/or examples of default values currently used to eds@ardx.net.
93	**03/02/2011**	**Q: The new format will require the NPI to be provided; however, plans do not store an NPI for groups such as Meals-on-Wheels. How will this be handled with the new format?** **A:** Plans will be provided with a default NPI to use when populating an encounter from an Atypical Provider. CMS plans to publish a list of acceptable Atypical Provider Types. If you have recommendations to add to this list, please send those to eds@ardx.net.
94	**03/04/2011**	**Q: The Date of Birth (DOB) field is required on the 837 format. If plans are required to populate the DOB, is CMS considering having a soft edit on this field?** **A:** For encounter data the HIC number will provide the necessary demographic information, including the date of birth. The date of birth will be optional on the 5010. The member's date of birth will be utilized as a validity check for the HICN. The date of birth is not required for risk adjustment processing and will not be edited against if it is not submitted on an encounter data claim. If date of birth is populated on the 5010 then a validity edit will be applied and may be used by plans as a tool to make sure the HICN is accurate.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
95	**03/08/2011**	**Q: If some required amount field values are populated on a claim and others are not, how should a plan manage this encounter?** **A:** Amount fields applicable to the claim are required and must be populated with numeric characters. If information is available for some but not all of the amount fields, '0' should be inputted for those fields where no data is available. The remaining amount fields should be submitted to CMS as is. Based on pilot test results, the service lines will reject due to translator level edits, if service lines do not balance.
96	**03/08/2011**	**Q: Which data elements from 837-I and 837-P transactions does CMS expect would change between an inbound 837 from a provider and an adjudicated outbound 837 from the health plan?** **A:** We anticipate that there will be various fields that change. We are developing tools to assist the plans in understanding these differences and will release further guidance as soon as it is available.
97	**03/09/2011**	**Q: Are vision encounters required for submission under the 5010 Encounter Data Project?** **A:** Vision data should be submitted on the 837-I and 837-P.
98	**03/11/2011**	**Q: Testing requirements documented the plan ID should be sent in the 2010BB REF 02, where should plans place the HICN within the 837 file?** **A:** For the purposes of encounter data, the HICN will be placed in Loop 2010BA segment NM108 with a value of "MI" and segment NM109 with the beneficiary's HIC number.
99	**03/16/2011**	**Q: Where is the technical EDI specification or requirements document for the Encounter Data Institutional and Professional 5010 files (outbound 837-I and outbound 837-P) located?** **A:** Information on the CEM edits that will be used for encounter data, as well as, the 5010 format crosswalks for both the 837-I and 837-P are available on the CMS website at http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp. Please use the link titled "5010 Institutional and Professional Edits Spread sheet" to find the CEM edits, as well as the links for the Professional and Institutional Crosswalks from the 4010A1 to the 5010.
100	**03/17/2011**	**Q: Will CMS use any non-standard processes for file formats or data requirements, or will encounter data submission follow HIPAA standards?** **A:** Encounter data submission will follow HIPAA standards.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
101	**03/31/2011**	**Q: Is CMS expecting to see the 2320, 2330, and 2430 loops for encounter data reporting when there is no Coordination of Benefits (COB) data available?** **A:** Plans should populate the COB fields on the 837I and 837P as described in the WPC. If COB information applies to the data submitted, then these fields should be populated.
102	**04/01/2011**	**Q: Will plans be required to submit the 837-D format for dental encounters?** **A:** CMS has determined that the 837-D format will not be used for dental encounter data. The only formats that will be accepted are the 837-I, 837-P, and the 276 (optional claim status inquiry transaction). For any encounter data claim with dental information, plans can submit as appropriate on the 837-I or 837-P.
103	**04/04/2011**	**Q: Pharmacy services are not received on an 837 format. How would we report Part B drugs (for example, immunosuppressive) as an encounter?** **A:** Any drug benefit must be reported on the PDE format and processed through the Drug Data Processing System (DDPS) as is currently done.
104	**04/07/2011**	**Q: For the new 5010 format files, the rules indicate that NDM users can have a maximum of 15,000 claims per file. Is a claim defined as an ISA-IEA sequence or an ST-SE sequence?** **A:** While claims are located in the ST-SE transaction set, the combination of all ST-SE transaction sets within the ISA-IEA should not exceed 15,000 claims.
105	**04/11/2011**	**Q: Does the "destination payer" of the outbound 837 have to be CMS, or is CMS considered a trading partner?** **A:** Yes, the "destination payer" must be CMS for outbound claims submitted from the plan to CMS.
106	**04/11/2011**	**Q: One of the new requirements for 5010 is that all zip codes are nine (9) digits in length. Much of our address data is still in 5-digit format. Will it be permissible for plans to add four (4) zeroes to a zip code that is only five (5) digits in length for testing purposes?** **A:** As of now, a valid nine (9) digit zip code must be populated on the 5010 in order to successfully process through the CEM edits.

ENCOUNTER DATA FORMATS AND 5010 POPULATION		
FAQ Number	**Submission Date**	**Question and Response**
107	**04/13/2011**	**Q: In reporting the encounter information to CMS, is the plan considered to be the "destination payer"? If so, should submitters use the 2430 loop (SVD, CAS, DTP, and AMT segments) to report payment information such as in a "payer-to-payer" transaction?** **A:** When preparing the outbound file for CMS, CMS becomes the "destination payer." Plans would submit the information as received in the SVD segment, but include the CMS Payer ID.
108	**04/15/2011**	**Q: The document regarding common Pilot Testing errors stated that "2U" was to be populated in the following segment: Reference Information (REF)-2010BB Payer Name** • **REF01--Populate "2U"** • **REF02--Contract Plan ID (ex: Hnnnn)** **This is a direct conflict with the previous testing guidelines document, which stated Loop 2010BB REF01 should be populated with "G2" along with the plan ID in REF02. What should be populated in Loop 2010BB REF01?** **A:** After analysis of the results of the Pilot Test, the team determined that Loop 2010BB REF01 should be populated with "2U." The revised Test Package posted at www.csscoperations.com reflects this information. Should you have any additional questions, please feel free to contact CSSC at 1-877-534-2772.

SUBMISSION OF CHART REVIEW DATA		
FAQ Number	**Submission Date**	**Question and Response**
109	**12/15/2010**	**Q: Will submission of chart review data be accepted on the 837 file format?** **A:** Chart review data must be submitted to CMS in the 5010 837 format.
110	**12/15/2010**	**Q: Could chart review data be submitted to CMS as a separate file from the health plan's system? Or would it have to be one large file combined with other claims data?** **A:** This depends on your business process flow. The 5010 format must be in tact but there is no rule currently regarding separation of chart review and claims data as it is submitted.
111	**12/17/2010**	**Q: Currently, some may have an internal process to filter encounter data that is electronically submitted to ensure that the same diagnosis is not submitted more than once and to be certain that the data is able to be submitted by auditing the chart. Is the expectation to still not send duplicate diagnoses (regardless if there are different dates of service)? Otherwise, with now having to submit all encounter data, will CMS still hold plans accountable to submitting the one best medical record? For example, if there is a member with three (3) different encounters for the same condition, currently one (1) is submitted and after verifying this one (1) is true. Now with having to submit all encounter data, would plans be accountable for all submissions?** **A:** There was never an issue with submitting duplicate diagnoses. Currently, under RAPS, duplicate clusters should not be submitted. At this time, CMS requests that plans do not filter their data. As long as the submitted encounter is not the same diagnosis, same procedure, same provider, and same date of service, then send it to CMS. CMS is currently developing the definition of a duplicate encounter.
112	**01/12/2011**	**Q: How will additional HCCs found during the HRA process be submitted (typically a contracted physician or nurse practitioner visits plan members to fill out a medical risk assessment in which they may identify an HCC for a diagnosis code not reported on a previous claim submission)?** **A:** MAOs will submit data using the PKW01, CAS, and CLM05-3 segments and data elements.
113	**01/19/2011**	**Q: When will there be a final decision regarding the chart review data submission option?** **A:** A final decision regarding methods for submitting chart review data will be determined prior to the end of front-end testing of the Encounter Data Front-End System (EDFES). Plans will receive further policies regarding the Chart Review Process at a later time.

SUBMISSION OF CHART REVIEW DATA		
FAQ Number	**Submission Date**	**Question and Response**
114	**01/19/2011**	**Q: What is the PWK01 Segment Report?** **A:** The PWK Segment reports claim supplementation information. PWK01 segment reports the specific name of the document.
115	**01/19/2011**	**Q: Since chart audit data would follow the initial encounter submission, CMS is likely to receive a high percentage of adjustment encounters containing the PWK segments with chart audit data. Will this present an issue due to the current use of RAPS 502?** **A:** Until CMS can determine the volume of adjustment encounters that will be submitted with chart audit data, benchmarks for data submission cannot be established. Further policies regarding encounter data quality benchmarks will be forthcoming.
116	**02/16/2011**	**Q: Will the same Chart Review Processes be used for home care and PPS?** **A:** This is still under evaluation.
117	**02/16/2011**	**Q: If there is a lag for encounter data that comes in and chart review data needs to be submitted, how should plans submit?** **A:** The timeline for this is under development.
118	**02/16/2011**	**Q: If a diagnosis was submitted as a result of a chart review using the PWK segment, and later reviewed and identified to be deleted, how should this be handled?** **A:** The CAS segment should indicate CR to overwrite the original and the CLM segment should be populated with an "OA."
119	**02/16/2011**	**Q: Why wouldn't the '09' values be excluded from the utilization measurements? Chart reviews are for diagnosis code accuracy only.** **A:** The purpose of collecting encounter data is to be able to collect all data elements needed for pricing, as this will help achieve accurate estimation of the cost of care in the MA population.
120	**02/16/2011**	**Q: In a RADV, will CPT levels also be considered as proper documentation elements when audits are conducted?** **A:** The RADV policies are under review currently.

SUBMISSION OF CHART REVIEW DATA		
FAQ Number	**Submission Date**	**Question and Response**
121	**02/16/2011**	**Q: In regards to data elements that will be reflected in the reports for chart review activity, will they include similar element as the RAPS reports today?** **A:** This is currently being evaluated by CMS. If plans have recommendations or suggestions ideal format of the reports, please submit these to eds@ardx.net.
122	**02/17/2011**	**Q: CMS is currently proposing setting a requirement that encounter data be submitted within 12 months of the date of the encounter(s). Will the 12-month proposed requirement be the final requirement? If the 12-month requirement ends up being the final timeline, then how will the risk score updating process work? Risk scores are updated every 12 months based on data going back as far as 18 months. How would a 12 month timelines change this and the final score calculation or reconciliation processes?** **A:** CMS is currently evaluating the timely filing requirements for encounter data. Updated information regarding timely filing rules will be presented upon final approval from CMS leadership.
123	**02/23/2011**	**Q: Should chart review data be submitted as an adjustment (as an addition to an original claim)?** **A:** If a chart review results in an adjustment to the original claim, then the plan must submit the chart review data as an adjustment. If the chart review data is used solely for adding diagnoses, it should not be submitted as an adjustment. It should be identified as a chart review (using the PWK01 segment, populated with a value '09' to flag the claim as chart review data) and, if possible, link the chart review data to an original claim.
124	**02/23/2011**	**Q: How will data collected from other sources in addition to regular claims submissions and chart reviews be transmitted to CMS?** **A:** This is currently under evaluation. Participants should send examples of alternate data sources for encounter data to eds@ardx.net. The PWK segment should only be used for submitting chart review data.
125	**03/02/2011**	**Q: For submission of chart review data, are MAOs required to populate all of the other fields on the 837, or just those necessary for RAPS payment adjudication?** **A:** Plans should populate as much information as possible for encounter data. It will benefit plans long-term because this information will be used for pricing and recalibration of the model, which will ultimately affect plan payments. CMS is still making final determinations on the data elements that will be required for chart review validation and therefore populated on the 837 format.

SUBMISSION OF CHART REVIEW DATA		
FAQ Number	**Submission Date**	**Question and Response**
126	**03/02/2011**	**Q: How would an MAO delete codes from a chart review submission?** **A:** If a plan finds in a chart review that erroneous diagnosis codes were previously submitted, then this would be submitted as an adjustment using the CAS segment to delete erroneous items. If an MAO is only adding codes from a chart review, then the PWK01 segment and ICN would be used.
127	**03/02/2011**	**Q: Will chart review submissions be subject to the 12-month timely filing rule?** **A:** CMS is currently evaluating the timely filing requirements for the purposes of encounter data submission. Plans will be notified once guidance is released.
128	**03/02/2011**	**Q: If plans are able to link chart review data to an original claim, would MAOs follow the pattern of submitting an adjustment claim (replacing or appending a prior claim)?** **A:** No, chart review data should be submitted separately from adjustment data. If plans are able to link chart review data to an original encounter, then the PWK segment should be populated with the value '09' and the ICN on the 277CA report for the original claim submission should be inputted in the REF segment.
129	**03/02/2011**	**Q: What if there is no prior claim to link chart review data?** **A:** The MAO should populate the PWK segment with value '09.' The ICN from the 277CA report will not be required since there was no initial claim submitted for the encounter. Plans will be required to populate additional fields based on what is available in the medical record. CMS is evaluating what fields will be required for chart review validation.
130	**03/02/2011**	**Q: Timing allowed to submit the chart reviews has shortened and no clear definitions have been given on sweep dates. Can you tell us more around the sweep dates and timelines?** **A:** CMS is currently evaluating the timely filing requirements for encounter data. Once the timely filing requirements are finalized CMS will evaluate how to operationalize the requirement.
131	**03/02/2011**	**Q: When beneficiaries change plans there is mention that the new plan may not have the original encounter data in which to link the chart review data. It is the working assumption of GHP that if the member is not on our plan it is not our data to report and would like further clarification around this topic.** **A:** Operational guidance for submitting chart review data is currently under development. The industry will be notified with further guidance on this process in the coming months.

SUBMISSION OF CHART REVIEW DATA		
FAQ Number	**Submission Date**	**Question and Response**
132	**03/04/2011**	**Q: If a claim is submitted and it needs to be corrected based on chart audit findings after the 12-month timely filing period, how is that going to be handled?** **A:** CMS is currently evaluating the timely filing requirements for encounter data. Once the timely filing requirements are finalized CMS will evaluate how to operationalize the requirement.
133	**04/07/2011**	**Q: Should MAO's submit at least one chart review claim in each test file utilizing the PWK01 segment for front-end testing.** **A:** During front-end testing, submitters should not include any chart review data. This data should be submitted during the Encounter Data Processing System testing. Further requirements and guidance on the processing testing will be provided in the coming months.

ADJUSTMENT AND CANCELLATION PROCESSES		
FAQ Number	**Submission Date**	**Question and Response**
134	**12/15/2010**	**Q: How do plans delete and add codes at the same time?** **A:** There will be a work group on deletions and submissions. The details of options for submitting and/or correcting previously submitted data will continue to be discussed.
135	**01/12/2011**	**Q: For adjustments, the plan needs to make sure all diagnosis codes are present in the adjustment encounter because all previous diagnoses for the original claim will be overwritten. Is this a true statement?** **A:** Yes.
136	**01/12/2011**	**Q7: If a claim is rejected, should a reversal or a new claim be submitted?** **A7:** If a claim is rejected, the plan would need to send a new claim, since the rejected claim was not stored.
137	**01/12/2011**	**Q: Will the submission of adjustment claims take into consideration payment amounts?** **A:** Yes, the adjusted claim should be submitted with the updated and correct payment amounts included.
138	**01/12/2011**	**Q: Will adjustments be deleted from the cumulative report of rejects (if this report is established)?** **A:** Rejects are not currently stored in RAPS only adjustments. The adjustment supersedes the reject. The linking of adjustment claims submissions to the cumulative report needs to be further discussed in the Work Groups.
139	**01/12/2011**	**Q: For adjustments, do plans always populate the CAS segment to supersede the original claim with the adjusted claim? Does this handle reversals?** **A:** Yes, submitters can submit a correction or a deletion. For adjustments, use the CAS "CR" for correction or CAS "OA" for deletion and CLM05-3 frequency "1" original claim, "7" replace prior claim, "8" void/cancel/delete prior claim indicators.
140	**01/12/2011**	**Q: For adjustment submissions, how will plans reference the original claim?** **A:** The original claim will be referenced by using CLM01, which is the patient control number, CAS "CR" for correction CLM05-3 frequency "7" replace prior claim.
141	**01/12/2011**	**Q: For remediated claims that were rejected and resubmitted, are these sent back with a claim frequency of '01'?** **A:** No, they should have a CLM05-3 frequency of "7" if the desire is to replace the prior claim, "1" is used to denote the original claim.
142	**01/12/2011**	**Q: If the CAS segment balances charges and paid amounts, do plans use the 'CAS 01' for the correction reason?** **A:** Yes, along with CLM05-3. CAS "CR" for correction or CAS "OA" for deletion and CLM05-3 frequency "1" original claim, "7" replace prior claim, "8" void/cancel/delete prior claim indicators.

ADJUSTMENT AND CANCELLATION PROCESSES		
FAQ Number	**Submission Date**	**Question and Response**
143	**01/12/2011**	**Q: If a claim is rejected, the claims status code field is populated and it is flagged in the database. What loop is this in?** **A:** 2300 loop 2000B CLM 17.
144	**01/19/2011**	**Q: Are adjustment claims included in the submission process?** **A:** Plans are required to submit adjudicated claims. If the need arises to adjust an adjudicated claim, the submitter should use the CAS segment, value "CR" Correction, in data element CAS01 (Claim Adjustment Group Code), and CLM segment, value "7" Replace Prior Claim, in data element CLM05-3 (Claim Frequency Type Code).
145	**01/19/2011**	**Q: How will MAOs perform corrections/deletions/cancellations of individual fields or line items on a claim?** **A:** The plan must replace or delete the entire claim and not a line item or field. The CLM segment is used for all claims, and data element CLM05-3"(Claim Frequency Type Code) is the data element that will indicate if the claim is an original "1," a replacement "7," or a deletion "8." When values "7" or "8" is used in data element CLM05-3, the CAS segment must be populated. Data element CAS01 (Claim Adjustment Group Code) should have the value "CR" Correction or "OA" Other/Deletion.
146	**01/19/2011**	**Q: What is the difference between a denied and rejected claim?** **A:** Plans can deny a claim for policy or payment reason but the claim is "good." CMS wants MAOs and submitters to send these claims. Plans can reject claims as a result of incorrect formats, values, codes, etc. CMS does not want these claims.
147	**01/19/2011**	**Q: Is a claim deletion the same as cancelling a claim using the CLM05 segment?** **A:** Claim deletion and cancelation will be performed the same. The following should be used: CLM segment, data element CLM05-3 value "8" indicating Deletion, and CAS segment, data element CAS01 "OA" indicating Other/Deletion.
148	**01/19/2011**	**Q: If there are several diagnosis codes on an encounter and one of the diagnosis codes submitted needs to be removed based on an internal audit, does the plan need to request that the provider re-bill based on the corrected diagnosis code?** **A:** The provider would not need to resubmit. The plan would submit the diagnoses using the CAS segment "CR" for correction or "OA" indicating Other/Deletion.

ADJUSTMENT AND CANCELLATION PROCESSES		
FAQ Number	**Submission Date**	**Question and Response**
149	**01/19/2011**	**Q: What frequency code should be entered for adjustment claims (07 or 08)?** **A:** The CLM segment is used for all claims, and data element CLM05-3"(Claim Frequency Type Code) value "7" = replacement and value "8" = deletion. When values “7” or “8” is used in data element CLM05-3, the CAS segment must be populated. Data element CAS01 (Claim Adjustment Group Code) should have the value “CR” Correction or “OA” Other/Deletion.
150	**01/19/2011**	**Q: What segments must be populated to denote that a claim has been adjusted or cancelled?** **A:** MAOs must populate the CAS and CLM05 segments to denote a claim cancellation or adjustment. The CLM05 segment should be populated with a '1' for an original claim and an '8' for a voided, cancelled, or deleted claim.
151	**01/19/2011**	**Q: If an MAO or Third Party submits a 25 line professional encounter, will the entire 25 line encounter be accepted or denied as a whole or will it be accepted/ denied by line item?** **A:** Claim line items will be accepted or rejected. When correcting a line item, the entire claim must be replaced or deleted. The CLM segment is used for all claims, and data element CLM05-3"(Claim Frequency Type Code) value "7" = replacement and value "8" = deletion. When values “7” or “8” is used in data element CLM05-3, the CAS segment must be populated. Data element CAS01 (Claim Adjustment Group Code) should have the value “CR” Correction or “OA” Other/Deletion.
152	**01/19/2011**	**Q: Are adjustment claims required to be submitted within 12 months of the date of service?** **A:** Final policy regarding the 12-month timely filing requirements are under development with regards to the encounter data.
153	**02/09/2011**	**Q: How would a diagnosis code be added to a claim?** **A:** An adjustment claim would be submitted using the CAS segment. The adjustment claim would supersede the original claim and should be submitted as the finalized claim.
154	**02/09/2011**	**Q: Can MAOs submit more than 12 diagnosis codes on a professional claim?** **A:** No, professional claims only allow 12 diagnosis codes. Institutional claims allow a maximum of 25 diagnosis codes.
155	**02/23/2011**	**Q: Are plans required to submit deletions/adjustments within the timely filing requirement period?** **A:** Yes, any adjustments to an original encounter would have to be made within the timely filing requirement deadline. CMS is currently evaluating the timely filing requirements for the purposes of encounter data submission.

ADJUSTMENT AND CANCELLATION PROCESSES		
FAQ Number	**Submission Date**	**Question and Response**
156	**02/23/2011**	**Q: When submitting "add only" adjustments using the CAS segment and 'CO' option, is the ICN (claim control number) from the 277CA report required?** **A:** Yes, this is the only way to link the adjustment submission to the original claim. When claims are submitted, a 277CA report will be returned to the plan identifying which claims were accepted or rejected. An ICN for each claim will be present on the 277CA report and may be different from the ICN submitted by the plan on the original claim. This is the number that should be populated in the REF02 segment when submitting an adjustment.
157	**02/23/2011**	**Q: If a claim is rejected at the GS level of transmission file (999R report), would everything within the GS level need to be re-submitted to CMS?** **A:** Yes, everything within the GS segment would need to be re-submitted.
158	**02/23/2011**	**Q: If one (1) line on a claim rejects during processing, must the entire claim be resubmitted?** **A:** Yes, if the claim rejects it will not be stored for risk adjustment and should be re-submitted as an initial claim submission.
159	**02/23/2011**	**Q: If the 277 rejects a claim and the claims data is not stored, should the claim be resubmitted as an adjustment or as an original claim?** **A:** The claim should be submitted as the initial claim, not as an adjustment.
160	**03/04/2011**	**Q: If there are more than 12 diagnosis codes that a plan needs to submit, then the first 12 are submitted on one (1) claim and the remaining are submitted on a second claim after obtaining the ICN from the first submission. What other data has to be submitted on the secondary claim besides the remaining diagnosis codes (service lines, amounts, etc.)?** **A:** To add more than 12 diagnosis codes to a professional claim (837-P) or more than 25 diagnosis codes to an institutional claim (837-I), plans must submit an "add only" adjustment claim containing the additional diagnoses which were not included in the original submission. The 'CO' option of the CAS segment will be used for MA plans adding more than the allowable number of diagnoses on a professional (837-P) or institutional (837-I) encounter. To submit the adjustment, populate: • The REF segment (REF01 data element) with the ICN provided on the 277CA (from the original submission), • The CAS segment with the value option 'CO' (add only), and • The CLM segment (CLM05-3 data element) with value '7' for replacing or appending a prior claim.

ADJUSTMENT AND CANCELLATION PROCESSES		
FAQ Number	**Submission Date**	**Question and Response**
161	**03/04/2011**	**Q: If an adjustment of an adjustment claim needs to be submitted, what ICN number has to be used in the REF segment (i.e., previous adjustment claim or original claim)?** **A:** Any adjustment claim submission will supersede the previous claim submission. If an adjustment of a previously submitted adjustment claim needs to be submitted, then the original ICN number should be populated in the REF segment (REF01 data element). The ICN will not change due to an adjustment. The ICN should always remain the same in order to link the data.
162	**03/04/2011**	**Q: Based on the notes from the Editing and Reporting Work Group, if a claim is rejected, the claim's status code field is populated and is flagged in the database. Please clarify what loop this is in.** **A:** Rejections are not returned on the 837 format. If a claim is rejected, the status would be returned to the plan on the 277CA in the 2200D loop.
163	**03/22/2011**	**Q: If a claim has more than 12 diagnosis codes, it was explained that plans should submit the claim with the first 12 diagnosis codes, wait for the 277CA, and then send the claim again with "F8" in the 2300 REF segment with the ICN received in the 277CA, along with a "CO" in the CAS segment and a "7" in the CLM05-03 element along with diagnosis codes 13-24. However, the 2400 loop requires that each service line must have at least a primary diagnosis code pointer. If a given service line only had one (1) of the first 12 diagnosis codes and diagnosis codes 13-24 are not valid for a particular service line, then there will be no primary diagnosis code pointer to put into SV107-1. Are the edits going to be relaxed for such claims so that plans can associate a service line to at least one of the 13-24 diagnosis codes, even if the diagnosis code is not valid for the procedure and would cause the claim to fail an edit?** **A:** To add more than 12 diagnosis codes to a professional claim (837-P) or more than 25 diagnosis codes to an institutional claim (837-I), plans must submit an ""add only"" adjustment claim containing the additional diagnoses which were not included in the original submission. The 'CO' option of the CAS segment will be used for MA plans adding more than the allowable number of diagnoses on a professional (837-P) or institutional (837-I) encounter. To submit the adjustment, you would populate: • The REF segment (REF01 data element) with the ICN provided on the 277CA (from the original submission), • The CAS segment with the value option 'CO' (add only), and • The CLM segment (CLM05-3 data element) with value '7' for replacing or appending a prior claim.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
164	**12/09/2010**	**Q: Will remittance be in the 835 format and will that specs for that remittance, be different for those of Medicare FFS?** **A:** CMS has not made a final decision regarding the remittance advice. If the remittance advice is used for encounter data, the 835 format will be used.
165	**12/09/2010**	**Q: How and where can plans obtain a document that provides a list of the CEM/CEDI edits for encounter data?** **A:** For more information about the CEM edits please reference this site, http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp.
166	**12/15/2010**	**Q: Would CMS consider relaxing edits that are not necessary to pricing?** **A:** CMS is currently in the process of analyzing existing edits and determining which are appropriate to encounter data collection. There are no final decisions as of yet but this is being considered.
167	**12/20/2010**	**Q: Please provide information on the volume of response reports/files submitters will be supplied with. Will these all come from Palmetto?** **A:** CMS is still determining the number of transaction reports/files. All will be received from Palmetto and will include at least the TA1, 999, and 277.
168	**01/06/2011**	**Q: What is the purpose and use of the 276/277 transactions in the encounter data process?** **A:** The 277 will provide the front-end responses (Common Edits Module – CEM). This will tell the plan if the data was passed to the processing system or not. The 276 will allow the plan to determine where the encounter is in the process. It is a method to request status of encounter processing.
169	**01/06/2011**	**Q: Will CMS return acknowledgements for claims files in the X12 standard formats (TA1, 999, 277CA) or in some other format?** **A:** We will use the TA1, 999, and 277CA, as well as customized reports that are yet to be determined.
170	**01/12/2011**	**Q: Will details be provided on filters used for risk adjustment versus encounter data submissions?** **A:** Yes, details will be a part of the new training modules and companion guides.
171	**01/12/2011**	**Q: Where can plans locate the 5010 acknowledgement report layouts?** **A:** The report layouts are available online at the Washington Publishing Company website at http://www.wpc-edi.com/content/view/817/1. A link for the report layout specifications will be provided.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
172	**01/12/2011**	**Q: Are the 5010 response reports industry standard?** **A:** Yes, they are the industry standard.
173	**01/12/2011**	**Q: Can we assume that for all 5010 response reports there will be a corresponding flat file that plans can use for internal systems processing?** **A:** All reports will be in the form of a flat file upon receipt.
174	**01/12/2011**	**Q: How will CMS validate providers?** **A:** Plans can expect data to edit against the National Provider Identification (NPI) number. The NPPES will be used to validate the NPI number.
175	**01/12/2011**	**Q: Will MAOs receive a provider file so that plans can validate providers and compare data?** **A:** CMS will determine if there is a resource that can be made available to the MAOs.
176	**01/12/2011**	**Q: Will plans be responsible for applying the new licensing provider requirements?** **A:** Plans are already responsible for credentialing providers. For non-contracted providers that do not meet the credential requirements as approved providers, use of an NPI indicates the provider is credentialed.
177	**01/12/2011**	**Q: If the National Provider Identification (NPI) number determines provider acceptability, what fields will CMS use for Risk Adjustment?** **A:** CMS will be using NPPES. NPI to determine whether a service or facility is acceptable (i.e., data source). Plans must submit all data received without filtering. CMS plans to provide a report showing fields that were used for Risk Adjustment based on CMS filters.
178	**01/12/2011**	**Q: Will CMS be drafting a Custom Reject Reason Code list for the 277CA report?** **A:** Further information will be provided in the coming months regarding the possible customization of reports.
179	**01/12/2011**	**Q: Has CMS established duplicate criteria?** **A:** Duplicate claims information will be provided during the training sessions conducted in the summer of 2011.
180	**01/19/2011**	**Q: It was previously stated that CMS would be verifying taxonomy through NPPES. Are MAOs required to include the taxonomy on the claim since CMS will be obtaining taxonomy from NPPES?** **A:** This topic needs to be explored further. Currently, MAOs must populate all required fields in the 5010 format if the information is available.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
181	**01/19/2011**	**Q: When including the taxonomy for the 5010 format, sometimes there are discrepancies between the taxonomy given by the provider and what is listed on NPPES. How can MAOs prevent claim errors when taxonomies reported from the providers and taxonomies listed in NPPES do not match?** **A:** The pilot testing phase will enable CMS to determine what the risks are in populating certain fields of the 5010 and whether fields such as taxonomy should be populated by the MAOs or if a different procedure is needed. We are currently investigating this issue and will provide the industry with a determination as soon as possible.
182	**01/19/2011**	**Q: If CMS is applying an edit to ensure that health plans are submitting taxonomy on the 5010, is the expectation that the plans demand this information from the providers?** **A:** CMS is planning to use any of the required fields that are also required in Fee-For-Service. Currently, the expectation is that plans are populating the fields that are required based on Fee-For-Service standards. If taxonomy is a required field, then it should be populated. Therefore, provider outreach will be necessary, just as it will be for the conversion from ICD-9 to ICD-10 and using 5010 format overall.
183	**01/19/2011**	**Q: Will an online provider file be available for MAOs?** **A:** CMS is currently researching the ability to provide an electronic file to plans with a listing of providers and will update the industry if this can be done.
184	**01/19/2011**	**Q: Is the provider specialty on the submitted encounter record to the plan going to be validated against the taxonomy code that is listed in the NPPES NPI file? What about providers that have multiple NPIs and/or multiple taxonomy codes? For example, a provider may only have taxonomy code 170100000X (Genetics) listed in NPPES, but in the plan's internal provider system, the plan has verified that the provider has been credentialed for Maternal/Fetal Medicine and Genetics. If the provider doesn't have both specialties listed in NPPES would a record submitted with their specialty as 207VM0101X (Maternal/Fetal Medicine) be rejected?** **A:** Thank you for raising the issue. We are investigating the issue for handling multiple NPIs at this time.
185	**01/19/11**	**Q: If there are edits on the addresses, will those be compared to the NPPES NPI file? Also, if the addresses are going to be validated, will formatting be an issue? For example, if an address in NPPES is listed as 4000 14th ST STE 310, would the record be rejected if the address was listed as 4000 14th STREET #300?** **A:** We are only applying soft edits on the address fields.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
186	**01/19/2011**	**Q: If a record is submitted with a valid diagnosis code but a non-payable Medicare CPT or HCPC code, would the record be rejected? Also, what if the submitted CPT or HCPC code did not match the provider specialty in the NPPES file?** **A:** Yes, the record would be rejected if there is a non-payable Medicare CPT or HCPC code submitted. The encounter claim must be sent with the appropriate data elements, so the provider specialty will need to match with submitted CPT or HCPC codes.
187	**01/19/2011**	**Q: Is an active NPI on NPPES the only requirement to qualify a provider as a valid Medicare provider or must the provider also possess a Medicare identifier on NPPES?** **A:** CMS is currently developing processes for verifying valid Medicare providers. If MAOs have any additional input on this topic, please send comments to eds@ardx.net.
188	**01/25/2011**	**Q: Submitters may calculate and project risk scores for clients based on the diagnoses that have been submitted to CMS and that have been approved by CMS. Once plans begin submitting RAPS and encounter data simultaneously, which return files should we use to make risk score projections: Raps response files only, encounter response files only, or a combination of both files?** **A:** The reports for encounter data are currently under development by CMS. Therefore, it is too soon to determine the exact manner that the RAPS and Encounter Data return files will be used, especially in the projection of risk scores. Preliminarily, CMS expects plans to use both the RAPS return files and the Encounter Data reports (which will be returned to plans via unique mailboxes) to reconcile data, ensure all elements are captured, and project risk scores. More information on the Encounter Data reports will be provided during the Trainings to be held in the Summer of 2011. Registration information will be available by the end of March. Please refer to www.tarsc.info to register to participate in the trainings.
189	**01/25/2011**	**Q: As we move to encounter data will the MOR/RxMOR files be replaced? If so, what will replace these files? Will it be an extraction of diagnoses from the encounter data that was used for the risk adjustment payment process?** **A:** Since the RAPS data will continue to be the driver for information regarding risk scores through 2012, the MOR/RxMOR will continue to be the appropriate reports for plans to use. CMS is currently developing reports to support the encounter data process and will make plans aware of those reports soon.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
190	**01/26/2011**	**Q: Where can the Encounter Data Report layout be located?** **A:** The Encounter Data report layouts can be located on the Washington Publishing Company (WPC) website at http://www.wpc-edi.com/content/view/817/1.
191	**02/08/2011**	**Q: What other flat files besides 277CA are coming?** **A:** The TA1, 999, and any other customized files still to be determined will be returned to plans, in addition to the 277CA.
192	**02/08/2011**	**Q: If a plan submits a 25 line professional encounter, will the entire 25 line encounter be accepted or denied as a whole or will it accept/deny by line?** **A:** CMS EDS will not "deny" claims; CMS will only accept or reject claims. CEM will perform claim level editing. CMS EDS will accept the entire claim, if ALL line items are valid (editable data elements needed for pricing and National Codes (Diagnosis, Procedure, etc.) are correct. CMS EDS will "reject" the entire claim if one line item/data element on the claim does not pass edits needed for pricing and/or if the National Codes (Diagnosis, Procedure, etc.) are invalid.
193	**02/08/2011**	**Q: Will CMS pend or reject encounters? If a plan sends an encounter to CMS will it be accepted, pended, or denied?** **A:** CMS will NOT pend a claim. There are only two responses, accept , or reject.
194	**02/08/2011**	**Q: If a plan is sending an encounter to CMS in January or February and the revenue code was dated in October (not based on date of service, but based on date the transaction was created), will the encounter be accepted or denied for an invalid revenue code?** **A:** This would be denied due to an invalid date for the revenue code. The revenue codes' date must be within the dates of service covered by the encounter claim.
195	**02/09/2011**	**Q: Should duplicate claims be submitted to CMS?** **A:** No, duplicate claims should not be submitted. A benchmark will be set for the submission of duplicate claims.
196	**02/09/2011**	**Q: Is a duplicate defined as all fields of an encounter being the same (i.e., service date, diagnosis code, ID numbers, etc.)?** **A:** Yes.
197	**02/16/2011**	**Q: Can a diagnosis be rejected for pricing purposes but accepted for risk adjustment?** **A:** Diagnosis would need to be valid and pass all edits before the data will be finalized and stored.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
198	**02/17/2011**	**Q: Are the 276 and 277 optional or mandatory files when it comes to meeting encounter data program requirements?** **A:** The 277CA is a standard report plans will receive following each claims submission to identify processing and does not require a 276 transaction. The 277 is a response to the 276 and is an optional transaction for plans to request information on the status of a claims submission.
199	**02/23/2011**	**Q: Will plans be able to see how CMS is pricing claims on the response files returned?** **A:** CMS is currently investigating the types of reports that would benefit MAOs. Any ideas or suggestions for customized encounter data reports should be sent to eds@ardx.net.
200	**02/23/2011**	**Q: Will edits beyond the standard 837 format fields be turned on?** **A:** Yes, CEM module and processing edits (i.e., data validation edits) will be part of the processing system, as well as any other edits that may impact pricing.
201	**02/23/2011**	**Q: Will CMS' filtering logic and editing rules be included in the companion guide?** **A:** Edits will not be published in the companion guide. However, plans may review a list of the CEM module edits on the CMS website. Note that some of the edits not needed for pricing encounter data may be turned off.
202	**02/23/2011**	**Q: Will CMS be utilizing the 277CA report for encounter data?** **A:** Yes, plans will receive the 277CA report following each claims submission. The standard HIPAA compliant format for the 277CA is available on the Washington Publishing Company (WPC) website at http://www.wpc-edi.com/content/view/817/1.
203	**02/23/2011**	**Q: Will the 277CA report include diagnoses that were processed and stored for risk adjustment?** **A:** No, the 277CA report only displays which encounters were accepted or rejected following processing through the CEM module edits.
204	**02/23/2011**	**Q: On the 277CA report, if a claim is accepted is it safe to assume that all diagnoses were accepted for risk adjustment?** **A:** No, this only reflects if an encounter was successfully processed through the CEM and/or CEDI edits. Risk adjustment editing and storage would be completed after the claim processes through the CEM module edits.
205	**02/23/2011**	**Q: Today RAPS response reports are produced in one (1) day. What will the new turnaround time be for encounter data response reports?** **A:** The turnaround time is expected to be similar to the current RAPS response time.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
206	**02/23/2011**	**Q: Will the current rejection codes be used for encounter data?** **A:** There will be more rejection codes than the current codes used for RAPS. Error messages and edits will be published on the CMS website.
207	**02/23/2011**	**Q: Will there still be an MOR, MMR, and TRR reports?** **A:** Yes, plans will continue to receive the MOR, MMR, and TRR reports. However, the MOR and MMR reports may be adjusted to reflect encounter data submission.
208	**02/23/2011**	**Q: How will the differences between what diagnosis data plans should consider acceptable for risk adjustment and what CMS considers acceptable for risk adjustment be addressed?** **A:** There will be no difference in what is acceptable data for risk adjustment between the plans and CMS. Plans are not filtering data prior to submission. CMS will filter data submitted based on established risk adjustment rules. However, there may be differences in payment due to data compliance with risk adjustment rules.
209	**02/23/2011**	**Q: Will CMS use the 5% duplicate benchmark threshold?** **A:** There will be a duplicate benchmark established for encounter data and CMS is evaluating what the benchmark percentage will be. Plans should not submit duplicate encounter data claims.
210	**03/02/2011**	**Q: Where does the 276 transaction factor into the encounter data process?** **A:** The 276 is an optional transaction MA plans can use to communicate with CMS about the status of a submitted claim that has not already been returned on a 277CA report. Participants should submit thoughts regarding the value and function of the 276 transaction to eds@ardx.net.
211	**03/02/2011**	**Q: When will the 277CA report be returned to plans?** **A:** Plans can expect to receive the 277CA report within one (1) business day after submitting a claim.
212	**03/02/2011**	**Q: Will accepted claims on the 277CA have an ICN?** **A:** Yes, accepted encounters will have an ICN and rejected encounters will not.
213	**03/02/2011**	**Q: Will claims be rejected at the line level or claim level?** **A:** Encounters will be rejected at the claim level and will either be completely accepted or completely rejected.
214	**03/02/2011**	**Q: For eligibility rejections, will MA plans be required to resubmit the entire claim?** **A:** Yes.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
215	**03/02/2011**	**Q: Will CMS be monitoring claim rejections or will this be the responsibility of the MAO?** **A:** CMS will provide the 277CA acknowledgement report, which will include claims that were rejected and those claims that were accepted. MAOs will be responsible for tracking their claim rejection corrections. At present, CMS is not developing a cumulative report of all claim rejects and accepts.
216	**03/02/2011**	**Q: Will both the original claim number submitted by the plan and the ICN be available on the 277CA for accepted claims?** **A:** Yes, both numbers will be reported back to the submitter for accepted claims. If a claim rejects, only the claim number submitted by the plan will be returned.
217	**03/02/2011**	**Q: Will a claim reject if an MAO submits more than 12 diagnosis codes on a professional claim (837-P)?** **A:** The maximum allowable amount for diagnosis codes on the 837-P is 12 diagnosis codes, so plans will be unable to input more than 12 diagnosis codes according to 5010 standards. Plans must wait for the initial encounter to process and receive the 277CA report with an ICN in order to submit an additional encounter with more diagnosis codes.
218	**03/02/2011**	**Q: Will the companion guide contain the 277 CEM edits?** **A:** Yes.
219	**03/02/2011**	**Q: To add more than 12 diagnosis codes to a professional claim (837-P), do plans submit the initial claim and then wait for the 277CA to return with the ICN before sending the second claim with the additional diagnosis codes?** **A:** Yes.
220	**03/04/2011**	**Q: Will plans receive the 999R and 999E as two (2) different response files or will plans receive only one 999 file including accepted claims, rejected claims, and warnings?** **A:** Plans will receive a 999 with accepted and rejected transactions on it.
221	**03/04/2011**	**Q: How are duplicate encounters going to be calculated given the need to adjust claims?** **A:** Additional duplicate claims information will be provided during the training sessions conducted in the summer of 2011.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
222	**03/04/2011**	**Q: What duplicate logic will CMS use for encounter data?** **A:** Claims entering the processing system with field values matching field values on a claim stored in the Encounter Operational Data Store (EODS) will be returned to the submitter with an error indicating the claim is a duplicate. Fields: • Beneficiary Demographics (HICN, Name), • Date of Service, • Place of Service or Uniform Type of Bill (Type of Service), • NPI (Rendering Provider), • Procedure Code(s), • Diagnosis Code(s), • Billed Amount (Claim Total), and • CAP Prescription Number.
223	**03/07/2011**	**Q: Regarding CMS 277CA data, what field lengths should be used when parsing the 277CA for the Internal Control Number (ICN) and the Submitter Claim Number?** **A:** According to the 5010 standards, the programming specifications should be 50 alpha-numeric (AN) characters in length. However, the ICN number will be represented by 14 AN characters and the remaining would be spaces.
224	**03/07/2011**	**Q: Sometimes there are discrepancies between the billing NPI submitted by the provider and what is listed on the plans system of record. Can the billing NPI from the plans system of record be utilized in these situations when the NPI submitted by the provider and the billing NPI from the plans system of record do not match?** **A:** The MAOs standard practices for reconciling this discrepancy in order to adjudicate the claim should be followed so that a valid NPI can be submitted.

EDITING AND REPORTING		
FAQ Number	**Submission Date**	**Question and Response**
225	**03/08/11**	**Q: What is the reason for requiring and editing diagnosis pointers for risk adjustment? If a plan denies a claim due to a diagnosis pointer edit but submits it to CMS as required, how will the claim be managed by CMS?** **A:** If a plan rejects a claim (it is unprocessable) due to the presence of an invalid diagnosis code pointer, then the claim should not be submitted to CMS. For encounter data, only adjudicated claims should be submitted. Plans should not send rejected or pending encounters (i.e., those encounters with invalid or missing data, or that have not been released for payment due to system errors). Diagnosis pointers are a required field of the 5010 837 format and are used to validate diagnosis codes submitted on an encounter. Encounter data requirements are in large part based on Fee-for-Service (FFS) logic and will be processed according to FFS PRICERS and Fee Schedules.
226	**03/16/2011**	**Q: On the last encounter call it was indicated that the ICN (claim ID) as well as the plans Claim ID (TRN) would be returned on the 277CA. Can you clarify which field each will go in on the 277CA?** **A:** The ICN is located in the 277CA in Loop 2200D, REF01 (Reference Identification Qualifier) with a value of '1k' (Payer's Claim Number) and REF02 (Reference Identification) with a value 'Claim Number' (Payer Claim Control Number).
227	**03/29/2011**	**Q: When does CMS plan to publish the list of edits which will either be excluded or relaxed during the front-end testing period?** **A:** As we are able to analyze the results of the pilot test, we will publish the list of relaxed edits.

CAPITATED AND STAFF MODEL PLANS		
FAQ Number	**Submission Date**	**Question and Response**
228	**12/09/2010**	**Q: Since many encounters are for capitated services, will the Medicare Advantage program expect $0.00 claims?** **A:** Capitated plans should populate $0.00 for those amount fields that they do not capture data.
229	**01/19/2011**	**Q: Are all dollar fields on capitated claims to be filled with '0'?** **A:** Yes, if there are no actual amounts available, then plans submitting capitated data should fill dollar fields with '0.'
230	**01/19/2011**	**Q: If a price amount is included in the 'paid' column on a Capitated or Staff Model claim, will this affect anything?** **A:** If capitated or staff model plans include a pricing amount in the 'paid' column, this will not affect CMS pricing calculations of the encounter data. CMS wants plans to include this data when it is available, rather than changing it to '0'.
231	**01/19/2011**	**Q: Is '0' entered in the paid amount field for denied encounters (as well as Capitated claims)?** **A:** Yes, '0' is entered in the paid amount field for rejected encounters as well as for capitated model plans' encounter claims.
232	**02/09/2011**	**Q: Should MA plans input a '0' value for amount fields received with actual charges before submitting to CMS?** **A:** No, the claim should be submitted as it is received. The "0" is only used in situations where the actual charges are not populated.
233	**02/09/2011**	**Q: Will an encounter be rejected if it contains a mixture of '0' values and charge amounts?** **A:** Yes, the claim will be rejected as incomplete.
234	**02/09/2011**	**Q: Can capitated and FFS claims be submitted to CMS in the same file?** **A:** Yes.
235	**02/09/2011**	**Q: Should billed amounts on capitated claims be submitted to CMS?** **A:** Yes, capitated claims should be submitted as they are received.
236	**02/16/2011**	**Q: Do capitated and Fee-for-Service claims have to be submitted in separate batches?** **A:** No, submitters may submit capitated and FFS claims within the same batch.
237	**03/02/2011**	**Q: Should '0' be populated for any amount field or just the 'charge amount' field?** **A:** '0' should be inputted for any amount field that a plan is unable to populate.
238	**03/02/2011**	**Q: Should MA plans input '0' or zero out the charge and paid amount fields for capitated claims?** **A:** No, '0' should only be inputted if there is no data available in the amount fields. If the pricing information is available, the encounter and pricing information should be submitted to CMS as is.

CAPITATED AND STAFF MODEL PLANS		
FAQ Number	**Submission Date**	**Question and Response**
239	**03/02/2011**	**Q: If CMS is going to be using the billed charges and pricing services at 100% of the Medicare allowable amount, why are plans required to submit the paid amount information?** **A:** CMS will only be pricing encounters at 100% of the Medicare allowable amount for those claims in which '0' is inputted for the amount fields. MA plans should only input '0' for amount fields if data is missing when the claim is received. This may occur in cases where there is a capitated arrangement with the provider. By populating '0' this will allow the claim to process through the Encounter Data System (EDS) since these amounts fields are required to complete processing. If amount information is available the MAO should submit the claim as is.
240	**03/02/2011**	**Q: How will CMS identify if a claim is capitated?** **A:** CMS is not currently considering flagging capitated claims. If a claim is capitated and no pricing data is available, then plans should input '0' for those amount fields with no pricing information.
241	**03/04/2011**	**Q: How will CMS distinguish between denied and capitated encounters?** **A:** CMS is currently identifying a field to use to flag capitated claims so that the appropriate level of editing can be applied to the amount fields.
242	**03/04/2011**	**Q: Capitated claims can be submitted with $0.00 for the paid amount. For other claims, plans can submit the actual paid amount? In what loop/segment of the 5010 837 file does the plan submit paid amounts of capitated encounters? On the first occurrence of 2320/2430 loops?** **A:** Amount fields applicable to the claim are required and must be populated with numeric characters. If information is available for some but not all of the amount fields, '0' should be inputted for those fields where no data is available. The remaining amount fields should be submitted to CMS as is. Based on pilot test results, the service lines will reject due to translator level edits, if service lines do not balance.
243	**03/04/2011**	**Q: If capitated claims will be submitted as $0.00 paid amounts, will there be some other field that will need to be populated or will a '0' paid claim be assumed as capitated.** **A:** Currently, CMS is investigating a way to flag capitated encounters. The value of '0' should only be inputted if the claim is received with no data in the amount fields. If amount data is available, the data should be submitted to CMS as is. All service lines must balance (i.e., loop 2400 SV2 for institutional and SV1 for professional must equal CLM02 in the 2300 loop).

CAPITATED AND STAFF MODEL PLANS		
FAQ Number	**Submission Date**	**Question and Response**
244	**03/17/2011**	**Q: Please clarify the allowance for plans to submit $0.00 for capitated claims. Does this refer to all dollar amount fields on the 5010 837, or just selected fields?** **A:** Yes, this does refer to all dollar amount fields on the 837. Since this is a capitated claim, if true dollar amounts are unavailable, then '0' should be populated.

PACE ORGANIZATIONS		
FAQ Number	**Submission Date**	**Question and Response**
245	**01/26/2011**	**Q: If edits are relaxed on the 837 for PACE plans, does this mean that services would not have to be CPT coded?** **A:** CMS is evaluating the data necessary for a PACE encounter. Should CMS determine a data element is not necessary, then those edits would be relaxed.
246	**01/26/2011**	**Q: Is it possible for CMS to leave the RAPS system in place for PACE organizations to use since it's a smaller population?** **A:** There are agency costs to running dual systems long-term. The forecast right now is for the Encounter Data System (EDS) to replace the RAPS system once testing has been validated and completed.
247	**01/26/2011**	**Q: Encounter data requires face-to-face interactions for coding. Will that requirement be relaxed for PACE organizations?** **A:** CMS is currently evaluating PACE policies.
248	**01/26/2011**	**Q: What data elements does CMS need from PACE organizations other than ICD-9 codes?** **A:** As of right now, all data elements will be required.
249	**01/26/2011**	**Q: PACE organizations focus on preventing re-hospitalizations with an average of 20 inpatient claims per month in a population of 400. Is processing going to be based on quality of care and prevention of re-hospitalizations or will organizations be penalized for having fewer inpatient claims?** **A:** Pricing will be based on Fee-For-Service pricing methodology.
250	**01/26/2011**	**Q: Where should future PACE/Encounter Data questions be directed?** **A:** Please submit any future questions to eds@ardx.net.
251	**02/11/2011**	**Q: Is there updates regarding PACE and encounter data reporting?** **A:** PACE plans will not be required to test (July 15, 2011 – August 15, 2011) or submit live data on January 3, 2012. CMS has extended the deadline for the 5010 Encounter Data submission requirement for PACE plans. CMS will communicate the new 5010 Encounter Data submission schedule in the coming months. For questions, please contact an Encounter Data Specialist by email at eds@ardx.net.
252	**03/09/2011**	**Q: If PACE organizations will not be required to test (July 15, 2011-August 15, 2011) or submit live data on January 3, 2012, should PACE organizations complete the EDI agreement, submitter application at this time?** **A:** The PACE plan implementation schedule will be delayed by 12 months. Therefore, PACE organizations will not be required to complete the submitter application and EDI agreement until 2012.

PACE ORGANIZATIONS		
FAQ Number	**Submission Date**	**Question and Response**
253	**03/16/2011**	**Q: Are PACE organizations expected to attend the Regional IT Technical Assistance Trainings? Will there be PACE-specific information presented? Would it be possible for a National PACE Association staff member to attend?** **A:** Right now, there is no separate encounter data training for PACE organizations. Please plan to attend the encounter data trainings during the Regional IT Technical Assistance Trainings. Registration for the trainings opens April 1, 2011 at www.tarsc.info.
254	**03/29/2011**	**Q: What do PACE plans need to do before the March 30th deadline to submit the Encounter Data Submission package? Do PACE plans need to take any action at all regarding the Encounter Data Submission package? It seems as if this is on hold we would like to confirm that we do not need to do anything before the next PACE Encounter Data Workgroup on 4/27/2011.** **A:** The encounter data implementation dates and testing requirements do not apply to PACE. PACE Plan Pilot testing has been extended and is scheduled for the first quarter of 2012. Once CMS determines a definitive testing timeline for PACE Organizations, CMS will communicate this information to the industry.

ENCOUNTER DATA IMPLEMENTATION TIMELINE		
FAQ Number	**Submission Date**	**Question and Response**
255	**01/06/2011**	**Q: When does CMS expect to begin receiving real production data from MAOs? Will real production data be needed from MAOs during the CMS testing phases in 2011?** **A:** Production data will begin on 1/3/2012. If production data is available, it would be helpful to use that data during testing, so that you are able to have a better idea of how data will process in the system.
256	**01/19/2011**	**Q: If MAOs are submitting encounter data files every 30 days, would the first file submission be on January 31, 2012?** **A:** Yes, the first file submission for encounter data should be at the end of January 2012.
257	**01/19/2011**	**Q: What date does Institutional and Professional data need to be certified by?** **A:** MAOs must certify their data by October 2011 in order to submit production data by January 2012.
258	**02/16/2011**	**Q: What is the target date for the start of encounter data collection for dental claims (837-D)?** **A:** CMS has determined that the 837-D format will not be used for dental encounter data. The only formats that will be accepted are the 837-I, 837-P, and the 276 (optional claim status inquiry transaction). For any encounter data with dental information, plans can submit as appropriate on the 837-I or 837-P.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
PARALLEL SYSTEMS TESTING		
FAQ Number	**Submission Date**	**Question and Response**
259	**01/19/2011**	**Q: How long will the Encounter Data and RAPS systems be running in parallel? A:** The Encounter Data System (EDS) and RAPS will run parallel until CMS can validate that the data collected is high quality and can be used to calibrate the Risk Adjustment model. CMS has decided to run the systems parallel to ensure there is no impact to plan payments.
260	**01/19/2011**	**Q: During the parallel testing phase, are plans required to submit corrections for both the Encounter Data and RAPS systems?** **A:** Yes, during parallel testing plans will have to submit corrections for both the Encounter Data System and RAPS. Data will be processed using a separate submitter ID number, and communications/reports will be sent via a separate mailbox.
261	**02/09/2011**	**Q: CMS stated that the Risk Adjustment Processing System (RAPS) and the Encounter Data System (EDS) will run in parallel until the EDS is validated and working correctly. Will MAOs be notified in advance of the date RAPS will no longer be running?** **A:** Yes, plans will be given advanced notice of this. Premiums should be paid based on RAPS until plans hear otherwise.
262	**02/23/2011**	**Q: During parallel systems processing will there be a comparison between the RAPS and the Encounter Data System (EDS)?** **A:** Payment will continue to be driven by RAPS during parallel processing until the Encounter Data System is validated. The RAPS system will remain on until it is determined that the EDS yields accurate calculation of beneficiary risk scores and there is adequate data for calibration of the risk adjustment model.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
FRONT-END TESTING		
FAQ Number	**Submission Date**	**Question and Response**
263	**01/06/11**	**Q: MAOs will test front-end and processing, in phases, from March 2011 through June 2011. Can more specifics be provided on what the expectations are for front-end and processing testing in phases? Do we have to start testing in March 2011 or can we test any time between March and June 2011? Is there a possibility of starting testing occurring later than June 2011?** **A:** Plans will have from March 30 - June 30 to complete front-end testing. The overall testing plan is still under development, but the current objective of the front-end testing is for the front-end to receive and translate the 5010 file from plans. As of now, the front-end testing will end on June 30, 2011.
264	**01/19/2011**	**Q: Will the test system be available for MAOs to use if there are system changes at the MAO following implementation of the Encounter Data System (EDS)?** **A:** Yes. However, in order to test the new system, the system must be recertified if major modifications are made following initial certification.
265	**01/19/2011**	**Q: Are plans required to submit a front-end test file by 3/30/2011 or 6/30/2011?** **A:** At this time, front-end testing occurs from March 30, 2011 through June 30, 2011. Plans may submit a test file any time between the test dates.
266	**01/19/2011**	**Q: Will the 5010 errata version be ready by the front-end testing phase beginning in March 2011?** **A:** Yes, 5010 errata will be accepted by the front-end system testing phase beginning in March 30, 2011. The front-end testing phase will begin March 30, 2011 and continue through June 30, 2011. MAOs will have until June 30, 2011 to submit a test file to the Encounter Data Front-End System (EDFES).
267	**01/19/2011**	**Q: What EDI Translator will CMS be using?** **A:** Please see the approved of list of HIPAA compliant translators at http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp.
268	**01/19/2011**	**Q: What is the name of the COTS vendor utilized by CMS?** **A:** Please see the approved of list of HIPAA compliant translators at http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
FRONT-END TESTING		
FAQ Number	**Submission Date**	**Question and Response**
269	**01/19/2011**	**Q: What is the difference between test data and actual data?** **A:** Test data consists of formatted values that will process through the edits (i.e., numeric data in numeric only fields) which may not be true beneficiary data. Actual data consists of real beneficiary data.
270	**01/19/2011**	**Q: Are plans required to submit real data for the front-end testing or will dummy data suffice?** **A:** While actual data would be ideal, the Front-End test file can contain test data. Please note that the test data must be valid (i.e., CPT codes must be true CPT codes).
271	**01/19/2011**	**Q: What level of SNIP edits will be applied during Front-End testing and in the production system?** **A:** CMS will apply translator, Implementation Guide, and CEM (claim-level) edits.
272	**02/04/2011**	**Q: Since plans do not yet have production 5010 data, will 4010 data that has been converted to 5010 be acceptable for front-end testing? If so, does CMS have particular values we should populate in the extra fields that exist on HIPAA 5010 but not on HIPAA 4010?** **A:** Data does not have to be live (production) data, but it will need to be valid data (i.e., valid CPT codes) submitted in the 5010 format. All 5010 required fields should be submitted in the 5010 format.
273	**02/07/2011**	**Q: For front-end testing, is CMS expecting plans to submit only two files (one for Institutional and one for Professional) with no more than 100 claims per file?** **A:** Please limit the number of claims per file to no more than 100 claims per file. Please submit one (1) Institutional file and one (1) Professional file.
274	**02/09/2011**	**Q: What is the deadline for MAOs to participate in the Encounter Data Front-End System (EDFES) testing?** **A:** Front-end testing begins March 30, 2011 and ends June 30, 2011. MA plans must submit a 5010 test file during that time period.
275	**02/09/2011**	**Q: For the March through June 2011 testing of the front-end system, how many transactions should be submitted?** **A:** At least 1 institutional and 1 professional claim must be submitted for the test. Test data can be used because only the file format is being tested. Test data should meet all formatting requirements and values should be valid, despite the data not corresponding to an actual beneficiary. However, it is ideal for plans to submit real data. The data must pass all TA1 and 999 edits. Files larger than 100 claims should not be submitted. For Gentran users, specifics of testing requirements will be provided.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
FRONT-END TESTING		
FAQ Number	**Submission Date**	**Question and Response**
276	**02/10/2011**	**Q: For the first 837-I and 837-P test files sent for front-end testing, is there a preference or requirement for specific dates of service for the test claims submitted?** **A:** Plans should use 2010 dates of service for the test claims.
277	**02/10/2011**	**Q: Once plans have submitted their initial test files, what acknowledgement reports should plans expect to receive during the March through June testing timeframe?** **A:** Plans will receive the TA1, 999, and 277CA.
278	**02/10/2011**	**Q: If the initial submission is successful for front end testing, then will there be any additional testing requirements or test file deliverables?** **A:** If testing is successful there would be no further testing requirements.
279	**02/10/2011**	**Q: Is there a way for plans to verify the 837-I and 837-P test files generated before actually submitting them for front-end testing?** **A:** Plans can choose to use a vendor for a fee in order to validate the files prior to submission; However, CMS does require plans to submit a test file during the testing timeline.
280	**02/16/2011**	**Q: Will filtering edits be turned on for the Encounter Data System Front End (EDFES) testing?** **A:** All edits will remain on that are required for translator and Implementation Guide editing. All edits impacting formatting in CEM will also remain on.
281	**02/16/2011**	**Q: Will the testing for the PWK be part of the July 16th through October testing time frame?** **A:** We are in the process of finalizing the details regarding the Institutional and Professional Pricing testing requirements. A determination will be made regarding the PWK testing as the details are finalized.
282	**02/21/2011**	**Q: Can a plan have two (2) submitters to CMS, one (1) that will submit RAPS data and one (1) that will submit Encounter Data?** **A:** Yes, having two submitters, one (1) for RAPS and one (1) for Encounter Data, is fine.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
FRONT-END TESTING		
FAQ Number	**Submission Date**	**Question and Response**
283	**03/02/2011**	**Q: Will plans have to sponsor Third Party submitters or sign off on their application in order for them to obtain a submitter ID? If a plan is not sure if they are going to submit for themselves or have a Third Party submitter, should the plan submit their own application and participate in testing on their own? What if a plan decides to use a Third Party submitter for encounter data submission after June 30, 2011, will the Third Party still be able to apply for a submitter ID after the front-end testing period?** **A:** The submitter enrollment package will be available for completion after March 30, 2011. If a plan decides to utilize a Third Party submitter for encounter data submission after this date, then the submitter would be required to complete the Submitter ID Application and EDI Agreement posted on the CSSC operations website at: http://www.csscoperations.com/internet/cssc.nsf/docsCat/CSSC~Encounter%20Data~Enroll%20to%20Submit%20ED?open. The MAO would be required to submit a letter of authorization to CSSC allowing the organization to submit encounter data on their behalf. The same process would be utilized if an MAO were to change Third Party submitters after March 30, 2011. However, if either the MAO or the Third Party completed the package prior to March 30, 2011, and would like to make changes, the MAO should contact CSSC at 1-877-534-2772 to ensure the correct changes/updates are made.
284	**03/04/2011**	**Q: Beginning January 2012, will plans submit all claims data through the 837 format, as well as RAPS data, or will plans only submit 837 data?** **A:** Yes, plans will submit data to both RAPS and the Encounter Data System (EDS) beginning January 2012. The full 5010 HIPAA standard format will be submitted to the Encounter Data Processing System (EDPS) and the current RAPS format will be submitted for the Risk Adjustment Processing System.
285	**03/11/2011**	**Q: If plans are in the process of contract negotiations with a vendor for Encounter Data, can the deadline for completion of the submitter packet be extended?** **A:** The packet does not have to be completed by March 30, 2011. If there is a unique situation where this may pose a problem, contact CSSC at 1-877-534-2772 to discuss these concerns.
286	**03/11/2011**	**Q: Is the deadline for enrollment to submit encounter data 03/30/2011?** **A:** Enrollment to submit encounter data does not have to be completed by March 30, 2011. The requirement is that plans complete the encounter data enrollment package prior to submitting test files to the front-end system.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
FRONT-END TESTING		
FAQ Number	**Submission Date**	**Question and Response**
287	**03/28/2011**	**Q: Paragraph A.2 of the EDI Agreement, which relates to a plan's ability to use information concerning a Medicare beneficiary: In the CMS Data Use Agreement, Medicare Advantage plans are permitted to use beneficiary data for health plan operations. Will CMS confirm that the EDI Agreement permits the plan to use beneficiary information for the administration of the Medicare Advantage and/or Part D plan consistent with the Data Use Agreement and HIPAA?** **A:** CMS is confirming that this is a routine use of the data. Here is the HIPAA regulatory cite [67 FR 53268, Aug. 14, 2002]: **§ 164.502 Uses and disclosures of protected health information: general rules.** (a) *Standard.* A covered entity may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter. (1) *Permitted uses and disclosures.* A covered entity is permitted to use or disclose protected health information as follows: (i) To the individual; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with §164.506; **§ 164.506 Uses and disclosures to carry out treatment, payment, or health care operations.** (a) *Standard: Permitted uses and disclosures.* Except with respect to uses or disclosures that require an authorization under §164.508(a)(2) and (3), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart. (b) *Standard: Consent for uses and disclosures permitted.* (1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations. (2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under §164.508, is required or when another condition must be met for such use or disclosure to be permissible under this subpart. (c) *Implementation specifications: Treatment, payment, or health care operations.* (1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations. (2) A covered entity may disclose protected health information for treatment activities of a health care provider. (3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information. (4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is: (i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or (ii) For the purpose of health care fraud and abuse detection or compliance. (5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
FRONT-END TESTING		
FAQ Number	**Submission Date**	**Question and Response**
288	**03/29/2011**	**Q: When will the updated front-end testing requirements be available?** **A:** The front-end testing requirements are now posted on CSSC Operations at http://www.csscoperations.com/internet/Cssc.nsf/files/front-end-testing-redlined_040411.pdf/$FIle/front-end-testing-redlined_040411.pdf.
289	**04/05/2011**	**Q: Where can more information be found on the content and requirements for the authorization letter MAOs must send to authorize a Third Party to submit encounter data on their behalf? Specifically, what is the required content of the letter? Is a standard template for the letter available? To whom, is the authorization letter submitted and by what method (email, fax, mail)?** **A:** Details regarding the submitter enrollment application can be found at: http://apps.csscoperations.com/servlet/EDFSSubmitterApp?action=appMain. At this time, there is not a standard template that can be used for the authorization letter. If you would like additional guidance on what to include in the letter, please contact CSSC at 1-877-534-2772.
290	**04/15/2011**	**Q: According to the encounter data submission and processing front-end testing guide, in order to examine the test file format logic, the submitted claim file must include all of the following: Inpatient Institutional claims (837-I), Outpatient Institutional claims (837-I), and Professional claims (837-P). Do both formats (the 837-I and 837-P) need to be combined into one (1) test file for front-end testing? If so, what will be the indicator/differentiator among records of each format (segment/loop)?** **A:** The 837-I and 837-P will be processed separately. Plans should submit two (2) test files: one (1) test file should be submitted for professional claims (837-P) and one (1) test file should be submitted for inpatient and outpatient institutional claims (837-I). Test files should contain 50 to 100 claims per each file.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
PROCESSING AND PRICING SYSTEM TESTING		
FAQ Number	**Submission Date**	**Question and Response**
291	**01/19/2011**	**Q: For the Institutional and Professional Processing and Pricing system end-to-end testing, what is the expectation for completeness of the test file, since plans will be converting from 4010 data?** **A:** MAOs are expected to populate all required fields on the 5010, as is required by HIPPA, so that CMS is able to evaluate the internal systems.
292	**04/15/2011**	**Q: The original front-end testing guide had the dates for encounter data processing and pricing testing for both Institutional and Professional encounters. The updated front-end testing guide no longer has these dates. Are the dates from the previous guide no longer valid? If so, what are the new dates?** **A:** As of now, the EDPS processing and pricing system end to end testing phase for institutional and professional claims will occur no earlier than October 31, 2011.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
PILOT TESTING		
FAQ Number	**Submission Date**	**Question and Response**
293	**01/19/2011**	**Q: Is CMS considering increasing the amount of data submitted for the Encounter Data Pilot Test (all scenarios may not be captured)?** **A:** The amount of data submitted during the Pilot Test has already been established. There may be scenarios that are not captured during the Pilot Test. However, CMS expects that those scenarios will be addressed during the Front-End testing phase.
294	**01/19/2011**	**Q: If the pilot testing package is not received on January 21, 2011, does this mean that the plan was not chosen for participation in the Encounter Data Pilot Test?** **A:** The first round of invitations will be distributed by January 21. Based on responses to the request, a second round of invitations will be distributed during the first week of February.
295	**02/02/2011**	**Q: CMS documentation requests a submission of at least 10 claims for pilot testing. If plans would like to submit more than 10 claims, what is CMS' expectation of the number of claims? Is there an upper limit to the number of claims CMS can process as part of Pilot Test?** **A:** Please limit your submission to no more than 100 claims per file.
296	**02/02/2011**	**Q: Will CMS send any response files back to plans for pilot test data submission? If yes, does CMS expect the plans to process the return files within a certain period of time?** **A:** The purpose of this Pilot is to allow CMS to determine the type of data MAOs are positioned to submit to CMS. Based on this information, CMS will determine the appropriate policies required to support the encounter data process. Plans will not receive return reports during the Pilot.
297	**02/02/2011**	**Q: What kind of feedback can plans expect from CMS following submission of Pilot Test files? Will plans have the opportunity to discuss results of the pilot test edits with CMS?** **A:** After the completion of the analysis, CMS will conduct a conference call with all Pilot participants to provide an overview of our findings. We anticipate that this call will be conducted during the last week of March.
298	**02/02/2011**	**Q: Will CMS be applying edits for member eligibility during the Pilot Test? Are claims with masked PHI data acceptable for the Pilot Test?** **A:** Please provide actual claims data. Our goal is to apply as many edits as possible.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
PILOT TESTING		
FAQ Number	**Submission Date**	**Question and Response**
299	**02/02/2011**	**Q: What dates of service should plans submit for the Pilot Test?** **A:** Please submit 2010 dates of service.
300	**02/02/2011**	**Q: Are the following EDI versions acceptable for Pilot Test submission?** **Institutional Claims (Encounter) in version 005010X223A1** **Professional Claims (Encounter) in version 005010X222.** **A:** You are correct regarding the Institutional Encounter. The Professional Encounter should be 005010X22A1.
301	**02/07/2011**	**Q: If a plan is utilizing the current FTP site for production submissions for pilot testing, what naming convention should be used to distinguish that it is a test file? Will the same FTP site be used for future testing or will a new FTP connectivity be required for future tests?** **A:** Please put 'T' in ANSI field ISA15. Also, put 'test' somewhere in their File ID (ANSI field ISA13). This will help them identify the file as a test file. You will use their existing FTP connection for pilot and general testing.
302	**02/08/2011**	**Q: Will plans receive any formal acknowledgment of participation in the pilot from CMS? Also, is there any other reference material or guidance for plans participating in the pilot?** **A:** While the standard reports will not be generated, CMS will inform pilot test plans of receipt of the file and provide follow-up regarding the outcome of the editing process.
303	**02/09/2011**	**Q: Does the CSSC submitter package need to be completed for participants of the pilot test?** **A:** The submitter packet does not need to be completed for the pilot test. All plans must complete the submitter package prior to the Encounter Data Front-End Testing (EDFES). The application will be available for download on the CSSC operations website (www.cssc.operations.com) no later than March 15, 2011.
304	**02/09/2011**	**Q: For the pilot test, are plans submitting to the Front-End Risk Adjustment System (FERAS)?** **A:** No, plans should refer to the pilot testing package for submission directions. Please use the contact information included in the pilot test package for questions.

ENCOUNTER DATA SYSTEM (EDS) TESTING		
PILOT TESTING		
FAQ Number	**Submission Date**	**Question and Response**
305	**03/29/2011**	**Q: During the 3/16/11 Industry Update call, it was stated that the "Test Package" would be updated based upon the results of the Pilot Test. What is the estimated time of arrival and/or location for the revised document?** **A:** The updated test package is now posted on the CSSC website at http://www.csscoperations.com/internet/Cssc.nsf/files/front-end-testing-redlined_040411.pdf/$FIle/front-end-testing-redlined_040411.pdf.
306	**04/14/2011**	**Q: In the Encounter Data Newsletter (Volume 1 Issue 2), this notification was included: "CMS recruited six (6) plans to participate in an Encounter Data (ED) Pilot Test, to be conducted during March 2011. The selected plans will submit data so that CMS can determine information that will be accepted during processing and identify issues to resolve prior to the industry-wide front-end testing. Data from the Pilot Test will determine edits to turn on or off and CMS will use the information to provide MAOs/Third Party Submitters guidelines regarding policies, best practices, and implementation assistance to support the successful testing of the EDFES. MAOs/Submitters can expect to receive published Test Policy for the Encounter Data Front-End System (EDFES) by April 8, 2011." When will the test policy for the EDFES be published? Will it include companion guides for the 5010 837-I and 837-P formats?** **A:** Analysis of the Pilot Test results is currently underway and the industry will be notified when results of the Pilot Test are published. Publication of the Pilot Test results will not include companion guides for the 837-I and 837-P formats. However, the outcomes of the analysis will be the basis for the information included in the companion guide.

ICD-10 TRANSITION		
FAQ Number	**Submission Date**	**Question and Response**
307	**01/19/2011**	**Q: Will there be an ICD-10 conversion for RAPS?** **A:** Yes, Risk Adjustment will undergo an ICD-10 conversion. Further information on the conversion will be provided during the Regional Trainings in the Summer of 2011. Please refer to http://www.cms.gov/ICD10/ for CMS guidance on ICD-10.
308	**01/19/2011**	**Q: What will happen to RAPS if the parallel processing fails before the scheduled ICD-10 conversion?** **A:** RAPS and the Encounter Data System (EDS) will run parallel until CMS can validate that the encounter data collected is high quality data, which can be used to calibrate the Risk Adjustment model. Parallel processing is being used to ensure that there is no impact to plan payments during this transition. The conversion to ICD-10 occurs in October 2013 and should not impact the parallel processing established for RAPS and EDS.

DURABLE MEDICAL EQUIPMENT (DME)		
FAQ Number	**Submission Date**	**Question and Response**
309	**12/08/2010**	**Q: Can plans send DME claims data earlier than the schedule testing dates?** **A:** Yes, plans can send DME test data when it is ready. CMS does not want MAOs to filter their data at this time. Send in all claims data, including DME. CMS will store the data and then run these during the appropriate testing timeframe.
310	**01/19/2011**	**Q: Is CMS going to filter out DME claims following the 'go live' date of 01/03/2012?** **A:** Yes, it is anticipated that the Encounter Data DME Processing and Pricing System's 'go live' will be May of 2012. Any DME claims received prior to this date will be stored for processing once the DME Encounter Data Module is developed.
311	**01/19/2011**	**Q: Will plans receive a 277CA response for the DME claims that are being stored until DME testing begins in 2012?** **A:** Plans will not receive a 277CA reflecting any DME claims prior to the testing of the CEDI module, currently scheduled for May 2012.
312	**01/19/2011**	**Q: Are DME claims submitted using the 837-P?** **A:** Yes, DME claims are submitted through the 837-P. DME claims received by CMS will process through the front-end system and then be filtered out and sent to the DME processor.
313	**01/19/2011**	**Q: Will DME claims distributed through a doctor's office still go through the DME process due to the presence of a certain DME or HCPC code?** **A:** Yes, all DME claims will be submitted using the 837-P and will be processed through the DME processing system.
314	**01/19/2011**	**Q: Will there be a new 837 for DME transactions?** **A:** No. DME claims will be submitted using the 837-P.
315	**01/19/2011**	**Q: Is DME processed in the same way as Professional (837-P) and Institutional (837-I) claims?** **A:** DME claims will be processed through the DME pricing processor, not the professional pricing processor.
316	**03/02/2011**	**Q: Since the DME processing and pricing will be turned on at a later time and CMS will not be conducting line item level editing, how will pricing of DME items submitted on the same claim as other services be affected?** **A:** Because DME is scheduled to 'go live' later in the encounter data timeline, this could impact pricing and processing of DME services. CMS will investigate this issue further.

DURABLE MEDICAL EQUIPMENT (DME)		
FAQ Number	**Submission Date**	**Question and Response**
317	**03/04/2011**	**Q: Should MAOs exclude whole claims from submission to the front-end system if at least one line on the claim includes DME billing?** **A:** As we have moved forward in the implementation process, it has been determined that we will not have the capacity to store DME encounters submitted for DME processing through CEDI, until the CEDI module has been implemented. As a result, please do not submit 837-P/DME claims until the scheduled testing date of February 9, 2012.
318	**03/17/2011**	**Q: What is the submission timeline for DME encounters? It was originally discussed that DME claims could be submitted with other encounters beginning January 3, 2012, and that CMS would hold them for processing until the DME system goes live in May 2012.** **A:** As we have moved forward in the implementation process, it has been determined that we will not have the capacity to store DME encounters submitted for DME processing through CEDI, until the CEDI module has been implemented. As a result, please do not submit 837-P/DME claims until the scheduled testing date of February 9, 2012.

TRAINING AND RESOURCES		
FAQ Number	**Submission Date**	**Question and Response**
319	**12/15/2010**	**Q: What is the anticipated release date for the companion guide?** **A:** CMS has not yet published a companion guide. CMS is working to make decisions to complete the Companion Guide. In the mean time, on a weekly basis as decisions are made CMS will send information as decisions are made and communicate through the work groups.
320	**12/17/2010**	**Q: Will CMS be publishing a companion guide and will it include edits that CMS plans to apply for encounter data submission?** **A:** CMS is currently in the process of developing a Companion Guide for the collection of Encounter Data. In addition, guidance on the edits CMS intends to apply will be included in the Operational Guidance Manual, which is also under development. In order to keep plans informed until the guides are available, CMS will provide information regarding decisions made during the Industry Updates (scheduled for January 19, 2011, March 16, 2011, and May 11, 2011) and by using distribution lists. MAOs are encouraged to participate in the Encounter Data Work Groups and Industry Updates so that feedback from the industry can be incorporated in the decision-making process. For more information on the Encounter Data Work Groups and Industry Updates, please refer to www.tarsc.info.
321	**01/12/2011**	**Q: Will the companion guide be available before the first test file submission deadline?** **A:** The companion guide will not be completed before the start of testing. Plans must submit a 5010 test file sometime within the front-end testing time period. The objective of the test is to make sure that the 5010 file can communicate with the Front-End System. Plans do not need an entire month of data for the test. A minimum of 10 claims should be submitted. The companion guide will be made available to plans in phases as it is developed. Also, the Industry Updates scheduled for January 19, March 16, and May 11, 2011 will provide up-to-date information on decisions made or changes to encounter data requirements.

TRAINING AND RESOURCES		
FAQ Number	**Submission Date**	**Question and Response**
322	**01/25/2011**	**Q: CMS will be putting on one-week training sessions this summer in three different sites. Will this training include a discussion of how the risk adjustment calculation model might be changing as we move to the exclusive use of encounter data? Will the previously announced 2012 HCC model changes still take place?** **A:** During the Regional Trainings in the Summer of 2011, the industry can expect to receive further information on how the risk adjustment model might change as the industry transitions to the collection of encounter data. Information on these trainings will be posted on www.tarsc.info by the end of March 2011. Based on current legislation, the 2012 HCC model changes are still planned to occur on schedule.
323	**02/04/2011**	**Q: During the Encounter Data Industry Update call on 01/19/2011, MAOs were notified that the Regional Technical Assistance Training dates would be announced by the end of this quarter, is there any information related to the dates of these trainings available yet?** **A:** The Regional Technical Assistance training dates are as follows: • Orlando, FL - June 20 - June 24, 2011 • San Diego, CA - July 11 - 15, 2011 • Chicago, IL - August 1 - 5, 2011. For further information on Encounter Data and Regional Trainings, please view the Encounter Data Newsletter on www.tarsc.info.
324	**03/01/2011**	**Q: Where is volume 1, Issue 1 of the encounter data newsletters located?** **A:** The 1st and 2nd Quarter Encounter Data Newsletters can be viewed on the TARSC website (www.tarsc.info) under the ""Resources"" tab at http://www.tarsc.info/Encounter%20Data%20Newsletter_Quarter%201.pdf, and http://www.tarsc.info/Encounter%20Data%20Newsletter_Quarter%202.pdf.
325	**03/01/2011**	**Q: Is there any cost associated with the Regional IT Technical Assistance Trainings to be held in the summer 2011?** **A:** Registration for the Technical Assistance Regional Trainings began at the end of March 2011. While there is no cost to attend the sessions, participants will be responsible for travel and lodging.
326	**03/01/2011**	**Q: Will the Regional IT Technical Assistance Training sessions be one (1) week long for each topic or is the entire training one (1) week (covering all topics)?** **A:** The entire training is one (1) week long to include five (5) specific topics. The draft agendas can be found at www.tarsc.info.

TRAINING AND RESOURCES		
FAQ Number	**Submission Date**	**Question and Response**
327	**03/16/2011**	**Q: Can you provide more specifics on session topics for each day of the Regional IT Technical Assistance Trainings?** **A:** Please see www.tarsc.info for detailed information on each of these topics. Registration opened April 1, 2011.
328	**03/17/2011**	**Q: Will CMS have a separate regional training for RADV, or will RADV information be included in the Regional IT Technical Assistance Training sessions this summer?** **A:** RADV information will not be included in the Regional IT Technical Assistance Training sessions being held this summer. Currently, there is no separate RADV training session scheduled. CMS will notify the industry of any updates regarding training opportunities specific to RADV processes.
329	**03/22/2011**	**Q: Is there a companion guide for the CMS encounter data project?** **A:** CMS is currently developing the companion guide for encounter data collection. The companion guide will be made available to plans in sections as it is developed. The industry will be notified of details regarding release of the companion guide sections as they are completed.
330	**03/22/2011**	**Q: Are there other training programs related to the Encounter Data Processing System (EDPS) besides the Regional IT Technical Assistance Trainings scheduled for summer 2011?** **A:** Currently, the Regional Technical Assistance Training sessions are the only scheduled training opportunities for encounter data. The industry will be notified of any schedule updates regarding additional training sessions or opportunities related to encounter data collection.
331	**03/28/2011**	**Q: Will the Encounter Data Call on April 20, 2011 and the Industry Update on May 25, 2011 be conducted in addition to or in place of the scheduled work group calls?** **A:** As of now, the encounter data call scheduled for April 20, 2011 and the Industry Update scheduled for May 25, 2011 will replace the original work group schedule.
332	**03/29/2011**	**Q: Will there be allotted seats in the Regional IT Technical Assistance Training registration for Third Party submitters?** **A:** One (1) seat is allocated per Third Party entity. Please visit www.tarsc.info for further information on registration. If space allows, those on the waitlist will have the opportunity to join.

TRAINING AND RESOURCES		
FAQ Number	**Submission Date**	**Question and Response**
333	**04/05/2011**	**Q: Can you provide more specifics regarding the agenda for the Industry Update scheduled for May 25, 2011? Will it focus on giving instructions about how plans will submit/prepare encounter data or will it focus more on policy updates, dissemination, structure, and use of the data?** **A:** During this meeting, CMS will provide updated policy and operational guidance to the industry to promote capabilities and preparations for systems testing and Encounter Data Systems implementation. Please refer to www.tarsc.info for information about the upcoming Industry Update scheduled for May 25, 2011.
334	**04/14/2011**	**Q: Does CMS have a generic, but detailed end-to-end process flow chart for RAPS?** **A:** A flow chart for RAPS is available on the CSSC website at http://www.csscoperations.com/internet/Cssc.nsf/files/raps-submission-timetable_030910.pdf/$FIle/raps-submission-timetable_030910.pdf. More detailed information regarding RAPS data submission and processing can be located in the CSSC 2008 participant guide (Module 2) at http://www.csscoperations.com/internet/Cssc.nsf/files/participant-guide-publish_052909.pdf/$FIle/participant-guide-publish_052909.pdf.

ENCOUNTER DATA PRICING AND MODEL RECALIBRATION		
FAQ Number	**Submission Date**	**Question and Response**
335	**12/08/2010**	**Q: What is the source for Risk Adjustment payments?** **A:** Initially this will not change. The Risk Adjustment Processing System will calculate the risk score and then the payment will be calculated in MARx. This process will be phased out and all systems will be transitioned to the Encounter Data System in advance of turning off the Risk Adjustment Processing System. CMS expects this to take at least a year.
336	**01/19/2011**	**Q: Regarding pricing, will CMS take an average for all plans or will each plan be looked at independently for encounter data?** **A:** CMS will price each encounter data claim received, and will recalibrate the model based on the data received at the time of recalibration. The recalibrated model will apply to all plans.
337	**01/26/2011**	**Q: Is it possible to build the pricing methodology based on diagnosis codes (If not, the MA industry will need time to adapt to collecting and reporting CPT codes)?** **A:** As of right now, CMS does not plan to change the risk score calculation methodology.
338	**02/23/2011**	**Q: Will the pricing rules be published in the implementation guide?** **A:** CMS is using the standard Fee-for-Service PRICERs and fee schedules. The PRICER and fee schedule rules are available on the CMS website.
339	**03/07/2011**	**Q: What about the new enrollee factor? If CMS is going to essentially assign a concurrent risk score for new enrollees, to capture diagnoses for those without Medicare claims history, how does that affect encounter data reporting?** **A:** Encounter data will not impact the application of the new enrollee factor. The risk adjustment methodologies will not change with collection of encounter data, including risk score calculation for new enrollees. Beneficiaries with less than 12 months of Medicare Part B data during the data collection year will receive the new enrollee factors in the associated risk adjustment models and beneficiaries with 12 or more months of Medicare Part B data during the data collection period will be considered full-risk enrollees in which new enrollee factors would not apply. In essence, there is no relationship between the method of collecting the data (encounter data) and the number of months of Medicare Part B for a beneficiary.