Encounter Data System

Standard Companion Guide Transaction Information

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

Companion Guide Version Number: 29.0
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Preface

The Encounter Data System (EDS) Companion Guide contains information to assist Medicare Advantage Organizations (MAOs) and other entities in the submission of encounter data. The EDS Companion Guide is under development and the information in this version reflects current decisions and will be modified on a regular basis. All of the EDS Companion Guides are identified with a version number, which is located in the version control log on the last page of the document. Users should verify that they are using the most current version.

Questions regarding the contents of the EDS Companion Guide should be directed to encounterdata@cms.hhs.gov.

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1.0 Introduction

1.1 Scope

The CMS Encounter Data System (EDS) 837-I Companion Guide addresses how MAOs and other entities conduct Institutional claims Health Information Portability and Accountability Act (HIPAA) standard electronic transactions with CMS. The CMS EDS supports transactions adopted under HIPAA, as well as additional supporting transactions described in this guide.

The CMS EDS 837-I Companion Guide must be used in conjunction with the associated 837-I Implementation Guide (TR3) and the Encounter Data Front-End System (EDFES) CEM Edits Spreadsheets. The instructions in the 837-I CMS EDS Companion Guide are not intended for use as a stand-alone requirements document.

1.2 Overview

The CMS EDS 837-I Companion Guide includes information required to initiate and maintain communication exchange with CMS. The information is organized in the sections listed below:

- Contact Information: Includes telephone numbers and email addresses for EDS contacts.
- Control Segments/Envelopes: Contains information required to create the ISA/IEA, GS/GE, and ST/SE control segments in order for transactions to be supported by the EDS.
- Acknowledgements and Reports: Contains information for all transaction acknowledgements and reports sent by the EDS.
- Transaction Specific Information: Describes the details of the HIPAA X12 Implementation Guides (IGs), using a tabular format. The tables contain a row for each segment with CMS and IG specific information. That information may contain:
    - Limits on the repeat of loops or segments
    - Limits on the length of a simple data element
    - Specifics on a sub-set of the IG's internal code listings
    - Clarification of the use of loops, segments, and composite or simple data elements
    - Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with CMS.

In addition to the row for each segment, one (1) or more additional rows are used to describe the EDS' usage for composite or simple data elements and for any other information.

1.3 Major Updates

1.3.1 EDS Acronyms

MAOs and other entities may reference Section 13.0, Table 19 for additional acronyms frequently used by the EDS.

1.4 References

MAOs and other entities must use the ASC X12N IG adopted under the HIPAA Administrative Simplification Electronic Transaction rule, along with CMS' Encounter Data Participant Guides and EDS Companion Guides, for development of the EDS transactions. These documents are accessible on the CSSC Operations website at www.csscoperations.com. Additionally, CMS publishes the EDS' submitter guidelines and application, testing documents, 837 EDS Companion Guides and Encounter Data Participant Guides on the CSSC Operations website.

MAOs and other entities must use the most current national standard code lists applicable to the 5010 transaction. The code lists may is accessible at the Washington Publishing Company (WPC) website at: http://www.wpc-edi.com.

The applicable code lists are as follows:

- Claim Adjustment Reason Code (CARC)
- Claim Status Category Codes (CSCC)
- Claim Status Codes (CSC)

CMS provides X12 5010 file format technical edit spreadsheets for the 837-I and 837-P. The edits included in the spreadsheets are provided to clarify the WPC instructions or add Medicare specific requirements. In order to determine the implementation date of the edits contained in the spreadsheet, MAOs and other entities should initially refer to the spreadsheet version identifier. The version identifier is comprised of ten (10) characters, as follows:

- Positions 1-2 indicate the line of business:
    - EA – Part A (837-I)
    - EB – Part B (837-P)
- Positions 3-6 indicate the year (e.g., 2011)
- Position 7 indicates the release quarter month
    - 1 – January release
    - 2 – April release
    - 3 – July release
    - 4 – October release
- Positions 8-10 indicate the spreadsheet version iteration number (e.g., V01-first iteration, V02-second iteration)

The effective date of the spreadsheet is the first calendar day of the release quarter month. The implementation date is the first business Monday of the release quarter month. Federal holidays that potentially occur on the first business Monday are considered when determining the implementation date. For example, the edits contained in a spreadsheet version of EA20131V01 are effective January 1, 2013 and implemented on January 7, 2013.

2.0 Contact Information

2.1 The Customer Service and Support Center (CSSC)

The Customer Service and Support Center (CSSC) personnel are available for questions from 8:00 AM – 7:00PM EST, Monday-Friday, with the exception of federal holidays. MAOs and other entities are able to contact the CSSC by phone at 1-877-534-CSSC (2772) or by email at csscoperations@palmettogba.com.

2.2 Applicable Websites/Email Resources

The following websites provide information to assist in the EDS submission:

RESOURCE	WEB ADDRESS
EDPS Bulletin	http://www.csscoperations.com/
EDS Inbox	encounterdata@cms.hhs.gov
EDS Participant Guides	http://www.csscoperations.com/
EDS User Group Materials	http://www.csscoperations.com/
ANSI ASC X12 TR3 Implementation Guides	http://www.wpc-edi.com/
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/
CMS Edits Spreadsheet	http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp

3.0 File Submission

3.1 File Size Limitations

Due to system limitations, ISA/IEA transaction sets should not exceed 5,000 encounters, as the EDS processes smaller files more efficiently than larger files.

In an effort to support and provide the most efficient processing system, and to allow for maximum performance, CMS recommends that FTP submitters' scripts upload no more than one (1) file per five (5) minute intervals. Zipped files should contain one (1) file per transmission. NDM and Gentran/TIBCO users may submit a maximum of 255 files per day.

3.2 File Structure – NDM/Connect Direct and Gentran/TIBCO Submitters Only

NDM/Connect Direct and Gentran/TIBCO submitters must format all submitted files in an 80-byte fixed block format. This means MAOs and other entities must upload every line (record) in a file with a length of 80 bytes/characters.

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

Note: If MAOs and other entities are using a text editor to create the file, pressing the Enter key will create a new line. If MAOs and other entities are using an automated system to create the file, create a new line by using a CRLF (Carriage Return Line Feed) or a LF (Line Feed).
For example, the ISA record is 106 characters long:

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

ISA*00* *00* *ZZ* ENH9999*ZZ* 80881*120816*114
4*^*00501*000000031*1*P*:~

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

4.0 Control Segments/Envelopes

4.1 ISA/IEA

The term interchange denotes the transmitted ISA/IEA envelope. Interchange control is achieved through several "control" components, as defined in Table 1. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element IEA02 of the IEA segment. MAOs and other entities must populate all elements in the ISA/IEA interchange. There are several elements within the ISA/IEA interchange that must be populated specifically for encounter data purposes. Table 1 below provides EDS Interchange Control (ISA/IEA) specific elements.

Note: Table 1 presents only those elements that provide specific details relevant to encounter data. When developing the encounter data system, users should base their logic on the highest level of specificity. First, consult the WPC/TR3. Second, consult the CMS edits spreadsheets. Third, consult the CMS EDS 837-I Companion Guide. If there are options expressed in the WPC/TR3 or the CEM edits spreadsheet that are broader than the options identified in the CMS EDS 837-I Companion Guide, MAOs and other entities must use the rules identified in the Companion Guide.

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

TABLE 1 – ISA/IEA INTERCHANGE ELEMENTS

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	No authorization information present
	ISA02	Authorization Information		Use 10 blank spaces
	ISA03	Security Information Qualifier	00	No security information present
	ISA04	Security Information		Use 10 blank spaces
	ISA05	Interchange ID Qualifier	ZZ	CMS expects to see a value of "ZZ" to designate that the code is mutually defined
	ISA06	Interchange Sender ID		EN followed by Contract ID Number
	ISA08	Interchange Receiver ID	80881	
	ISA11	Repetition Separator	^	
	ISA13	Interchange Control Number		Must be fixed length with nine (9) characters and match IEA02 Used to identify file level duplicate collectively with GS06, ST02, and BHT03

TABLE 1 – ISA/IEA INTERCHANGE ELEMENTS (CONTINUED)

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
ISA		Interchange Control Header		
	ISA14	Acknowledgement Requested	1	A TA1 will be sent if the file is syntactically incorrect, otherwise only a '999' will be sent
	ISA15	Usage Indicator	T P	Test Production
IEA		Interchange Control Trailer		
	IEA02	Interchange Control Number		Must match the value in ISA13

4.2 GS/GE

The functional group is outlined by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

MAOs and other entities must populate all elements in the GS/GE functional group. There are several elements within the GS/GE that must be populated specifically for encounter data collection. Table 2 provides EDS functional group (GS/GE) specific elements.

Note: Table 2 presents only those elements that require explanation.

TABLE 2 - GS/GE FUNCTIONAL GROUP ELEMENTS

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
GS		Functional Group Header		
	GS02	Application Sender's Code		EN followed by Contract ID Number This value must match the value in the ISA06
	GS03	Application Receiver's Code	80881	This value must match the value in ISA08
	GS06	Group Control Number		This value must match the value in GE02 Used to identify file level duplicates collectively with ISA13, ST02, and BHT03
	GS08	Version/Release/Industry Identifier Code	005010X223A2	
GE		Functional Group Trailer		
	GE02	Group Control Number		This value must match the value in GS06

4.3 ST/SE

The transaction set (ST/SE) contains required, situational loops, unused loops, segments, and data elements. The transaction set is outlined by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifies the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments. Several elements must be populated specifically for encounter data purposes. Table 3 provides EDS transaction set (ST/SE) specific elements.

Note: Table 3 presents only those elements that require explanation.

TABLE 3 - ST/SE TRANSACTION SET HEADER AND TRAILER ELEMENTS

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
ST		Transaction Set Header		
	ST01	Transaction Set Identifier Code	837	
	ST02	Transaction Set Control Number		This value must match the value in SE02 Used to identify file level duplicates collectively with ISA13, GS06, and BHT03
	ST03	Implementation Convention Reference	005010X223A2	
SE		Transaction Set Trailer		
	SE01	Number of Included Segments		Must contain the actual number of segments within the ST/SE
	SE02	Transaction Set Control Number		This value must be match the value in ST02

5.0 Transaction Specific Information

5.1 837 Institutional: Data Element Table

Within the ST/SE transaction set, there are multiple loops, segments, and data elements that provide billing provider, subscriber, and patient level information. MAOs and other entities should reference www.wpc-edi.com to obtain the most current Implementation Guide. MAOs and other entities must submit EDS transactions using the most current transaction version.

The 837 Institutional Data Element table identifies only those elements within the X12N Implementation Guide that require comment within the context of the EDS' submission. Table 4 identifies the 837 Institutional Implementation Guide by loop name, segment name, segment identifier, data element name, and data element identifier for cross reference. Not all data elements listed in the table below are required, but if they are used, the table reflects the values CMS expects to see.

TABLE 4 - 837 INSTITUTIONAL HEALTH CARE CLAIM

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
	BHT	Beginning of Hierarchical Transaction		
	BHT03	Originator Application Transaction Identifier		Must be a unique identifier across all files Used to identify file level duplicates collectively with ISA13, GS06, and ST02.
	BHT06	Claim Identifier	CH	Chargeable
1000A	NM1	Submitter Name		
	NM102	Entity Type Qualifier	2	Non-Person Entity
	NM109	Submitter Identifier		EN followed by Contract ID Number
1000A	PER	Submitter EDI Contact Information		
	PER03	Communication Number Qualifier	TE	It is recommended that MAOs and other entities populate the submitter's telephone number
	PER05	Communication Number Qualifier	EM	It is recommended that MAOs and other entities populate the submitter's email address

TABLE 4 - 837 INSTITUTIONAL HEALTH CARE CLAIM (CONTINUED)

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
1000A	PER	Submitter EDI Contact Information		
	PER07	Communication Number Qualifier	FX	It is recommended that MAOs and other entities populate the submitter's fax number
1000B	NM1	Receiver Name		
	NM102	Entity Type Qualifier	2	Non-Person Entity
	NM103	Receiver Name		EDSCMS
	NM109	Receiver ID	80881	Identifies CMS as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID
2010AA	NM1	Billing Provider Name		
	NM108	Billing Provider ID Qualifier	XX	NPI Identifier
2010AA	NM109	Billing Provider Identifier	1999999976	Must be populated with a ten digit number, must begin with 1 Institutional provider default NPI when the provider has not been assigned an NPI
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Zip Code		The full nine (9) digits of the ZIP Code are required. If the last four (4) digits of the ZIP code are not available, populate a default value of "9998".
2010AA	REF	Billing Provider Tax Identification Number		
	REF01	Reference Identification Number	EI	Employer's Identification Number (EIN)
	REF02	Billing Provider Tax Identification Number	199999997	Institutional provider default EIN
2000B	SBR	Subscriber Information		
	SBR01	Payer Responsibility Number Code	S	EDSCMS is considered the destination (secondary) payer
	SBR09	Claim Filing Indicator Code	MA	Must be populated with a value of MA – Medicare Part A
2010BA	NM1	Subscriber Name		
	NM108	Subscriber Id Qualifier	MI	Must be populated with a value of MI – Member Identification Number
	NM109	Subscriber Primary Identifier		This is the subscriber's Health Insurance Claim (HIC) number. Must match the value in Loop 2330A, NM109
2010BB	NM1	Payer Name		
	NM103	Payer Name		EDSCMS
	NM108	Payer ID Qualifier	PI	Must be populated with the value of PI – Payer Identification
	NM109	Payer Identification	80881	

TABLE 4 - 837 INSTITUTIONAL HEALTH CARE CLAIM (CONTINUED)

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2010BB	N3	Payer Address		
	N301	Payer Address Line	7500 Security Blvd	
2010BB	N4	Payer City, State, ZIP Code		
	N401	Payer City Name	Baltimore	
	N402	Payer State	MD	
	N403	Payer ZIP Code	212441850	
2010BB	REF	Other Payer Secondary Identifier		
	REF01	Contract ID Identifier	2U	
	REF02	Contract ID Number		MAO or other entities Contract ID Number
2300	CLM	Claim Information		
	CLM02	Total Claim Charge Amount		
	CLM05-3	Claim Frequency Type Code	1 2 3 4 7 8 9	1=Original claim submission 2=Interim – First Claim 3=Interim – Continuing Claim 4=Interim – Last Claim 7=Replacement 8=Deletion 9=Final Claim for a Home Health PPS Episode
2300	DTP	Date – Admission Date/Hour		
	DTP02	Date Time Period Format Qualifier	D8 DT	D8=CCYYMMDD DT=CCYYMMDDHHMM
	DTP03	Admission Date/Hour		Hours (HH) are expressed as “00” for midnight, “01” for 1A.M., and so on through “23” for 11P.M. Minutes (MM) are expressed as “00” through “59”. If the actual minutes are not known, use a default of “00”. This is only required for original or final bills
2300	PWK	Claim Supplemental Information		
	PWK01	Report Type Code	09 OZ PY	Populated for chart review submissions only Populated for encounters generated as a result of paper claims only Populated for encounters generated as a result of 4010 submission only
	PWK02	Attachment Transmission Code	AA	Populated for chart review, paper generated, and 4010 generated encounters
2300	CN1	Contract Information		
	CN101	Contract Type Code	05	Populated for capitated/ staff model arrangements

TABLE 4 - 837 INSTITUTIONAL HEALTH CARE CLAIM (CONTINUED)

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2300	REF	Payer Claim Control Number		
	REF01	Original Reference Number	F8	
	REF02	Payer Claim Control Number		Identifies ICN from original encounter when submitting adjustment or chart review data
2300	REF	Medical Record Number		
	REF01	Medical Record Identification Number	EA	
	REF02	Medical Record Identification Number	8	***Chart review delete diagnosis code only submission*** – Identifies the diagnosis code populated in Loop 2300, HI must be deleted from the encounter ICN in Loop 2300, REF02.
			Deleted Diagnosis Code(s)	Diagnosis code(s) that must be deleted from the encounter ICN in Loop 2300, REF02 ***for "chart review – add and delete specific diagnosis codes on a single encounter" submissions only.***
2300	NTE	Claim Note		
	NTE01	Note Reference Code	ADD	
	NTE02	Claim Note Text		See Section 11.0 for the use and message requirements of default data information
2300	HI	Value Information		
	HI01-2	Value Code	A0	Required on all ambulance encounters
	HI01-5	Value Code Amount		Must include the ambulance pick-up location ZIP Code+4, when available, in the following format: xxxxxxxx.x
2320	SBR	Other Subscriber Information		
	SBR01	Payer Responsibility Sequence Number Code	P T	P=Primary (when MAOs or other entities populate the payer paid amount) T=Tertiary (when MAOs or other entities populate a true COB)
	SBR09	Claim Filing Indicator Code	16	Health Maintenance Organization (HMO) Medicare Risk
2330A	NM1	Other Subscriber Name		
	NM108	Identification Code Qualifier	MI	
	NM109	Subscriber Primary Identifier		Must match the value in Loop 2010BA, NM109
2330B	NM1	Other Payer Name		
	NM108	Identification Code Qualifier	XV	
	NM109	Other Payer Primary Identifier	Payer 01	MAO or other entity's Contract ID Number. Only populated if there is no Contract ID Number available for a true other payer

TABLE 4 - 837 INSTITUTIONAL HEALTH CARE CLAIM (CONTINUED)

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2330B	N3	Other Payer Address		
	N301	Other Payer Address Line		MAO or other entity's address
	N4	Other Payer City, State, ZIP Code		
	N401	Other Payer City Name		MAO or other entity's City Name
	N402	Other Payer State		MAO or other entity's State
	N403	Other Payer ZIP Code		MAO or other entity's ZIP Code
2430	SVD	Line Adjudication Information		
	SVD01	Other Payer Primary Identifier		Must match the value in Loop 2330B, NM109
2430	CAS	Line Adjustments		
	CAS02	Adjustment Reason Code		If a service line is denied in the MAO or other entities' adjudication system, the denial reason must be populated
2430	DTP	Line Check or Remittance Date		
	DTP03			Populate the claim receipt date minus one (1) day as the default primary payer adjudication date only in the instance that the primary payer adjudication date is not available

6.0 Acknowledgements and/or Reports

6.1 TA1 – Interchange Acknowledgement

The TA1 report enables the receiver to notify the sender when there are problems with the interchange control structure. As the interchange envelope enters the EDFES, the EDI translator performs TA1 validation of the control segments/envelope. The sender will only receive a TA1 there are syntax errors in the file. Errors found in this stage will cause the entire X12 interchange to be rejected with no further processing.

MAOs and other entities will receive a TA1 interchange report acknowledging the syntactical inaccuracy of an X12 interchange header ISA and trailer IEA and the envelope's structure. Encompassed in the TA1 is the interchange control number, interchange date and time, interchange acknowledgement code, and interchange note code. The interchange control number, date, and time are identical to those populated on the original 837-I or 837-P ISA line, which allows for MAOs and other entities to associate the TA1 with a specific file previously submitted.

Within the TA1 segment, MAOs and other entities will be able to determine if the interchange rejected by examining the interchange acknowledgement code (TA104) and the interchange note code (TA105). The interchange acknowledgement code stipulates whether the interchange (ISA/IEA) rejected due to syntactical errors. An "R" will be the value in the TA104 data element if the interchange rejected due to errors. The interchange note code is a numeric code that notifies MAOs and other entities of the specific error. If a fatal error occurs, the EDFES generates and returns the TA1 interchange acknowledgement report within 24 hours of the interchange submission. If a TA1 interchange control structure error is identified, MAOs and other entities must correct the error and resubmit the interchange file.

6.2 999 – Functional Group Acknowledgement

After the interchange passes the TA1 edits, the next stage of editing is to apply Implementation Guide (IG) edits and verify the syntactical correctness of the functional group(s) (GS/GE). Functional groups allow for organization of like data within an interchange; therefore, more than one (1) functional group with multiple claims within the functional group can be populated in a file. The 999 acknowledgement report provides information on the validation of the GS/GE functional group(s) and the consistency of the data. The 999 report provides MAOs and other entities information on whether the functional groups were accepted or rejected.

If a file has multiple GS/GE segments and errors occurred at any point within one of the syntactical and IG level edit validations, the GS/GE segment will reject, and processing will continue to the next GS/GE segment. For instance, if a file is submitted with three (3) functional groups and there are errors in the second functional, the first functional group will accept, the second functional group will reject, and processing will continue to the third functional group.

The 999 transaction set is designed to report on adherence to IG level edits and CMS standard syntax errors as depicted in the CMS edit spreadsheet. Three (3) possible acknowledgement values are:

- "A" – Accepted
- "R" – Rejected
- "P" – Partially Accepted, At Least One Transaction Set Was Rejected

When viewing the 999 report, MAOs and other entities should navigate to the IK5 and AK9 segments. If an "A" is displayed in the IK5 and AK9 segments, the claim file is accepted and will continue processing. If an "R" is displayed in the IK5 and AK9 segments, an IK3 and an IK4 segment will be displayed. These segments indicate what loops and segments contain the error that needs correcting so the interchange can be resubmitted. The third element in the IK3 segment identifies the loop that contains the error. The first element in the IK3 and IK4 indicates the segment and element that contain the error. The third element in the IK4 segment indicates the reason code for the error.

6.3 277CA – Claim Acknowledgement

After the file is accepted at the interchange and functional group levels, the third level of editing occurs at the transaction set level within the CEM in order to create the Claim Acknowledgement Transaction (277CA) report. The CEM checks the validity of the values within the data elements. For instance, data element N403 must be a valid nine (9)-digit ZIP code. If a non-existent ZIP code is populated, the CEM will reject the encounter. The 277CA is an unsolicited acknowledgement report from CMS to MAOs and other entities.

The 277CA is used to acknowledge the acceptance or rejection of encounters submitted using a hierarchical level (HL) structure. The first level of hierarchical editing is at the Information Source level. This entity is the decision maker in the business transaction receiving the X12 837 transactions (EDSCMS). The next level is at the Information Receiver level. This is the entity expecting the response from the Information Source. The third hierarchal level is at the Billing Provider of Service level; and the fourth and final level is done at the Patient level. Acceptance or rejection at this level is based on the WPC and the CMS edits spreadsheet. Edits received at any hierarchical level will stop and no further editing will take place. For example, if there is a problem with the Billing Provider of Service submitted on the 837, individual patient edits will not be performed. For those encounters not accepted, the 277CA will detail additional actions required of MAOs and other entities in order to correct and resubmit those encounters.

If an MAO or other entity receives a 277CA indicating that an encounter was rejected, the MAO or other entity must resubmit the encounter until the 277CA indicates no errors were found.

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

If an encounter rejects, the 277CA will provide edit information in the STC segment. The STC03 data element will convey whether the HL structures accepted or rejected. The STC03 is populated with a value of "WQ" if the HL was accepted. If the STC03 data element is populated with a value of "U", the HL is rejected and the STC01 data element will list the acknowledgement code.

6.4 MAO-001 – Encounter Data Duplicates Report

When the MAO-002 Encounter Data Processing Status Report is returned to an MAO or other entity, and contains edit 98325 – Service Line(s) Duplicated, the EDPS will also generate and return the MAO-001 Encounter Data Duplicates Report. MAOs and other entities will not receive the MAO-001 report if there are no duplicate errors received on submitted encounters.

The MAO-001 report is a fixed length report available in flat file and formatted report layouts. It provides information for encounters and service lines that receive a status of "reject" and the specific error message of 98325 – Service Line(s) Duplicated. MAOs and other entities must correct and resubmit only those encounters containing service lines that received edit 98325. The MAO-001 report allows MAOs and other entities the opportunity to more easily reconcile these duplicate encounters and service lines.

6.5 MAO-002 – Encounter Data Processing Status Report

After a file accepts through the EDFES, the file is transmitted to the Encounter Data Processing System (EDPS) where further editing, processing, pricing, and storage occurs. As a result of EDPS editing, the EDPS will return the MAO-002 – Encounter Data Processing Status Report.

The MAO-002 report is a fixed length report available in flat file and formatted report layouts that provide encounter and service line level information. The MAO-002 reflects two (2) statuses at the encounter and service line level: "accepted" and "rejected". Lines that reflect a status of "accept" yet contain an error message in the Error Description column are considered "informational" edits. MAOs and other entities are not required to take further action on "informational" edits.

The '000' line on the MAO-002 report identifies the header level and indicates either "accepted" or "rejected" status. If the '000' header line is rejected, the encounter is considered rejected and MAOs and other entities must correct and resubmit the encounter. If the '000' header line is "accepted" and at least one (1) other line (i.e., 001 002 003 004) is accepted, then the overall encounter is accepted.

6.6 Reports File Naming Conventions

In order for MAOs and other entities to receive and identify the EDFES acknowledge reports (TA1, 999 and 277CA) and EDPS MAO-002 Encounter Data Processing Status Report, specific reports file naming conventions have been used. The file name ensures that the specific reports are appropriately distributed to each secure, unique mailbox. The EDFES and EDPS have established unique file naming conventions for reports distributed during testing and production.

6.6.1 Testing Reports File Naming Convention

Table 5 below provides the EDFES reports file naming conventions according to connectivity method. MAOs and other entities should note that Connect:Direct (NDM) users' reports file naming conventions are user defined.

TABLE 5 – TESTING EDFES REPORTS FILE NAMING CONVENTIONS

REPORT TYPE	GENTRAN/TIBCO MAILBOX	FTP MAILBOX
EDFES Notifications	T.xxxxx.EDS_RESPONSE.pn	RSPxxxxx.RSP.REJECTED_ID
TA1	T.xxxxx.EDS_REJT_IC_ISAIEA.pn	X12xxxxx.X12.TMMDDCCYYHHMMS
999	T.xxxxx.EDS_REJT_FUNCT_TRANS.pn	999#####.999.999
999	T.xxxxx.EDS_ACCPT_FUNCT_TRANS.pn	999#####.999.999
277CA	T.xxxxx.EDS_RESP_CLAIM_NUM.pn	RSPxxxxx.RSP_277CA

Table 6 below provides the EDPS reports file naming convention by connectivity method. MAOs and other entities should note that Connect:Direct (NDM) users' reports file naming conventions are user defined.

TABLE 6 – TESTING EDPS REPORTS FILE NAMING CONVENTIONS

CONNECTIVITY METHOD	TESTING NAMING CONVENTION FORMATTED REPORT	TESTING NAMING CONVENTION FLAT FILE LAYOUT
GENTRAN/ TIBCO	T .xxxxx.EDPS_001_DataDuplicate_Rpt T.xxxxx.EDPS_002_DataProcessingStatus_Rpt T .xxxxx.EDPS_004_RiskFilter_Rpt T.xxxxx.EDPS_005_DispositionSummary_Rpt T .xxxxx.EDPS_006_EditDisposition_Rpt T .xxxxx.EDPS_007_DispositionDetail_Rpt	T .xxxxx.EDPS_001_DataDuplicate_File T.xxxxx.EDPS_002_DataProcessingStatus_File T .xxxxx.EDPS_004_RiskFilter_File T.xxxxx.EDPS_005_DispositionSummary_ File T .xxxxx.EDPS_006_EditDisposition_ File T .xxxxx.EDPS_007_DispositionDetail_ File
FTP	RPTxxxxx.RPT.EDPS_001_DATDUP_RPT RPTxxxxx.RPT.EDPS_002_DATPRS_RPT RPTxxxxx.RPT.EDPS_004_RSKFLT_RPT RPTxxxxx.RPT.EDPS_005_DSPSUM_RPT RPTxxxxx.RPT.EDPS_006_EDTDSP_RPT RPTxxxxx.RPT.EDPS_007_DSTDTL_RPT	RPTxxxxx.RPT.EDPS_001_DATDUP_File RPTxxxxx.RPT.EDPS_002_DATPRS_File RPTxxxxx.RPT.EDPS_004_RSKFLT_ File RPTxxxxx.RPT.EDPS_005_DSPSUM_ File RPTxxxxx.RPT.EDPS_006_EDTDSP_ File RPTxxxxx.RPT.EDPS_007_DSTDTL_ File

Table 7 below provides a description of the file name components, which will assist MAOs and other entities in identifying the report type.

TABLE 7 –FILE NAME COMPONENT DESCRIPTION

FILE NAME COMPONENT	DESCRIPTION
RSPxxxxx	The type of data 'RSP' and a sequential number assigned by the server 'xxxxx'
X12xxxxx	The type of data 'X12' and a sequential number assigned by the server 'xxxxx'
TMMDDCCYYHHMMS	The Date and Time stamp the file was processed
999xxxxx	The type of data '999' and a sequential number assigned by the server 'xxxxx'
RPTxxxxx	The type of data 'RPT' and a sequential number assigned by the server 'xxxxx'
EDPS_XXX	Identifies the specific EDPS Report along with the report number (i.e., '002', etc.)
XXXXXXX	Seven (7) characters available to be used as a short description of the contents of the file
RPT/FILE	Identifies if the file is a formatted report 'RPT' or a flat file 'FILE' layout

6.6.2 Production Reports File Naming Convention

A different production reports file naming convention is used so that MAOs and other entities may easily identify reports generated and distributed during production. Table 8 below provides the reports file naming conventions per connectivity method for production reports.

TABLE 8 – PRODUCTION EDFES REPORTS FILE NAMING CONVENTIONS

REPORT TYPE	GENTRAN/TIBCO MAILBOX	FTP MAILBOX
EDFES Notifications	P.xxxxx.EDS_RESPONSE.pn	RSPxxxxx.RSP.REJECTED_ID
TA1	P.xxxxx.EDS_REJT_IC_ISAIEA.pn	X12xxxxx.X12.TMMDDCCYYHHMMS
999	P.xxxxx.EDS_REJT_FUNCT_TRANS.pn	999#####.999.999
999	P.xxxxx.EDS_ACCPT_FUNCT_TRANS.pn	999#####.999.999
277CA	P.xxxxx.EDS_RESP_CLAIM_NUM.pn	RSPxxxxx.RSP_277CA

Table 9 below provides the production EDPS reports file naming conventions per connectivity method.

TABLE 9 – PRODUCTION EDPS REPORTS FILE NAMING CONVENTIONS

CONNECTIVITY METHOD	PRODUCTION NAMING CONVENTION FORMATTED REPORT	PRODUCTION NAMING CONVENTION FLAT FILE LAYOUT
GENTRAN/ TIBCO	P.xxxxx.EDPS_001_DataDuplicate_Rpt P.xxxxx.EDPS_002_DataProcessingStatus_Rpt P.xxxxx.EDPS_004_RiskFilter_Rpt P.xxxxx.EDPS_005_DispositionSummary_Rpt P.xxxxx.EDPS_006_EditDisposition_Rpt P.xxxxx.EDPS_007_DispositionDetail_Rpt	P.xxxxx.EDPS_001_DataDuplicate_File P.xxxxx.EDPS_002_DataProcessingStatus_File P.xxxxx.EDPS_004_RiskFilter_File P.xxxxx.EDPS_005_DispositionSummary_ File P.xxxxx.EDPS_006_EditDisposition_ File P.xxxxx.EDPS_007_DispositionDetail_ File
FTP	RPTxxxxx.RPT.PROD_001_DATDUP_RPT RPTxxxxx.RPT.PROD_002_DATPRS_RPT RPTxxxxx.RPT.PROD_004_RSKFLT_RPT RPTxxxxx.RPT.PROD_005_DSPSUM_RPT RPTxxxxx.RPT.PROD_006_EDTDSP_RPT RPTxxxxx.RPT.PROD_007_DSTDTL_RPT	RPTxxxxx.RPT.PROD_001_DATDUP_File RPTxxxxx.RPT.PROD_002_DATPRS_File RPTxxxxx.RPT.PROD_004_RSKFLT_ File RPTxxxxx.RPT.PROD_005_DSPSUM_ File RPTxxxxx.RPT.PROD_006_EDTDSP_ File RPTxxxxx.RPT.PROD_007_DSTDTL_ File

6.7 EDFES Notifications

The EDFES distributes special notifications to submitters when encounters have been processed by the EDFES, but will not proceed to the EDPS for further processing. These notifications are distributed to MAOs and other entities, in addition to standard EDFES Acknowledgement Reports (TA1, 999, and 277CA) in order to avoid returned, unprocessed files from the EDS.

Table 10 below provides the file type, EDFES notification message, and EDFES notification message description.

The file has an 80 character record length and contains the following record layout:

1. File Name Record
    a. Positions 1 – 7 = Blank Spaces
    b. Positions 8 – 18 = File Name:
    c. Positions 19 – 62 = Name of the Saved File
    d. Positions 63 – 80 = Blank Spaces
2. File Control Record
    a. Positions 1 – 4 = Blank Spaces
    b. Positions 5 – 18 = File Control:

c. Positions 19 – 27 = File Control Number
d. Positions 28 – 80 = Blank Spaces

3. File Count Record
    a. Positions 1 – 18 = Number of Claims:
    b. Positions 19 – 24 = File Claim Count
    c. Positions 25 – 80 = Blank Spaces
4. File Separator Record
    a. Positions 1 – 80 = Separator (----------)
5. File Message Record
    a. Positions 1 – 80 = FILE WAS NOT SENT TO THE EDPS BACK-END PROCESS FOR THE FOLLOWING REASON(S)
6. File Message Records
    a. Positions 1 – 80 = File Message

The report format example is as follows:
FILE NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
FILE CONTROL: XXXXXXXXX
NUMBER OF CLAIMS: 99,999
FILE WAS NOT SENT TO THE EDPS BACK-END PROCESS FOR THE FOLLOWING REASON(S)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Table 10 provides the complete list of testing and production EDFES notification messages.

TABLE 10 – EDFES NOTIFICATIONS

APPLIES TO	ENCOUNTER TYPE	NOTIFICATION MESSAGE	NOTIFICATION MESSAGE DESCRIPTION
All files submitted	All	FILE ID (XXXXXXXXX) IS A DUPLICATE OF A FILE ID SENT WITHIN THE LAST 12 MONTHS	The file ID must be unique for a 12 month period
All files submitted	All	SUBMITTER NOT AUTHORIZED TO SEND CLAIMS FOR PLAN (CONTRACT ID)	The submitter is not authorized to send for this plan
All files submitted	All	PLAN ID CANNOT BE THE SAME AS THE SUBMITTER ID	The Contract ID cannot be the same as the Submitter ID
All files submitted	All	AT LEAST ONE ENCOUNTER IS MISSING A CONTRACT ID IN THE 2010BB-REF02 SEGMENT	The Contract ID is missing
All files submitted	All	SUBMITTER NOT FRONT-END CERTIFIED	The submitter must be front-end certified to send encounters for validation or production
Production files submitted	All	SUBMITTER NOT CERTIFIED FOR PRODUCTION	The submitter must be certified to send encounters for production
Tier 2 files submitted	All	THE INTERCHANGE USAGE INDICATOR MUST EQUAL 'T'	The Institutional Tier 2 file is being sent with a 'P' in the ISA15 field

TABLE 10 – EDFES NOTIFICATIONS (CONTINUED)

APPLIES TO	ENCOUNTER TYPE	NOTIFICATION MESSAGE	NOTIFICATION MESSAGE DESCRIPTION
Tier 2 file submitted	All	PLAN (CONTRACT ID) HAS (X,XXX) CLAIMS IN THIS FILE. ONLY 2,000 ARE ALLOWED	The number of encounters for a Contract ID cannot be greater than 2,000
Institutional End-to-End Testing – File 1 Institutional End-to-End Testing – Additional File(s)	Institutional	FILE CANNOT CONTAIN MORE THAN 24 ENCOUNTERS	The number of encounters cannot be greater than 24
PACE End-to-End Testing – File 1 PACE End-to-End Testing – Additional File(s)	PACE Institutional	FILE CANNOT CONTAIN MORE THAN 14 ENCOUNTERS	The number of encounters cannot be greater than 14
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	All	PATIENT CONTROL NUMBER IS MORE THAN 20 CHARACTERS LONG THE TC# WAS TRUNCATED	The Claim Control Number, including the Test Case Number, must not exceed 20 characters
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	Institutional, PACE Institutional	FILE CANNOT CONTAIN BOTH UNLINKED AND LINKED TEST CASES	The test cases from File 1 and File 2 cannot be in the same file
End-to-End Testing – File 1 End-to-End Testing – Additional File(s)	Institutional, PACE Institutional	CANNOT SEND LINKED TEST CASES UNTIL ALL UNLINKED TEST CASES HAVE BEEN ACCEPTED	The test cases for File 2 cannot be sent before all File 1 test cases are accepted
End-to-End Testing – File 1	All	FILE CONTAINS (X) TEST CASE (X) ENCOUNTER(S)	The file must contain two (2) of each test case
Test	All	NO TEST CASES FOUND IN THIS FILE	This file was processed with the Interchange Usage Indicator = 'T' and the Submitter was not yet Front-End Certified
End-to-End Testing – Additional File(s)	All	ADDITIONAL FILES CANNOT BE VALIDATED UNTIL AN MAO-002 REPORT HAS BEEN RECEIVED	The MAO-002 report must be received before additional files can be submitted
All files submitted	All	FILE CANNOT EXCEED 5,000 ENCOUNTERS	The maximum number of encounters allowed in a file
All files submitted	All	TRANSACTION SET (ST/SE) (XXXXXXXXX) CANNOT EXCEED 5,000 CLAIMS	There can only be 5,000 claims in each ST/SE Loop
All files submitted	All	DATE OF SERVICE CANNOT BE BEFORE 2011	Files cannot be submitted with a date of service before 2011

7.0 Front-End Edits

CMS provides a list of the edits used to process all encounters submitted to the EDFES. The Fee-for-Service (FFS) Institutional CEM Edits Spreadsheet identifies currently active and deactivated edits for MAOs and other entities to reference for programming their internal systems and reconciling EDFES Acknowledgement Reports.

The Institutional CEM Edits Spreadsheet provides documentation regarding edit rules that explain how to identify an EDFES edit and the associated logic. The Institutional CEM Edits Spreadsheet also provides a change log that lists the revision history for edit updates.

MAOs and other entities are able to access the Institutional CEM Edits Spreadsheet on the CMS website at https://www.cms.gov/Medicare/Billing/MFFS5010D0/Technical-Documentation.html and on the CSSC Operations website at: http://www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Encounter%20Data~Resources?open&expand=1&navmenu=Encounter^Data||,

7.1 Deactivated Front-End Edits

Several CEM edits currently active in the FFS Institutional CEM edits spreadsheet will be deactivated in order to ensure that syntactically correct encounters pass front-edit editing. Table 11 provides a list of the deactivated EDFES CEM edits. The edit reference column provides the exact reference for the deactivated edits. The edit description column provides the Claim Status Category Code (CSCC), the Claim Status Code (CSC), and the Entity Identifier Code (EIC), when applicable. The notes column provides a description of the edit reason. MAOs and other entities should reference the WPC website at www.wpc-edi.com for a complete listing of all CSCCs and CSCs.

TABLE 11 - 837 INSTITUTIONAL DEACTIVATED EDFES EDITS

EDIT REFERENCE	EDIT DESCRIPTION	EDIT NOTES
X223.084.2010AA.NM109.040	CSCC A8: "Acknowledgement / Rejected for relational field in error." CSC 562: "Entity's National Provider Identifier (NPI)" EIC: 85 Billing Provider	Valid NPI Crosswalk must be available for this edit. 2010AA.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109.
X223.084.2010AA.NM109.050	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 496 "Submitter not approved for electronic claim submissions on behalf of this entity." EIC: 85 Billing Provider	This Fee for Service edit validates the NPI and submitter ID number to ensure the submitter is authorized to submit on the provider's behalf. Encounter data cannot use this validation as we validate the plan number and submitter ID to ensure the submitter is authorized to submit on the plans behalf. 2010AA.NM109 billing provider must be "associated" to the submitter (from a trading partner management perspective) in 1000A.NM109.
X223.087.2010AA.N301.070	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 503: "Entity's Street Address" EIC: 85 Billing Provider	Remove edit check for 2010AA N3 PO Box variations when ISA08 = 80881 (Institutional Payer Code).
X223.090.2010AA.REF02.050	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 562: "Entity's National Provider Identifier (NPI)" CSC 128: "Entity's tax id" EIC: 85 Billing Provider	Valid NPI Crosswalk must be available for this edit. 2010AA.REF must be associated with the provider identified in 2010AA.NM109.

TABLE 11 - 837 INSTITUTIONAL DEACTIVATED EDFES EDITS (CONTINUED)

EDIT REFERENCE	EDIT DESCRIPTION	EDIT NOTES
X223.127.2010BB.REF.010	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 732: "Information submitted inconsistent with billing guidelines." CSC 560: "Entity's Additional/Secondary Identifier." EIC: PR "Payer"	This REF Segment is used to capture the Plan number as this is unique to Encounter Submission only. The CEM has the following logic that is applied: Non-VA claims: 2010BB.REF with REF01 = "2U", "EI", "FY" or "NF" must not be present. VA claims: 2010BB.REF with REF01 = "EI", "FY" or "NF" must not be present. This edit needs to remain off in order for the submitter to send in his plan number.
X223.143.2300.CLM02.020	IK403 = 6: "Invalid Character in Data Element"	2300.CLM02 must be numeric.
X223.424.2400.SV202-7.025	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 306 Detailed description of service 2400.SV202-7 must be present when 2400.SV202-2 contains a non-specific procedure code.	When using a not otherwise classified or generic HCPCS procedure code the CEM is editing for a more descriptive meaning of the procedure code. For example, the submitter is using J3490. The description for this HCPCS is Not Otherwise Classified (NOC) Code. CMS has made a decision not to price claims with these types of codes.
X223.109.2000B.SBR03.040 X223.109.2000B.SBR03.050	CSCC A8: Acknowledgement/ Rejected for relational field in error CSC 163: Entity's Policy Number CSC 732: Information submitted inconsistent with billing guidelines EIC IL: Subscriber	
X223.109.2000B.SBR04.004 X223.109.2000B.SBR04.007	CSCC A8: Acknowledgement/Rejected for relational field in error CSC 663: Entity's Group Name CSC 732: Information submitted inconsistent with billing guidelines EIC IL: Subscriber	
X223.153.2300.CL103.015	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 234: "Patient discharge status"	When 2300.CL103 value "20", "40", "41", or "42" is present, at least one occurrence of 2300.HI01-2 thru HI12-2 must = "55" where HI01-1 is "BH".
X223.364.2320.AMT.040	CSCC A7: Acknowledgement/Rejected for Invalid Information CSC 41: Special handling required at payer site CSC 286: Other Payer's Explanation of Benefits/payment information CSC 732: Information submitted inconsistent with billing guidelines	

TABLE 11 - 837 INSTITUTIONAL DEACTIVATED EDFES EDITS (CONTINUED)

EDIT REFERENCE	EDIT DESCRIPTION	EDIT NOTES
X223.424.2400.SV203.060	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 400: "Claim is out of balance: CSC 583:"Line Item Charge Amount" CSC 643: "Service Line Paid Amount"	SV203 must = the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts.
X223.476.2430.SVD02.020	IK403 = 6: Invalid Character in Data Element	

7.2 Temporarily Deactivated Front-End Edits

Table 12 provides a list of the temporarily deactivated EDFES Institutional CEM balancing edits in order to ensure that encounters that require balancing of monetary fields will pass front-end editing.

Note: The Institutional edits listed in Table 12 are not all-inclusive and are subject to amendment.

TABLE 12 – 837 INSTITUTIONAL TEMPORARILY DEACTIVATED CEM EDITS

EDIT REFERENCE	EDIT DESCRIPTION	EDIT NOTES
X223.143.2300.CLM02.080	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 400: "Claim is out of Balance" CSC 672 "Payer's payment information is out of balance	CLM02 must equal the sum of all 2320 CAS amounts & all 2430 CAS amounts and 2320 AMT02 (when AMT01=D).
X223.143.2300.CLM02.070	CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 400: "Claim is out of balance" CSC 178: "Submitted Charges"	2300.CLM02 must = the sum of all 2400.SV203 amounts.
X223.424.2400.SV202-7.025	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 306 Detailed description of service 2400.SV202-7 must be present when 2400.SV202-2 contains a non-specific procedure code.	When using a not otherwise classified or generic HCPCS procedure code the CEM is editing for a more descriptive meaning of the procedure code. For example, the submitter is using J3490. The description for this HCPCS is Not Otherwise Classified (NOC) Code. CMS has made a decision not to price claims with these types of codes.

8.0 Duplicate Logic

In order to ensure encounters submitted are not duplicates of encounters previously submitted, the EDS will perform header and detail level duplicate checking. If the header and/or detail level duplicate checking determines that the file is a duplicate, the file will reject, and an error report will be returned to the submitter.

8.1 Header Level

When a file (ISA/IEA) is received, the system assigns a hash total to the file based on the entire ISA/IEA interchange. The EDS uses hash totals to ensure the accuracy of processed data. The hash total is a total of several fields or data in a file, including fields not normally used in calculations, such as the

account number. At various stages in processing, the hash total is recalculated and compared with the original. If a file comes in later in a different submission, or a different submission of the same file, and gets the same hash total, it will reject as a duplicate.

In addition to the hash total, the system also references the values collectively populated in ISA13, GS06, ST02, and BHT03. If two (2) files are submitted with the exact same values populated as a previously submitted and accepted file, the file will be considered a duplicate and the error message CSCC - A8 = Acknowledgement / Rejected for relational field in error, CSC -746 = Duplicate Submission will be provided on the 277CA.

8.2 Detail Level

Once an encounter passes through the Institutional or Professional processing and pricing system, it is stored in an internal repository, the Encounter Operational Data Store (EODS). If a new encounter is submitted that matches specific values on another stored encounter, the encounter will reject as a duplicate encounter. The encounter will be returned to the submitter with an error message identifying it as a duplicate encounter. Currently, the following values are the minimum set of items used for matching an encounter in the EODS:

- Beneficiary Demographic
    - Health Insurance Claim Number (HICN)
    - Name
- Date of Service
- Type of Bill (TOB)
- Revenue Code(s)
- Procedure Code(s) and 4 modifiers
- Billing Provider NPI
- Paid Amount*

* Paid Amount is the amount paid by the MAO or other entity and should be populated in Loop ID-2320, AMT02.

9.0 837 Institutional Business Cases

In accordance with 45 CFR 160.103 of the HIPAA, Protected Health Information (PHI) has been removed from all business cases. As a result, the business cases have been populated with fictitious information about the Subscriber, MAO, and provider(s). The business cases reflect 2012 dates of service.

Although the business cases are provided as examples of possible encounter submissions, MAOs and other entities must populate valid data in order to successfully pass translator and CEM level editing. MAOs and other entities should direct questions regarding the contents of the EDS Test Case Specification to encounterdata@cms.hhs.gov.

Note: The business cases identified in the CMS EDS 837-I Companion Guide indicate paid amounts and DTP segments at the line level.

The Adjudication or Payment Date (DTP 573 segment) must follow the paid amount. For example, if the paid amount is populated at the claim level, the DTP 573 segment must be populated at the claim level. If the paid amount is populated at the line level, the DTP 573 segment must be populated at the line level.

9.1 Standard Institutional Encounter

Business Scenario 1: Mary Dough is the patient and the subscriber, and was admitted into Mercy Hospital because she was complaining of heart pain. Happy Health Plan was the MAO. Mercy Hospital diagnosed Mary with Congestive Health Failure as the primary diagnosis and diabetes as an additional diagnosis.

File String 1:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000031*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*31*X*005010X223A2~
ST*837*0034*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY HOSPITAL***XX*1299999999~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*344232321~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578798A*200.00*11:A:1**A*Y*Y~**
DTP*096*TM*0958~
DTP*434*RD8*20120330-20120331~
DTP*435*D8*20120330~
CL1*2*9*01~
HI*BK:4280~
HI*BJ:4280~
HI*BF:25000~
HI*BR:3121:D8:20120330~
HI*BH:41:D8:20110501*BH:27:D8:20110715*BH:33:D8:20110718*BH:C2:D8:20110729~
HI*BE:30:::20~
HI*BG:01~
NM1*71*1*JONES*AMANDA*AL*XX*1005554104~**
SBR*P*18*XYZ1234567****16~**

AMT*D*200.00~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**
N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
REF*T4*Y~
LX*1~
SV2*0300*HC:81099*200.00*UN*1~
DTP*472*D8*20120330~
SVD*H9999*200.00*HC:81099*0300*1~
DTP*573*D8*20120401~
SE*50*0034~
GE*1*31~
IEA*1*000000031~

9.2 Capitated Institutional Encounter

Business Scenario 2: Mary Dough is the patient and the subscriber, and went to Mercy Hospital because she was experiencing leg pain. Happy Health Plan was the MAO and has a capitated arrangement with Mercy Hospital. Mercy Hospital diagnosed Mary with diabetes and leg pain.

File String 2:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000331*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*30*X*005010X223A2~
ST*837*0021*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY HOSPITAL***XX*1299999999~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*344232321~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578798A *0.00*11:A:1**A*Y*Y~**
DTP*096*TM*0958~
DTP*434*RD8*20120330-20120331~
DTP*435*D8*20120330~
CL1*2*9*01~
CN1*05~
HI*BK:4280~
HI*BJ:4280~
HI*BF:25000~
HI*BR:3121:D8:20120330~
HI*BH:41:D8:20110501*BH:27:D8:20110715*BH:33:D8:20110718*BH:C2:D8:20110729~
HI*BE:30:::20~
HI*BG:01~
NM1*71*1*JONES*AMANDA*AL*XX*1005554104~**
SBR*P*18*XYZ1234567****ZZ~**

AMT*D*100.50~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**
N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
LX*1~
SV2*0300*HC:81099*0.00*UN*1~
DTP*472*D8*20120330~
SVD*H9999*100.50*HC:81099*0300*1~
CAS*CO*24*-100.50~
DTP*573*D8*20120401~
SE*50*0021~
GE*1*30~
IEA*1*000000331~

9.3 Chart Review Institutional Encounter – No Linked ICN

Business Scenario 3: Mary Dough is the patient and the subscriber, and went to Mercy Hospital because she was experiencing leg pain. Happy Health Plan was the MAO. Happy Health Plan performs a chart review at Mercy Hospital and determines that a diagnosis for Mary Dough was never submitted on a claim. The medical record does not contain enough information to submit a full claim, yet there is enough information to support the diagnosis and link the chart review encounter back to the medical record. Happy Health Plan submits a chart review encounter with no linked ICN to add the diagnosis.

File String 3:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000031*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*31*X*005010X223A2~
ST*837*0034*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY HOSPITAL***XX*1299999899~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*344232321~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578798A*0.00*11:A:1**A*Y*Y~**
DTP*096*TM*0958~
DTP*434*RD8*20120330-20120331~
DTP*435*D8*20120330~
CL1*2*9*01~
PWK*09*AA~
HI*BK:4280~
HI*BJ:4280~
HI*BF:25000~
HI*BR:3121:D8:20120330~
HI*BH:41:D8:20110501*BH:27:D8:20110715*BH:33:D8:20110718*BH:C2:D8:20110729~

HI*BE:30:::20~
HI*BG:01~
NM1*71*1*JONES*AMANDA*AL*XX*1005554104~**
SBR*P*18*XYZ1234567****16~**
AMT*D*0.00~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**
N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
REF*T4*Y~
LX*1~
SV2*0300*HC:81099*0.00*UN*1~
SVD*H9999*65.00*HC:810991~**
DTP*472*D8*20120330~
SE*49*0034~
GE*1*31~
IEA*1*000000031~

9.4 Chart Review Institutional Encounter – Linked ICN

Business Scenario 4: Mary Dough is the patient and the subscriber, and went to Mercy Hospital because she was experiencing leg pain. Happy Health Plan was the MAO. Mercy Hospital submits the encounter to CMS and receives an ICN of 1294598098746. Happy Health Plan performs a chart review related to ICN 1294598098746 and determines that there is an incorrect NPI was populated for the Billing Provider.

File String 4:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000031*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*31*X*005010X223A2~
ST*837*0034*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY HOSPITAL***XX*1299999899~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*344232321~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578798A*0.00*11:A:1**A*Y*Y~**
DTP*096*TM*0958~
DTP*434*RD8*20120330-20120331~
DTP*435*D8*20120330~
CL1*2*9*01~
PWK*09*AA~
REF*F8*1294598098746~
HI*BK:4280~
HI*BJ:4280~
HI*BF:25000~
HI*BR:3121:D8:20120330~
HI*BH:41:D8:20110501*BH:27:D8:20110715*BH:33:D8:20110718*BH:C2:D8:20110729~
HI*BE:30:::20~

HI*BG:01~
NM1*71*1*JONES*AMANDA*AL*XX*1005554106~**
SBR*P*18*XYZ1234567****16~**
AMT*D*0.00~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**
N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
REF*T4*Y~
LX*1~
SV2*0300*HC:81099*0.00*UN*1~
SVD*H9999*87.50*HC:810991~**
DTP*472*D8*20120330~
SE*50*0034~
GE*1*31~
IEA*1*000000031~

9.5 Complete Replacement Institutional Encounter

Business Scenario 5: Mary Dough is the patient and the subscriber, and went to Mercy Hospital because she was experiencing heart pain. Happy Health Plan is the MAO. Mercy Hospital diagnosed Mary with Congestive Heart Failure and diabetes. Happy Health Plan submits the encounter to CMS and receives an ICN 1122978564098. After further investigation, it was determined that Happy Health Plan should not have paid for $120.00. Happy Health Plan submits a correct and replace adjustment encounter to replace encounter 1122978564098 with the newly submitted encounter.

File String 5:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000554*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*80*X*005010X223A2~
ST*837*0567*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY HOSPITAL***XX*1299999999~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*344232321~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578798A*200.00*11:A:7**A*Y*Y~**
DTP*096*TM*0958
DTP*434*RD8*20120330-20120331~
DTP*435*D8*20120330-20120331~
CL1*2*9*01~
REF*F8*1222978564098~
HI*BK:4280~
HI*BJ:4280~
HI*BR:3121:D8:20120330~
HI*BH:41:D8:20110501*BH:27:D8:20110715*BH:33:D8:20110718*BH:C2:D8:20110729~
HI*BE:30:::20~

HI*BG:01~
NM1*71*1*JOHNSON*AMANDA*AL*XX*1005554104~**
SBR*P*18*XYZ1234567****16~**
CAS*CO*39*120.00~
AMT*D*80.00~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**
N3*705 E HUGH ST~
N4*NORFOLK*VA*235048769~
LX*1~
SV2*0300*HC:81099*200.00*UN*1~
DTP*472*D8*20120330~
SVD*H9999*0.00*HC:992121~**
DTP*573*20120401~
SE*50*0567~
GE*1*80~
IEA*1*000000554~

9.6 Complete Deletion Institutional Encounter

Business Scenario 6: Mary Dough is the patient and the subscriber, and went to Dr. Elizabeth A. Smart because she was experiencing abdominal pain. Happy Health Plan is the MAO. Dr. Smart diagnosed Mary with abdominal pain. Happy Health Plan submits the encounter to CMS and receives ICN 1212487000032. Happy Health Plan then determines that they mistakenly sent the encounter without it being adjudicated in their internal system, so they want to delete the encounter. Happy Health Plan submits an adjustment encounter to delete the previously submitted encounter 1212487000032.

File String 6:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120430*114
4*^*00501*000000298*1*P*:~
GS*HC*ENH9999*80881*20120430*1144*82*X*005010X222A1~
ST*837*0290*005010X222A1~
BHT*0019*00*3920394930206*20120428*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*1*SMART*ELIZABETH*AMD*XX*1299999999~**
N3*123 CENTRAL DRIVE~
N4*NORFOLK*VA*235139999~
REF*EI*765879876~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ123456747****MB~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850~
REF*2U*H9999~
CLM*2997677856479709654A*100.50*11:B:8*Y*A*Y*Y~**
REF*F8*1212487000032~
HI*BK:78901~
SBR*P*18*XYZ1234567****16~**
CAS*CO*223*100.50~
AMT*D*0.00~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**

N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
REF*T4*Y~
LX*1~
SV2*HC:99212*100.50*UN*1*1~**
DTP*472*D8*20120401~
SVD*H9999*0.00*HC:992121~**
DTP*573*D8*20120403~
SE*41*0290~
GE*1*82~
IEA*1*000000298~

9.7 Atypical Provider Institutional Encounter

Business Scenario 7: Mary Dough is the patient and the subscriber, and receives services from an atypical provider. Happy Health Plan was the MAO.

File String 7:

```
ISA*00*          *00*          *ZZ*ENH9999       *ZZ*80881         *120816*114
4*^*00501*000000032*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*35*X*005010X223A2~
ST*837*0039*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN*****46*ENH9999~
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS*****46*80881~
HL*1**20*1~
NM1*85*2*MERCY SERVICES*****XX*1999999976~
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*199999997~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567******MA~
NM1*IL*1*DOUGH*MARY****MI*672148306~
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS*****PI*80881~
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578799A*50.00***83:A:1**A*Y*Y~
DTP*434*RD8*20120330-20120331~
CL1*9*9*01~
HI*BK:78099~
NTE*ADD* NO NPI ON PROVIDER CLAIM NO EIN ON PROVIDER CLAIM~
SBR*P*18*XYZ1234567******16~
AMT*D*50.00~
OI***Y***Y~
NM1*IL*1*DOUGH*MARY****MI*672148306~
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN*****XV*H9999~
N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
REF*T4*Y~
LX*1~
```

SV2*0300*HC:D0999*50.00*UN*1~
DTP*472*D8*20120330~
SVD*H9999*50.00*HC:D0999*0300*1~
DTP*573*D8*20120401~
SE*41*0039~
GE*1*35~
IEA*1*000000032~

9.8 Paper Generated Institutional Encounter

Business Scenario 8: Mary Dough is the patient and the subscriber, and receives services from Mercy Health Plan. Mercy Health Plan submits the claim to Happy Health Plan on a UB-04. Happy Health Plan is the MAO and converts the paper claim into an electronic submission.

File String 8:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000032*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*35*X*005010X223A2~
ST*837*0039*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY SERVICES***XX*1234999999~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*128752354~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850~
REF*2U*H9999~
CLM*22350578967509876984536578799A*50.00*83:A:1**A*Y*Y~**
DTP*434*RD8*20120330-20120331~
CL1*9*9*01~
PWK*OZ*AA~
HI*BK:78099~
SBR*P*18*XYZ1234567****16~**
AMT*D*50.00~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**
N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
REF*T4*Y~

LX*1~
SV2*0300*HC:D0999*50.00*UN*1~
DTP*472*D8*20120330~
SVD*H9999*50.00*HC:D0999*0300*1~
DTP*573*D8*20120403~
SE*42*0039~
GE*1*35~
IEA*1*000000032~

9.9 True Coordination of Benefits Institutional Encounter

Business Scenario 9: Mary Dough is the patient and the subscriber and was admitted into Mercy Hospital because she was complaining of heart pain. Happy Health Plan was the MAO. Other Health Plan also provided payment for Mary Dough. Mercy Hospital diagnosed Mary with Congestive Health Failure as the primary diagnosis and diabetes.

File String 9:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000031*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*31*X*005010X223A2~
ST*837*0034*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY HOSPITAL***XX*1299999999~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*344232321~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578799A*712.00*11:A:1**A*Y*Y~**
DTP*096*TM*0958~
DTP*434*RD8*20120330-20120331~
DTP*435*D8*20120330~
CL1*2*9*01~
HI*BK:78901~
NM1*71*1*JONES*AMANDA*AL*XX*1005554104~**
SBR*P*18*XYZ1234567****16~**
AMT*D*700.00
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**

N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
SBR*T*18*XYZ3489388****16~**
CAS*CO*223*700.00~
AMT*D*12.00~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*OTHER HEALTH PLAN***XV*PAYER01~**
N3*400 W 21 ST~
N4*NORFOLK*VA*235059999~
DTP*573*D8*20120401~
REF*T4*Y
LX*1~
SV2*0300*HC:81099*712.00*UN*1~
DTP*472*D8*20120330~
SVD*H9999*700.00*HC:D0999*0300*1~
CAS*CO*45*12.00~
DTP*573*D8*20120401~
SE*56*0034~
GE*1*31~
IEA*1*000000031~

9.10 Bundled Institutional Encounter

Business Scenario 10: Mary Dough is the patient and the subscriber and was admitted into Mercy Hospital because she was complaining of heart pain. Happy Health Plan was the MAO. Mercy Hospital diagnosed Mary with Congestive Health Failure as the primary diagnosis and diabetes.

File String 10:

ISA*00* *00* *ZZ*ENH9999 *ZZ*80881 *120816*114
4*^*00501*000000031*1*P*:~
GS*HC*ENH9999*80881*20120816*1144*31*X*005010X223A2~
ST*837*0034*005010X223A2~
BHT*0019*00*3920394930203*20120814*1615*CH~
NM1*41*2*HAPPY HEALTH PLAN***46*ENH9999~**
PER*IC*JANE DOE*TE*5555552222~
NM1*40*2*EDSCMS***46*80881~**
HL*120*1~**
NM1*85*2*MERCY HOSPITAL***XX*1299999999~**
N3*876 MERCY DRIVE~
N4*NORFOLK*VA*235089999~
REF*EI*344232321~
PER*IC*BETTY SMITH*TE*9195551111~
HL*2*1*22*0~
SBR*S*18*XYZ1234567****MA~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
DMG*D8*19390807*F~
NM1*PR*2*EDSCMS***PI*80881~**
N3*7500 SECURITY BLVD~
N4*BALTIMORE*MD*212441850
REF*2U*H9999~
CLM*22350578967509876984536578798A*100.00*11:A:1**A*Y*Y~**
DTP*096*TM*0958~
DTP*434*RD8*20120330-20120331~
DTP*435*D8*20120330~
CL1*2*9*01~
HI*BK:4280~
HI*BJ:4280~
HI*BF:25000~
HI*BR:3121:D8:20120330~
HI*BH:41:D8:20110501*BH:27:D8:20110715*BH:33:D8:20110718*BH:C2:D8:20110729~
HI*BE:30:::20~
HI*BG:01~
NM1*71*1*JONES*AMANDA*AL*XX*1005554104~**
SBR*P*18*XYZ1234567****16~**

AMT*D*9.48~
OI*Y***Y~**
NM1*IL*1*DOUGH*MARY**MI*672148306~**
N3*1234 STATE DRIVE~
N4*NORFOLK*VA*235099999~
NM1*PR*2*HAPPY HEALTH PLAN***XV*H9999~**
N3*705 E HUGH ST~
N4*NORFOLK*VA*235049999~
REF*T4*Y~
LX*1~
SV2*HC:82374*50.00*UN*1*1~**
DTP*472*D8*20120401~
SVD*H9999*9.48*HC:800511~**
CAS*CO*45*40.52~
DTP*573*D8*20120403~
LX*2~
SV2*HC:82435*50.00*UN*1*11~
DTP*472*D8*20120401~
SVD*H9999*0.00*HC:800511*1~**
CAS*OA*97*50.00~
DTP*573*D8*20120403~
SE*57*0034~
GE*1*31~
IEA*1*000000031~

10.0 Encounter Data Institutional Processing and Pricing System Edits

After an Institutional encounter passes translator and CEM level editing and receives an ICN on the 277CA acknowledgement report, the EDFES then transfers the encounter to the Encounter Data Institutional Processing and Pricing System (EDIPPS), where editing, processing, pricing, and storage occurs. In order to assist MAOs and other entities with submission of encounter data through the EDIPPS, CMS has provided the current list of the EDIPPS edits identified in Table 13.

Note: The edit descriptions listed in Table 13 were revised to identify a maximum of 41 characters in order to display a more comprehensive explanation of edits on the MAO-002 Reports.

The EDIPPS edits are organized in nine (9) different categories, as provided in Table 13, Column 2. The EDIPPS edit categories include the following:

- Validation
- Provider
- Beneficiary
- Reference
- Limit
- Conflict
- Pricing
- Duplicate
- NCCI

Table 13, Column 3 identifies two (2) edit dispositions: Informational and Reject. Informational edits will cause the encounter to be flagged; however, the Informational edit will not cause processing and/or pricing to cease. Reject edits will cause an encounter to stop processing and/or pricing, and the MAO or other entity must resubmit the encounter through the EDFES. The encounter must then pass translator and CEM level editing prior to transferring the data to the EDIPPS for reprocessing. The EDIPPS edit description, as found in Table 13, Column 4, is included on the EDPS transaction reports to provide further information for the MAO or other entity to identify the specific reason for the edit generated.

If there is no reject edit at the header level and at least one of the lines is accepted, then the encounter is accepted. If there is no reject edit at the header level, but all lines reject, then the encounter will reject. If there is a reject edit at the header level, the encounter will reject.

Table 13 reflects only the currently programmed EDIPPS edits. MAOs and other entities should note that, as testing progresses, it may be determined that the current edits require modifications, additional edits may be necessary, or edits may be deactivated. MAOs and other entities must always reference the most recent version of the CMS EDS 837-I Companion Guide to determine the current edits in the EDIPPS.

TABLE 13 - ENCOUNTER DATA INSTITUTIONAL PROCESSING AND PRICING SYSTEM (EDIPPS) EDITS

EDIPPS EDIT#	EDIPPS EDIT CATEGORY	EDIPPS EDIT DESCRIPTION	EDIPPS EDIT ERROR MESSAGE
00010	Validation	Reject	From DOS Greater Than TCN Date
00011	Validation	Reject	Missing DOS in Header/Line
00012	Validation	Reject	DOS Prior to 2012
00025	Validation	Reject	Through DOS After Receipt Date
00175	Validation	Reject	Verteporfin
00265	Validation	Reject	Correct/Replace or Void ICN Not in EODS
00699	Validation	Reject	Void Must Match Original
00750	Pricing	Reject	Service(s) Not Covered Prior To 4/1/2013
00755	Validation	Reject	Void Encounter Already Void/Adjusted
00760	Validation	Reject	Adjusted Encounter Already Void/Adjusted
00761	Validation	Reject	Billing Provider Different from Original
00762	Validation	Reject	Unable to Void Rejected Encounter
00764	Validation	Reject	Original Must Be Chart Review to Void
00765	Validation	Reject	Original Must Be Chart Review to Adjust
01405	Provider	Reject	Sanctioned Provider
01415	Provider	Informational	Rendering Provider Not Eligible For DOS
02106	Beneficiary	Informational	Invalid Beneficiary Last Name
02110	Beneficiary	Reject	Beneficiary HICN Not On File
02112	Beneficiary	Reject	DOS After Beneficiary DOD
02120	Beneficiary	Reject	Beneficiary Gender Mismatch
02125	Beneficiary	Reject	Beneficiary DOB Mismatch
02240	Beneficiary	Reject	Beneficiary Not Enrolled In MAO For DOS
02255	Beneficiary	Reject	Beneficiary Not Part A Eligible For DOS
02256	Beneficiary	Reject	Beneficiary Not Part C Eligible For DOS
02260	Validation	Reject	TOB Conflict With The Coverage Services
03022	Pricing	Reject	Invalid CMG for IRF Encounter
17085	Validation	Reject	CC 40 Required for Same Day Transfer
17100	Validation	Reject	DOS Required for HH Encounter
17257	Validation	Informational	Rev Code 091X Not Allowed
17310	Validation	Reject	Rev Code 036X Requires Surgical CPT/HCPCS
17330	Reference	Reject	RAP Not Allowed
17404	Validation	Reject	Duplicate CPT/HCPCS and Unit Exceeds 1
17407	Validation	Reject	Modifier Requires HCPCS Code
17595	Validation	Reject	VC 05 Invalid with Rev Code
17735	Validation	Reject	Modifier Not Within Effective Date
18010	Reference	Informational	Age and Dx Code Conflict
18012	Reference	Informational	Gender and Dx Code Conflict
18018	Reference	Informational	Gender and CPT/HCPCS Conflict
18120	Reference	Reject	ICD-9 Dx Code Error
18121	Reference	Reject	ICD-9 CPT/HCPCS Error

TABLE 13 - ENCOUNTER DATA INSTITUTIONAL PROCESSING AND PRICING SYSTEM (EDIPPS) EDITS (CONTINUED)

EDIPPS EDIT#	EDIPPS EDIT CATEGORY	EDIPPS EDIT DESCRIPTION	EDIPPS EDIT ERROR MESSAGE
18130	Reference	Reject	Duplicate Principal Dx Code
18135	Reference	Reject	Principal Dx Code is Manifestation Code
18140	Reference	Reject	Principal Dx Code is E-Code
18145	Reference	Reject	Unacceptable Dx Code
18260	Reference	Reject	Invalid Rev Code
18265	Reference	Informational	Dx Code V70.7 Required
18270	Validation	Informational	Rev Code and HCPCS Required
18500	Conflict	Informational	Multiple CPT/HCPCS for Same Service
18540	Reference	Informational	CPT/HCPCS Service Unit Out Of Range
18705	Validation	Reject	Invalid Discharge Status
18710	Validation	Reject	Missing/Invalid POA Indicator
18730	Reference	Reject	Invalid Modifier Format
18905	Validation	Reject	Age Is 0 Or Exceeds 124
20035	Validation	Reject	Requires DOS for Rev Code 057X
20270	Validation	Reject	From & Thru Dates Equal - Day Count > 1
20450	Validation	Reject	Attending Physician is Sanctioned
20455	Validation	Informational	Operating Provider Is Sanctioned
20500	Conflict	Reject	Invalid DOS for Rev Code Billed
20505	Conflict	Reject	Correct Ambulance HCPCS/Rev Code Required
20510	Conflict	Reject	Rev Code 054X Requires Specific HCPCS
20515	Conflict	Informational	Dx Code V053 Must Be Aligned With HCPCS
20520	Validation	Reject	Invalid Ambulance Pick-up Location
20530	Validation	Reject	Zip Cannot Be 0 or Blank
20835	Pricing	Reject	Service Line DOS Not Within Header DOS
20980	Pricing	Informational	Provider Cannot Bill TOB 12X or 22X
21925	Pricing	Reject	Swing Bed SNF Conditions Not Met
21950	Pricing	Reject	Line Level DOS Required
21951	Pricing	Informational	No OSC 70 or Covered Days Less Than 3
21958	Pricing	Informational	Rehab Therapy Ancillary Codes Required
21976	Validation	Informational	OSC 70 Dates Outside of Coverage Period
21979	Validation	Reject	Charges for Rev Code 0022 Must Be Zero
21980	Validation	Reject	CC D2 Requires Change in One HIPPS
21994	Validation	Informational	From Date Greater Than Admit Date
22015	Validation	Informational	Number of Days Conflicts With HH Episode
22020	Validation	Informational	Conflict Between CC and OSC
22095	Validation	Reject	Encounter Must Be Submitted on 837-P DME
22100	Validation	Informational	Rev Code 0023 Invalid for DOS
22135	Validation	Reject	Multiple Rev Code 0023 Lines Present
22205	Validation	Reject	Service Line Missing DOS
22220	Validation	Reject	DOS Prior to Provider Effective Date
22225	Validation	Reject	Missing Provider Specific Record

TABLE 13 - ENCOUNTER DATA INSTITUTIONAL PROCESSING AND PRICING SYSTEM (EDIPPS) EDITS (CONTINUED)

EDIPPS EDIT#	EDIPPS EDIT CATEGORY	EDIPPS EDIT DESCRIPTION	EDIPPS EDIT ERROR MESSAGE
22280	Validation	Reject	Rev Code 277 Invalid for a HH
22290	Validation	Reject	Service Line Requires DOS
22390	Validation	Informational	HIPPS Code Required for SNF/HH
22395	Validation	Informational	HIPPS Codes Conflicts with Revenue Code
22400	Validation	Informational	HP Qualifier Must Exist for HIPPS Code
22405	Validation	Informational	Occurrence Code 55 & DOD Required (*DOS through 12/31/2012*)
22405	Validation	Reject	Occurrence Code 55 & DOD Required (*DOS on or after 01/01/2013)*
22410	Pricing	Reject	Invalid Service(s) for TOB
22415	Pricing	Reject	Revenue Code 0274 Required
22420	Validation	Reject	TOB 33X Invalid for DOS
25000	NCCI	Informational	CCI Error
27000	Validation	Reject	Height or Weight Value Exceeds Limit
98315	Duplicate	Reject	Linked Chart Review Duplicate
98320	Duplicate	Reject	Chart Review Duplicate
98325	Duplicate	Reject	Service Line(s) Duplicated

10.1 EDIPPS Edits Enhancements Implementation Dates

As the EDS matures, the EDPS may require enhancements to the EDIPPS editing logic. As enhancements occur, CMS will provide the updated information (i.e., disposition changes and activation or deactivation of an edit). Table 14 provides MAOs and other entities with the implementation dates for enhancements made to the EDIPPS since the last release of the CMS EDS 837-I Companion Guide.

Note: Table 14 will not be provided when there are no enhancements implemented for the current release of the CMS EDS Companion Guides.

10.2 EDPS Edits Prevention and Resolution Strategies

In order to assist MAOs and other entities with the prevention of potential errors in their encounter data submission and with resolution of edits received on the generated MAO-002 reports, CMS has provided comprehensive strategies and scenarios. CMS has identified strategies and scenarios in three (3) phases.

10.2.1 EDPS Edits Prevention and Resolution Strategies – Phase I: Frequently Generated EDIPPS Edits

Table 15 outlines Phase 1 of the prevention and resolution strategies for Institutional edits most frequently generated on the MAO-002 reports.

TABLE 15 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE I

FREQUENTLY GENERATED EDIPPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
17310	Rev Code 036X Requires Surgical CPT/HCPCS	Reject	Revenue Code 036X was submitted without required Surgical CPT/HCPCS code. Provide appropriate CPT/HCPCS code associated with this Revenue Code.
Scenario: Life and Health Associates submitted an encounter for Dr. Joshua Canterbury, who performed a prostate cryosurgery on 5/15/2012. The encounter reported the Revenue Code of 036X, but did not include CPT code 55873.			
17407	Modifier Requires HCPCS Code	Reject	Service line submitted with HCPCS modifier, but not the required HCPCS code. Verify that codes/ modifiers are accurate.
Scenario: Dr. Whitty submitted the HCPCS modifier code 25- Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure, without the appropriate level of E&M service.			
17735	Modifier Not Within Effective Date	Reject	Modifier not active for DOS reported. Submitter must verify that modifiers reported are valid and current.
Scenario: As a follow up to a postoperative surgery on 8/1/2012, Dr. Whitty submitted HCPCS modifier code 21- Prolonged evaluation and management services on 9/28/2012; however, the modifier was deactivated on 9/1/2012.			
20035	Requires DOS for Rev Code 057X	Reject	Revenue Code 57X requires that DOS be reported on separate service lines for each DOS. Ensure each service line for Revenue Code 57X includes the appropriate DOS.
Scenario: Super Nurse Health submitted a claim to Grand Plan for five (5) nursing visits during the month of August. Grand Plan submitted an encounter to the EDS with five (5) separate service lines all populated with "from" DOS of 8/2/2012 and "through" DOS of 8/30/2012. Grand Plan received an MAO-002 report with error message 20035 because each service line requires a single "from" and "through" DOS.			
20270	From & Thru Dates Equal - Day Count > 1	Reject	Inpatient encounter contains same "from" and "through" DOS; however, the day count reported in Loop 2320 MIA15 does not equal 1. Verify that DOS are accurate or that day count is equal to 1.
Scenario: Nightline Hospital admitted a patient at 8 p.m. on 10/23/2012 and the patient was discharged at 2 p.m. on 10/24/2012. Dawn to Dusk Healthcare submitted the encounter with a day count of "2" for admission, although the overnight stay is considered one (1) day.			
20505	Correct Ambulance HCPCS/Rev Code Required	Reject	Revenue Code 540 populated without appropriate ambulance HCPCS codes and/or a unit greater than 1 for the HCPCS code. Also provide HCPCS mileage codes.
Scenario: Blue Flight Health Plan submitted an encounter for ground ambulance services with Revenue Code 540; however, the HCPCS code was not populated.			
20510	Rev Code 054X Requires Specific HCPCS	Reject	HCPCS code is not valid for submission with Revenue Code 540. Use an appropriate HCPCS code from the list of HCPCS codes acceptable for submission with Revenue Code 540.
Scenario: Blue Flight Health Plan submitted a ground transportation ambulance Revenue Code 540 with a HCPCS code A0021-Out of State Per Mile, which was valid for the service, but is invalid for Medicare.			
20530	Zip Cannot Be 0 or Blank	Reject	Submitter must provide a valid nine (9)-digit ZIP code for ambulance pick-up location.
Scenario: Mystery Health Plan submits an encounter on behalf of Rush Ambulance with an ambulance service line that has the street address, city, state, and the ZIP code is indicated as "0".			

TABLE 15 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE I (CONTINUED)

FREQUENTLY GENERATED EDIPPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
20835	Service Line DOS Not Within Header DOS	Reject	Line level DOS reported that does not fall within "from" and "through" DOS range reported on header level of encounter. Verify the accuracy of all DOS.
Scenario: Who Knows Hospital admitted Janet Doe on 6/1/2012 and discharged her on 6/10. Padre Care Plan submitted an inpatient encounter on behalf of Who Knows Hospital for Ms. Doe. The service line DOS were correct; however, the claim header indicated that Ms. Doe was admitted on 6/6/2012 and discharged on 6/12/2012.			

10.2.2 EDPS Edits Prevention and Resolution Strategies – Phase II: Common EDPS Edits

Table 16 outlines Phase II for common edits generated in all subsystems of the EDPS (Professional, Institutional, and DME).

TABLE 16 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE II

COMMON EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
00010	From DOS Greater Than TCN Date	Reject	Encounter must have a DOS prior to submission date.
Scenario: Perfect Health of America submitted an encounter to the EDS on May 10, 2012 for a knee replacement performed at Wonderful Hills Mediplex for DOS May 12, 2012. The encounter was rejected because the "from" DOS was after the date of encounter submission.			
00011	Missing DOS in Header/Line	Reject	Encounter header and line levels must include "from" and "through" DOS (procedure or service start date).
Scenario: Chloe Pooh was admitted to Regional Port Hospital on October 21, 2012 for a turbinectomy and was released on October 22, 2012. Regional Port Hospital submitted a claim to Robbins Health for the surgical procedure. Robbins Health submitted the encounter to the EDS, but did not include the "through" DOS of October 22, 2012.			
00012	DOS Prior to 2012	Reject	Encounter must contain 2012 "through" DOS for each line.
Scenario: Ion Health submitted an encounter with DOS from December 2, 2011 through December 28, 2011, for an inpatient admission at Better Health Hospital. EDS will only process encounters that include 2012 "through" DOS or later.			
00025	Through DOS After Receipt Date	Reject	Encounter submitted with a service line "through" DOS that occurred after the date the encounter was submitted.
Scenario: Leverage Community Health submitted an encounter on August 23, 2012 for a myringotomy performed by Dr. Earwell. The service line DOS for the procedure was August 29, 2012. The encounter was rejected because the encounter was submitted to the EDS before the DOS listed on the encounter.			
00265	Correct/Replace or Void ICN Not in EODS	Reject	Adjustment/Void encounter submitted with an invalid ICN. Verify accuracy of ICN on the returned MAO-002 report.
Scenario: Chance Medical Services submitted an encounter to the EDS and received an MAO-002 report with an accepted ICN of 123456789. The encounter required adjustment. Chance Medical Services submitted an adjustment encounter using ICN 234567899. The adjustment encounter was rejected because there was no original record in the EDS for this ICN with the same Submitter ID.			

TABLE 16 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE II (CONTINUED)

COMMON EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
00699	Void Must Match Original	Reject	Voided encounter must have the same number of lines as the original encounter.
Scenario: Lamb Professional Care submitted an encounter for an inpatient hospital stay with five (5) service lines. Lamb Professional Care submitted a void encounter for the hospital stay. However, the void encounter contained only 4 lines from the original encounter. Lamb Professional Care received an MAO-002 report with edit 00699 because one of the lines from the original encounter was not included on the void encounter.			
00761	Billing Provider Different from Original	Reject	Billing provider's NPI must be identical in both the original and void encounters.
Scenario: Mastermind General Hospital submitted an encounter for a procedure performed by Dr. Jackson Martinez on October 17, 2012. Spartacus Regional Health submitted the encounter to the EDS and received an MAO-002 report with an accepted ICN of 342431098. On October 27, 2012, Spartacus Regional Health submitted a void encounter for ICN 342431098 using an NPI for Dr. Mary Jane. The encounter was rejected because the billing provider NPI on the void encounter did not match the billing provider on the original encounter.			
01405	Sanctioned Provider	Reject	CMS has suspended/terminated provider from performing services for DOS submitted. Verify the accuracy of provider's NPI and DOS submitted.
Scenario: Dr. Domuch performed a cystectomy for Wally Dowright on October 2, 2012. Dr. Domuch submitted a claim to Dermis Health Plan, who adjudicated the claim and submitted an encounter to the EDS. The EDS returned the encounter to Dermis Health Plan with edit 01405 because Dr. Domuch's privileges were suspended, effective August 29, 2012, for one (1) year; therefore, Dr. Domuch was not authorized to perform this procedure.			
01415	Rendering Provider Not Eligible For DOS	Informational	Verify that NPI is accurate and that the provider was eligible for DOS submitted.
Scenario: ABC Care Plan submitted an encounter for a procedure performed by Dr. Destiny on February 14, 2012. The EDPS provider reference files indicate that Dr. Destiny's NPI was not effective until February 16, 2012.			
02106	Invalid Beneficiary Last Name	Informational	Verify that last name populated on the encounter matches the last name listed in MARx database.
Scenario: Blue Skies Rural Health submitted an encounter for patient Ina Batiste-Rhogin. The MARx database listed the patient as Ina Rhogin. The EDPS processed and accepted the encounter with an informational flag indicating that the name provided on the encounter was not identical to the name listed in the eligibility database.			
02110	Beneficiary HICN Not On File	Reject	Verify that HICN populated on the encounter is valid in MARx database.
Scenario: Bright Medical Center submitted a claim to Sunshine Complete Health for an office visit for Mr. Everett Banks for DOS May 26, 2012. Sunshine Complete Health submitted an encounter to the EDS. The EDS rejected the encounter with edit 02110, because the HICN populated on the encounter was not on file in the MARx database.			
02112	DOS After Beneficiary DOD	Reject	Verify that DOS submitted is accurate and does not exceed the beneficiary DOD.
Scenario: Mountain Hill Health submitted an encounter for an inpatient admission for Ray Rayson for DOS July 15, 2012. EDPS was unable to process the encounter because the MARx database indicated Mr. Rayson expired on July 13, 2012.			
02120	Beneficiary Gender Mismatch	Reject	Verify that gender populated on the encounter is accurate and matches gender listed in MARx database.
Scenario: Jenna Jorgineski went to Lollipop Lab for a sleep study on September 4, 2012. Lollipop Lab submitted a claim for the sleep study to Capital City Community Care with Ms. Jorgineski's gender identified as "male". Capital City Community Care submitted the encounter. The EDS processed and accepted the encounter. The MAO-002 report was returned with an informational edit 02120, because Ms. Jorgineski's gender was listed as "female" in the MARx database.			

TABLE 16 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE II (CONTINUED)

COMMON EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
02125	Beneficiary DOB Mismatch	Reject	Verify that DOB populated on the encounter is accurate and matches DOB listed in MARx database.
Scenario: Swan Health submitted an encounter to the EDS for Joe Blough on March 3, 2012. The encounter listed Mr. Blough's DOB as December 13, 1940. The eligibility database (MARx) listed Mr. Blough's DOB as December 13, 1937. The EDS returned the MAO-002 report to Swan Health with edit 02125 due to the conflicting dates of birth.			
02240	Beneficiary Not Enrolled In MAO For DOS	Reject	Verify that beneficiary was enrolled in your MAO during DOS on the encounter.
Scenario: Gabrielle Boyd was admitted to Faith Hospital for an appendectomy on June 11, 2012 and was discharged on June 14, 2012. Faith Hospital submitted the claim for the hospital admission to Adams Healthcare. Adams Healthcare adjudicated the claim and submitted an encounter to the EDS on July 12, 2012. Ms. Boyd's effective date with Adams Healthcare was July 1, 2011. The EDS returned an MAO-002 report to Adams Health with edit 02240 because Ms. Boyd was not enrolled with the health plan for the DOS submitted by Faith Hospital.			
02255	Beneficiary Not Part A Eligible For DOS	Reject	Verify that beneficiary was enrolled in Part A for DOS listed on the encounter.
Scenario: Mr. Carl Evergreen was transferred from a VA hospital and admitted to Rainforest Regional on April 28, 2012. Mr. Evergreen was effective for Medicare Part A on May 1, 2012. Strides in Care Health Plan submitted the encounter for the admission to Rainforest Regional and received an MAO-002 report with edit 02255 because Mr. Evergreen was enrolled in Medicare Part A after the date of hospital admission.			
02256	Beneficiary Not Part C Eligible For DOS	Reject	Verify that beneficiary was enrolled in Part C for DOS listed on the encounter.
Scenario: On July 4, 2012, Gail Williams has severe chest pains and goes to the emergency room for a chest x-ray at Underwood Memorial Hospital. At the time of the emergency room visit, Ms. Williams only has Part A Medicare coverage. Underwood Memorial submits the claim to AmeriHealth and the claim is adjudicated under Part A Medicare. AmeriHealth submits an encounter to the EDS, which is rejected with edit 02256, because Ms. Williams is not covered under Part C Medicare for the DOS.			
25000	CCI Error	Informational	Ensure CCI code pairs are appropriately used. Ensure that CCI single codes meet the MUE allowable units of service (UOS).
Scenario: Hippos Health Plan submitted an encounter to the EDS with a DOS of May 5, 2012 and HCPCS code 15780 and two (2) units of service. The returned MAO-002 report indicated an informational edit of 25000 because HCPCS code 15780 – dermabrasion, is only valid for one (1) unit of service per day.			
98325	Service Line(s) Duplicated	Reject	Verify encounter was not previously submitted. If not a duplicate encounter, ensure that elements validated by duplicate logic are not the same (refer to the 2012 ED Participant Guide for duplicate logic validation elements)
Scenario: Sanford Health Systems submitted an encounter for two (2) service lines for 15-minute therapy services. The encounter lines submitted were the same for the timed procedure code, totaling 35 minutes and should have been submitted with 2 units of service under the total time rather than as separate duplicate lines.			

10.2.3 EDIPPS Edits Prevention and Resolution Strategies – Phase III: General EDIPPS Edits

Table 17 outlines Phase III for a portion of the remaining Institutional edits generated on the MAO-002 Encounter Data Processing Status Reports. Section 10.2.3 will be updated in future releases of the Institutional Companion Guide until all remaining edits are identified.

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
18010	Age and Dx Code Conflict	Informational	Verify that diagnosis populated on the encounter is age appropriate for beneficiary
Scenario: Clear Path Health submitted an encounter to the EDS for services provide to Mr. Jackson Leigh, who is 85-yrs old. The diagnosis provided on the encounter was V20.2-routine child health check. The MAO-002 report returned contained an informational edit of 18010 because the diagnosis provided was not appropriate for an 85-yr old.			
18018	Gender and CPT/HCPCS Conflict	Informational	Gender provided for beneficiary does not agree with procedure/service identified on the encounter. Verify gender populated on encounter matches date in MARx. Ensure that the procedure code is accurate and appropriate.
Scenario: Claims Health submitted an encounter for Jane Johnson with procedure code 58150-Total Hysterectomy. However, the gender populated on the encounter identified Ms. Johnson as a male. The MAO-002 report was returned with an informational error of 18018. CMS recommends that Claims Health verify the gender on Ms. Johnson's HICN information to ensure that it is corrected.			
18135	Principal Dx is Manifestation Code	Reject	Encounter submitted using a code for underlying disease or symptom instead of a principal diagnosis. Ensure that primary diagnosis is valid.
Scenario: Arbor Meadows Health submitted an encounter for an inpatient admission for Ms. Anabel Greaves. The diagnosis submitted on the encounter was 3214-Meningitis due to sarcoidosis. The EDS rejected the encounter because 3214 is not a primary diagnosis, but is a manifestation code for a condition related to the diagnosis.			
18260	Invalid Rev Code	Reject	Encounter submitted with a Revenue Code not related to services provided or a Revenue Code not used.
Scenario: Home Sweet Home submitted a claim to Foundation Health for Home Health services provided to Ms. Jean. Foundation Health submitted the encounter to the EDS using Revenue Code 0022. The encounter was rejected for edit 18260 because Foundation Health used a SNF revenue code for a Home Health encounter.			
21980	CC D2 Requires Change in One HIPPS	Reject	Adjustment encounter submitted with condition code D2; however, the associated HIPPS code was not revised to indicate the adjustment.
Scenario: Marxton Health sent an adjustment encounter to the EDS on behalf of Here For You Health, which contained condition code of 'D2" and an appropriate reason code to revise the HIPPs code originally submitted, but the HIPPS code itself was not revised.			
00755	Void Encounter Already Void/Adjusted	Reject	Submitter has previously voided or adjusted an encounter and is attempting to void the same encounter. Submitter should review returned MAO-002 reports to confirm processing of the voided encounter prior to resubmission of the void.
Scenario: Happy Trails Health Plan submitted a void/delete encounter on October 10, 2012. Happy Trails Health Plan voided the same encounter, in error, on October 15, 2012, prior to receiving the MAO-002 report for the initial void/delete encounter, which was returned on October 16, 2012. The MAO-002 report for the subsequent voided encounter was returned with edit 00755 due to the submission of the second void/delete encounter.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
00760	Adjusted Encounter Already Void/Adjusted	Reject	Submitter has previously adjusted or voided an encounter and is attempting to adjust the same encounter. Submitter should review returned MAO-002 reports to confirm processing of the adjusted encounter prior to resubmission of the adjustment.
Scenario: On August 20, 2012, Pragmatic Health submitted a correct/replace encounter to correct a CPT code. Pragmatic Health had not received their MAO-002 report by August 23, 2012 and decided to resubmit the correct/replace encounter. The MAO-002 report was returned on August 24, 2012 with the correct/replace encounter identified as accepted. Pragmatic Health received edit 00760 on the secondary MAO-002 report because the EDPS had already processed the resubmitted correct/replace encounter.			
00762	Unable to Void Rejected Encounter	Reject	Submitter is attempting to void a previously rejected encounter. Submitter should review returned MAO-002 reports to confirm the rejected encounter.
Scenario: On July 20, 2012, Hero Health Plan submitted an encounter with an invalid HICN. On July 26, 2012, Hero Health Plan attempted to void the encounter due to the invalid HICN without referencing the MAO-002 report, dated July 25, 2012, that indicated that the encounter was rejected. On August 1, 2012, Hero Health Plan received an MAO-002 report with edit 00762 for the voided encounter because the original encounter had already been processed and rejected.			
02260	TOB Conflict With the Coverage Services	Reject	TOB populated on the encounter is not appropriate for the services identified
Scenario: WindSong Health Plan submitted an encounter to the EDS for Miss Big Mama's admission to Lady of Love Skilled Nursing Facility (SNF) populated with a type of bill (TOB) 32X. The encounter was rejected because TOB 32X is used for Home Health Services.			
17330	RAP Not Allowed	Reject	Adjustments are not allowed for Type of Bill 322 or 332 (Request for Anticipated Payment)
Scenario: Magic Morning Health Plan submitted an encounter to the EDS for BackHome Health (a primary HHA) with TOB 322. The encounter was rejected because the EDS does not accept Request for Anticipated Payment (RAP) encounters.			
18012	Gender and Dx Code Conflict	Informational	Encounter submitted with a beneficiary gender that does not agree with the diagnosis populated on the encounter.
Scenario: Hindsight Health submitted an encounter for JuneBug Hospital for Mr. James Jewet with diagnosis code 641.1 – Hemorrhage from placenta previa. The encounter was rejected because the diagnosis submitted is a female specific diagnosis.			
18130	Duplicate Principal Dx Code	Reject	Secondary diagnosis code submitted is a duplicate of the primary diagnosis code.
Scenario: Solo Health Services submitted an encounter with a diagnosis code 413.9 in the 'BK' (primary diagnosis) and 'BF' (additional diagnosis) qualifier fields for the same service line. The encounter was rejected for duplicate primary diagnoses.			
18145	Unacceptable Dx Code	Reject	The diagnosis code populated on the encounter is invalid or incorrectly populated.
Scenario: Hopewell Health Plan submitted an encounter to the EDS for Cornerstone Hospital for services provide to Colonel Marcus on February 3, 2012. The diagnosis populated on the encounter was 518.5 – Pulmonary Insufficiency Following Trauma or Surgery. The encounter was rejected for an unacceptable diagnosis because diagnosis code was deleted and deemed invalid effective October 1, 2011.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
21994	From Date Greater Than Admit Date	Informational	Encounter submitted with a 'from' date prior to the date of the beneficiary's admission.
Scenario: Allison Oop was admitted to Mad Hatter Nursing Facility at 2:46 AM on April 1, 2012. Holiday Health submitted the SNF encounter to the EDS with an admit date of April 1, 2012, but the service line from date was listed as March 29, 2012.			
22220	DOS Prior to Provider Effective Date	Reject	Admission date indicated on encounter occurred before the provider's NPI was deemed active/effective.
Scenario: Halo Home Health submitted an encounter to the EDS for Mr. Sweets' admission on January 28, 2011 for DOS February 1, 2012 through February 11, 2012 with NPI 0002220001. The encounter was rejected because the NPI effective date was February 2, 2012, after the admission date.			
00764	Original Must Be a Chart Review to Void	Reject	Submitter must ensure that, if the void encounter (frequency code '8') is populated with PWK01='09 and PWK02='AA', the original encounter submission was a chart review encounter populated with PWK01='09' and PWK02='AA'. The submitter must also ensure that the ICN references the initial chart review encounter, not the original full encounter.
Scenario: On January 12, 2013, Paisley Community Health submitted an original encounter for Mr. Jolly Jones to the EDS and received the accepted ICN of 3029683010582. On February 2, 2013, Paisley Community Health submitted a chart review encounter to the EDPS to delete a diagnosis code from the original encounter and received the accepted ICN of 5039530285074. In April 2013, Paisley Community Health performed another chart review of Mr. Jones' medical records and discovered that the service was never provided. Paisley Community Health submitted a void encounter to the EDS using the reference ICN of 3029683010582 (the original encounter ICN) and populated PWK01='09' and PWK02='AA'. The EDS rejected the encounter because the ICN referenced was for the original encounter, not the initial chart review.			
00765	Original Must Be a Chart Review to Adjust	Reject	Ensure that, if the correct/replace encounter (frequency code '7') is populated with PWK01='09 and PWK02='AA', the original encounter submission was a chart review encounter populated with PWK01='09' and PWK02='AA'. The submitter must also ensure that the ICN references the initial chart review encounter, not the original full encounter.
Scenario: Flashback Health performed a chart review for Prosperous Living Medical Center. Flashback Health discovered two (2) additional diagnosis codes for an encounter previously submitted for Ms. Leanne Liberty. Flashback Health submitted an initial chart review encounter using the frequency code of '7'. The EDS rejected the chart review encounter submission because initial chart review encounters should contain a frequency code '1'.			
17404	Duplicate CPT/HCPCS and Unit Exceeds 1	Reject	Encounter should not be submitted with a unit of greater than 1 when any of the following HCPCS codes are provided for a pap smear on a single DOS: Q0060, Q0061, P3000, P3001, Q0091, G0123, G0124, G0143, G0144, G0145, G0147, and G0148 nor can duplicate pap smear HCPCS Codes be submitted for the same day.
Scenario: Dr. Michaels performed a pap smear on Miss Annabelle Lee prior to a gynecological procedure. The lab lost the test sample. Dr. Michaels repeated the pap smear and performed the gynecological procedure. Group Health Plan submitted the encounter for both of Miss Lee's pap smears, using HCPCS code Q0060, and her surgical procedure. The encounter was rejected because Medicare will not allow more than one (1) unit for Q0060 for a single service.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III (CONTINUED)

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
18120	ICD-9 Dx Code Error	Reject	Submitter must ensure that the diagnosis codes populated on an encounter are current and valid
Scenario: Mr. Jack Sprat was admitted to Mercy Me Hospital for an aortic endovascular graft placement. Mercy Me Hospital submitted the claim for Mr. Sprat's surgical services to Charity Health using diagnosis code 444.0 embolism and thrombosis of abdominal aorta. Charity Health submitted the encounter and received edit 18120 because the diagnosis code is no longer a valid ICD-9 CM code.			
18140	Principal Dx Code is E-Code	Reject	Submitter must ensure that an e-code is submitted as a subsequent diagnosis code. An E-code is never allowed as a primary/principal diagnosis code and must not be populated using the 'BK' qualifier
Scenario: Marney Gentos was admitted to Home Hospital for second degree burns. Fantasy Life Health Plan submitted the encounter to the EDS and received an accepted ICN. Fantasy Life Health Plan later performed a chart review and located an additional diagnosis code for services provided during Ms. Gentos' stay at Home Hospital. Fantasy Life submitted a chart review encounter to the EDS with a single diagnosis code of E9581 – Injury-burn, fire. The EDS rejected the chart review submission because e-codes must never be submitted without a primary/principal diagnosis.			
18905	Age Is 0 Or Exceeds 124	Reject	The age of the patient identified on the encounter must not contain non-numeric values; or the age must not be populated as 0 or greater than 124 years old
Scenario: Munali Mohair, a 27-yr old female was admitted to Petunia Mills General Hospital for an overnight stay due to complications following an outpatient procedure. Petunia Mills submitted a claim to Flowery Lanes Health with Ms. Mohair's DOB listed as 09/23/1985. Flowery Lanes Health submitted the encounter to the EDS with Ms. Mohair's DOB listed as 09/23/1885, due to a typographical error. The EDS returned edit 18905 on the MAO-002 report.			
20450	Attending Physician is Sanctioned	Reject	Submitter must ensure that the attending provider was not suspended or terminated from providing services to Medicare beneficiaries during the time(s) of service indicated on the encounter.
Scenario: Dr. Jernigan, attending physician at Hospice Hotel, made rounds on January 4, 2013, for fellow physician due to an emergency. Hospice Hotel submitted Dr. Jernigan's claim to Better Health. Better Health submitted the encounter to the EDS. Dr. Jernigan's privileges were terminated on December 20, 2012, and he was not authorized to provide services for Hospice patients. Better Health received an MAO-002 report with a reject edit of 20450.			
20455	Operating Provider Is Sanctioned	Informational	Submitter must ensure that the operating provider was not suspended or terminated from providing surgical services to Medicare beneficiaries during the time(s) of service indicated on the encounter.
Scenario: Dr. Madhatter performed a cholecystectomy at Highway Hospital on March 12, 2013. Highway Hospital submitted an Institutional claim to Providers Health Plan. Providers Health submitted the encounter to the EDS on May 6, 2013. It was discovered that Dr. Madhatter's operating/surgical privileges were suspended on March 3, 2013. The EDS returned the MAO-002 report to Providers Health with edit 20455.			
20520	Invalid Ambulance Pick-up Location	Reject	Encounter for ambulance services must contain a valid ZIP code in Loop 2300 HI01-5 when Revenue Code 540 is used with a Value Code of A0
Scenario: Family Health submitted an encounter for ambulance services provided by Monarch Medical Transport, but did not populate the ambulance pick-up location because Monarch Medical Transport did not provide the ZIP code when submitting the claim for services. The EDS rejected the encounter because the ambulance pick up location is a required field on all ambulance encounters.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III (CONTINUED)

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
27000	Height or Weight Value Exceeds Limit	Reject	Encounters submitted with TOB 72X Values for A8 and A9 must be submitted in kilograms. For Value Code A8: Weight must not exceed 318.2 Kg (700 lbs.). For Value Code A9: Height must not exceed 228.6 Kg (7ft 6 in)
Scenario: Mr. Nestle Parks, a 432 lb. male, was admitted to Mountain Top Memorial Hospital with kidney failure due to ESRD. River Run Health Plan submitted an encounter to the EDS for services provided to Mr. Parks during his stay at Mountain Top Memorial. The encounter contained Mr. Parks's weight in Loop 2300 HI Value Code A8 segment at 432.0. The encounter was rejected with edit 27000 because the A8 value exceeded the allowable value of 318.2 kg. The encounter should have been submitted with Mr. Parks weight identified as 196.36, because the EDS requires that the measurements be populated in kilograms.			
17257	Rev Code 091X Not Allowed	Informational	Medicare no longer accepts Revenue Code 910 for Psychiatric/Psychological Services. Ensure that the revenue code submitted for psychiatric services is current and valid.
Scenario: Mr. Zane Zany was admitted to Far Side Institution due to severe depression. Way Out There Health Care submitted an encounter on behalf of Far Side Institution populated with revenue code 0910, for services provided to Mr. Zany during his admission from December 15, 2012 to January 14, 2013. The EDPS rejected the encounter submission because, as of October 2003, revenue code 0910 was no longer a valid and acceptable Medicare revenue code.			
18730	Invalid Modifier Format	Reject	Submitter must ensure that the modifier on the encounter is acceptable and valid for EDS submission. Ensure that the format is accurate and the appropriate characters are used.
Scenario: Pinky Marvelous was admitted to Check-In Memorial Hospital for a radical mastectomy of her left breast. Check-In Memorial submitted a claim for the surgical procedure to Gallant Health Plan. Gallant Health Plan submitted the encounter to the EDS, populated with CPT 19307, modifier 'L6'. The EDPS rejected the encounter with edit 18730 because the modifier was not entered accurately. The correct submission should be CPT 19307, modifier 'LT'.			
22015	Number of Days Conflicts With HH Episode	Informational	Submitter must ensure that the sum of the from and through dates for the episode of care does not exceed 60 days
Scenario: Big Bell Home Health submitted a claim to Whamo Health Plan for Home Health services provided to Major Colonel from February 3, 2013 through April 17, 2013. Whamo Health Plan submitted the encounter to the EDS with the 'from' and 'through' dates of February 3, 2013 through April 17, 2013 on one (1) service line. The encounter was rejected because the episode of care exceeded the required maximum of 60 days.			
22095	Encounter Must Be Submitted on 837-P DME	Reject	If the NPI on the encounter identifies a DME Supplier, the submitter must use the Payer ID of 80887 to indicate a the service is for DMEPOS.
Scenario: Reach Rehab submitted an encounter for an electric hospital bed provided for Mr. Anton upon his discharge from Meyers Medical Center. Reach Rehab Services submitted the encounter to the EDS using the Institutional payer ID of 80882.The encounter was rejected because, although Mr. Anton was discharged from the hospital and received care that would be submitted on an Institutional encounter, services provided by Reach Rehab were specific to DMEPOS.			
22135	Multiple Rev Code 0023 Lines Present	Reject	TOB 32X Home Health encounters must not contain more than one (1) service line containing revenue code 0023. Only one (1) revenue code is defined for each prospective payment system that requires HIPPS codes.
Scenario: Harmony Home Health submitted an encounter with two (2) service lines containing HIPPS codes HBFK2 and HAEJ1. Harmony Home Health submitted separate revenue code 0023 service lines for each HIPPS code service line. The EDS rejected the encounter because revenue code 0023 may not be used more than once on a single Home Health encounter in conjunction with HIPPS codes.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III (CONTINUED)

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
22225	Missing Provider Specific Record	Reject	Encounter was submitted that contains a provider NPI that is not identified in the EDPS provider tables as a participating Medicare provider.
Scenario: Ipse Institutional Hospital submitted an encounter file to the EDS for an inpatient procedure performed by Dr. Wymee using NPI 0000000000. The EDPS rejected the encounter because Dr. Wymee was not identified in the EDS as a participating Medicare provider.			
22020	Conflict Between CC and OSC	Reject	Encounters submitted with condition code=C3 (Partial Approval) must contain Occurrence Span Code (OSC) 'MO' to indicate the service dates that were approved.
Scenario: Blue Bellman was admitted to The Best Nursing Facility on March 3, 2013 and discharged on April 26, 2013. The Quality Improvement Organization (QIO) reviewed the claim submitted to Service Plus Health Plan by The Besting Nursing Facility and denied service dates from April 3, 2013 through April 26, 2013. Service Plus Health Plan submitted the approved dates of service (DOS) using condition code C3, but did not populate the encounter with the 'MO' modifier to indicate that the March 3, 2013 through April 2, 2013 DOS were approved.			
21951	No OSC 70 or Covered Days Less Than 3	Informational	Skilled Nursing Facility (SNF) encounters submitted using revenue code 0022 and TOB 21X, 22X, or 23X must include the submission of Occurrence Span Code 70 to indicate the dates of a qualifying hospital stay of at least three (3) consecutive days, which qualifies the beneficiary for SNF service.
Scenario: Stay With Us Nursing Care submitted a claim to Cornerstone Health Care for Mr. Bobst's SNF stay from May 3, 2013 through May 13, 2013. Cornerstone Health Care submitted the encounter to the EDS using OSC 70; however, due to a data entry error, the 'from' and 'through' dates on the encounter were May 3, 2013, indicating a one day service.			
17085	CC 40 Required for Same Day Transfer	Reject	Encounters submitted with TOB 11X and a patient status code of 02, 03, 05, 50, 51, 61, 62, 63, 65, 66, or 70; and the admission date is equal to the statement covers through date must contain Condition Code 40.
Scenario: Wendy Wonder was admitted to Healthy Hospital on the morning of February 21, 2013 for a fall due to hallucinations. Healthy Hospital transferred Ms. Wonder to their inpatient psychiatric unit on the evening of February 21, 2013. Health Hospital submitted Ms. Wonder's claim to Wholeness Health using a patient status code of 65 (Discharged/ Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital) without providing the required Condition Code 40. Wholeness Health adjudicated the claim and submitted the encounter to the EDS. The EDPS rejected the encounter because inpatient hospital encounters populated with patient status code 65 must also contain Condition Code 40 to indicate that Ms. Wonder was admitted and discharged on the same date.			
22280	Rev Code 277 Invalid for a HH	Reject	Home Health encounters cannot be submitted using revenue code 277(Medical/surgical supplies oxygen (take home)).
Scenario: Fawn Home submitted a claim to Hulu Health Care for provision of oxygen to Cletus Clapp, using revenue cod 0023 for the home health service and revenue code 277 for the supply service. Hulu Health Care adjudicated the claim and submitted the encounter to the EDS. Home Health received an MAO-002 report rejecting the encounter with edit 22280 because revenue code 277 is not a Medicare acceptable revenue code.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III (CONTINUED)

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
18710	Missing/Invalid POA Indicator	Reject	Encounter type requires that an indicator of 'Y' or 'N' for Present on Admission according to NUBC requirements, but the indicator is not populated or is inaccurate for the data provided in the encounter.
Scenario: Miss Ames was admitted to Hope Hospital for a stroke and a cerebral infarction with complications on March 26, 2013. She was discharged on April 5, 2013. Hope Hospital submitted a claim to Mount Vios for Miss Ames' hospital admission. Hope Hospital submitted an encounter to the EDS that did not include the required POA indicator of 'Y' due to the diagnoses populated on the encounter. The EDS rejected the encounter with error code 18710.			
21925	Swing Bed SNF Conditions Not Met	Reject	Encounter submitted with TOB 18X or 21X with Revenue Code 0022 and Occurrence Span Code 70 is not present or Occurrence Code 50 is not present for each submission of Revenue Code 0022.
Scenario: Riverwalk Rehab, a Skilled Nursing Facility, submitted a claim to Haven Health Care for Mr. Benson's admission, following his transfer after a ten (10) day stay at Marco General Hospital. Haven Health submitted an encounter to the EDS using TOB 21X, Revenue Code 0022, and the required Occurrence Span Code of '70', which indicated Mr. Bensons' inpatient hospital stay of three (3) days or greater. The EDS rejected the encounter with error code 21925 because it did not include the Occurrence Code of '50', which is required for each service line submitted for Revenue Code 0022.			
22405	Occurrence Code 55 & DOD Required	Reject	When patient discharge status code is 20 (expired), 40 (expired at home), 41 (expired in a medical facility), or 42 (expired – place unknown), submitter must ensure that Occurrence Code 55 and the date of death are present.
Scenario: Gentle HealthCare submitted a final claim to Monument Medical Health Plan for Mr. G. Barnes, who expired on 9/15/2013. Monument Medical Health submitted and encounter to the EDS with a patient discharge status code of 41 in Loop 2300 CL103, but the Occurrence Code and Date of Death (occurrence code date) were not provided. The EDS rejected the encounter on the MAO-002 Report with error code 22405.			
17100	DOS Required for HH Encounter	Reject	Home Health encounters submitted with Revenue Codes 42X-44X and 55X-59X must contain dates of service for the revenue code line.
Scenario: Tympany Home Health submitted an encounter to the EDS for physical therapy services (Revenue Code 42X) provided during a Home Health episode of care to Mrs. Waterman from August 3, 2013 to August 31, 2013. The encounter was rejected with error code 17100 because, although the dates of service were populated on the encounter header level, the revenue code line did not contain the physical therapy service dates.			
00175	Verteporfin	Reject	Encounters submitted with TOB 13X or 85X for Ocular Photodynamic Tomography with Verteporfin must contain the same dates of service for the combination of these services, with the appropriate ICD-9 and ICD-10 diagnosis codes. Submitter must also ensure that the procedures are valid for the dates of service.
Scenario: Dr. Cuff conducted an OPT with Verteporfin (J3396 and 67225) for Mr. Jay Bird as treatment for Mr. Bird's diagnosis of atrophic macular degeneration (362.51). The encounter was submitted to the EDS by Strideways Health and rejected because the diagnosis of 362.51 should not be identified for the service submitted on the encounter.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III (CONTINUED)

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
00750	Service(s) Not Covered Prior To 4/1/2013	Reject	Encounters submitted for Ventricular Assist Devices (VADs) supplies/accessories with procedure code Q0507, Q0508, or Q0509 must contain dates of service on or after 04/01/2013
Scenario: Dr. Zhivago's office submitted a claim to Healthy Heart Health Plan for a battery and battery charger provided to Mr. Joe Schmeaux following the attachment of his VAD on February 3, 2013. Healthy Heart submitted an encounter to the EDS using Q0507. The EDS rejected the encounter with error code 00750 because Q0507 was not an effective code for DOS prior to 4/1/2013.			
22390	HIPPS Code Required for SNF/HH	Informational	Encounters must contain HIPPS codes when submitted with TOB 18X or 21X and Revenue Code 0022 or TOB 32X and Revenue Code 0023.
Scenario: Lamplight Home Health submitted an encounter to the EDS containing TOB 32X (Home Health – Inpatient), Revenue Code 0023, and procedure code G0154(x2). The encounter did not contain a HIPPS code on the Revenue Code 0023 service line. The EDS returned the encounter with error code 22390, because all Home Health encounters must be submitted with appropriate HIPPS codes.			
22395	HIPPS Code Conflicts with Revenue Code	Informational	Encounters must contain the appropriate HIPPS code for the service submitted. Revenue Code 0022 must contain appropriate SNF HIPPS codes. Revenue Code 0023 must contain appropriate HH HIPPS codes.
Scenario: Pink Lady Nursing Care submitted a claim to Aurelia Health Plan for SNF services provided for Ms. Jamella Fantastic. Aurelia Health Plan submitted the encounter to the EDS with TOB 21X, Revenue Code 0022 and HIPPS code HAEK2. The EDS returned the encounter with error code 22395, because the HIPPS code populated on the encounter indicated a Home Health service instead of a Skilled Nursing Facility service.			
22400	HP Qualifier Must Exist for HIPPS Code	Informational	Encounters submitted with TOB 18X or 21X and Revenue Code 0022 or TOB 32X and Revenue Code 0023 must contain a value of 'HP' in the SV202-1 element for HIPPS codes.
Scenario: Serenity Care Nursing submitted a claim to Universal Medical Health Plan for Mr. Bacchus' two (2) week stay at their Skilled Nursing Facility. Universal Medical Health Plan submitted the encounter to the EDS with the appropriate HIPPS codes; however, the qualifier was populated with 'HC' (procedure code qualifier).			
22410	Invalid Service(s) for TOB	Reject	Encounters submitted for Ventricular Assist Devices (VADs) supplies and accessories with procedure codes must only contain specific bill types (12X, 13X, 22X, 23X, 32X, 33X, 34X, 74X, or 85X). **Note:** TOB 33X is not applicable for DOS on or after 10/1/2013
Scenario: Dr. Pandora submitted a claim to Healthy Heart Health Plan for wound care and dressings provided after Mr. Jingleheimer's pacemaker insertion. The encounter was submitted to the EDS with TOB 14X. The encounter was rejected with error code 22410, because VAD supplies and accessories cannot be submitted with this bill type.			
22415	Revenue code 0274 Required	Reject	Encounters submitted for Ventricular Assist Devices (VADs) supplies/accessories with procedure code Q0507, Q0508, or Q0509 must contain Revenue Code 0274 and the appropriate bill types (12X, 13X, 22X, 23X, 32X, 33X, 34X, 74X, or 85X).
Scenario: Karma Health submitted an encounter to the EDS for VAD replacement leads using Revenue Code 0022. The encounter was rejected with error code 22415 because Revenue Code 0274 is the only appropriate code for submission of VAD supplies and accessories.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III (CONTINUED)

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
22420	TOB 33X Invalid for DOS	Reject	Encounters submitted with dates of service (DOS) on or after 10/01/2013 must not contain TOB 33X.
Scenario: Strong's Home Care submitted an encounter with TOB 33X (Home Health – Outpatient) to the EDS for Home Health services provided for Mr. V. Triumph from November 3, 2013 through November 18, 2013. The EDS rejected the encounter and returned an MAO-002 report with error code 22420, because TOB 33X was deactivated for all DOS on or after October 1, 2013.			
18500	Multiple CPT/HCPCS for Same Service	Informational	Encounters can not be submitted with multiple procedure codes to identify the same service/procedure.
Scenario: ProHealth submitted an encounter to the EDS with procedure code 15839 (labiaplasty) performed on Ms. Cross on November 13, 2013. The EDS returned an MAO-002 report to ProHealth with error code 18500 because ProHealth had already submitted another encounter for the same dates of service for Ms. Cross with procedure code 56620 (labiaplasty).			
20500	Invalid DOS for Rev Code Billed	Reject	Encounter's Revenue Code service date must be within the range of the procedure service line DOS when submitting: **a**)TOB 71X, 75X, or 77X with a valid Revenue Code; **b**) Revenue Code 054X with TOBs 13X, 22X, 23X, 83X, or 85X; **c**) Revenue Codes 042X, 43X, 044X, or 047X with TOBs 12X, 13X, 22X, 23X, 74X, or 83X; **d**) Revenue Code 047X with TOB 34X; or **e**) Revenue Codes within the range of 0300-0319 with HCPCS Codes 78267, 78268,80002-89399, or G0000-G9999 and TOBs 13X, 14X, 23X, 72X, 83X, or 85X
Scenario: Pink Acres Health Clinic submitted a claim to Way Out Health Plan for behavioral health services provided to Cookie Triton from March 26, 2013 through April 12, 2013. Way Out Health Plan submitted an encounter to the EDS with TOB 71X and Revenue Code 0900 with procedure service line DOS of March 26th – April 12th and Revenue Code service dates of April 26th – May 12th. The EDS rejected the encounter because the Revenue Code service dates were not valid for the dates of the service provided.			
21979	Charges for Rev Code 0022 Must Be Zero	Reject	For encounters submitted with TOB 18X or 21X and Revenue Code 0022, the billed amount (Loop 2400 SV203) and non-covered charge amount (Loop 2400 SV207) should equal zero when these fields are populated for the Revenue Code service line.
Scenario: Mohair Nursing Camp submitted a claim to Fancy Free Health Plan for services provided to Curly Sue Skumptik. Fancy Free Health Plan submitted an encounter for the services to the EDS containing a billed amount of $240.00 on the Revenue Code 0022 service line. The EDS rejected the encounter and returned an MAO-002 Report containing error code 21979 because the Revenue Code service line billed amount and non-covered charge amounts must be either blank or equal to zero.			
98315	Linked Chart Review Duplicate	Reject	Linked Chart Review encounters cannot be submitted where the HICN, Associated ICN, header DOS, diagnosis code(s) and TOB contain the exact same values as another Chart Review encounter already present within the EODS.
Scenario: Sequoia Health Plan conducted an audit of Langhorne Hospital and discovered an encounter previously submitted to the EDS contained an unnecessary diagnosis code. On 04/01/2014, Sequoia Health Plan submitted a linked chart review encounter to the EDS containing the associated ICN of the original encounter to identify the unnecessary diagnosis code. On 05/01/2014 Sequoia Health Plan inadvertently submitted the exact same linked chart review encounter to the EDS. The EDS rejected the second submission of the linked chart review encounter because no changes were detected between the two linked chart review encounters.			

TABLE 17 – EDPS EDITS PREVENTION AND RESOLUTION STRATEGIES – PHASE III (CONTINUED)

GENERAL EDPS EDITS			
Edit #	**Edit Description**	**Edit Disposition**	**Comprehensive Resolution/Prevention**
98320	Chart Review Duplicate	Reject	Unlinked Chart Review encounters cannot be submitted where the HICN, header DOS, diagnosis code(s) and TOB contain the exact same values as another Chart Review encounter already present within the EODS.
Scenario: Ohio Health Plan conducted an audit of Cincinnati City Hospital and discovered an encounter not previously submitted to the EDS required an additional diagnosis code. On 03/15/14, Ohio Health Plan submitted an unlinked chart review encounter to the EDS to include the additional diagnosis code. On 06/01/14, Ohio Health Plan submitted the same unlinked chart review encounter to the EDS due to a clerical error. The EDS rejected the second submission of the unlinked chart review encounter because the EDS detected no changes between the two unlinked chart review encounters.			

11.0 Submission of Default Data in a Limited Set of Circumstances

MAOs and other entities may submit default data in a limited set of circumstances, as identified and explained in Table 18. MAOs and other entities cannot submit default data for any circumstances other than those listed in the table below. CMS will use this interim approach for the submission of encounter data. In each circumstance where default information is submitted, MAOs and other entities are required to indicate in Loop 2300, NTE01='ADD', NTE02 = the reason for the use of default information. If there are any questions regarding appropriate submission of default encounter data, MAOs and other entities should contact CMS for clarification. CMS will provide additional guidance concerning default data, as necessary.

11.1 Default Data Reason Codes (DDRC)

Loop 2300, NTE02 allows for a maximum of 80 characters and one (1) iteration, which limits the submission of default data to one (1) message per encounter.

In order to allow the population of multiple default data messages in the NTE02 field, CMS will use a three (3)-digit default data reason code (DDRC), which will map to the full default data message in the EDS.

MAOs and other entities may submit multiple DDRCs with the appropriate three (3)-digit DDRC. Multiple DDRCs will be populated in a stringed sequence with no spaces or separators between each DDRC (i.e., 036040048). Table 18 provides the CMS approved situations for use of default data, the default data message, and the default data reason code.

TABLE 18 – DEFAULT DATA

*DEFAULT DATA	DEFAULT DATA MESSAGE (NTE02)	DEFAULT DATA REASON CODE
Rejected Line Extraction	REJECTED LINES CLAIM CHANGE DUE TO REJECTED LINE EXTRACTION	**036**
Medicaid Service Line Extraction	MEDICAID CLAIM CHANGE DUE TO MEDICAID SERVICE LINE EXTRACTION	**040**
EDS Acceptable Anesthesia Modifier	MODIFIER CLAIM CHANGE DUE TO EDS ACCEPTABLE ANESTHESIA MODIFIER	**044**
Default NPI for atypical, paper, and 4010 claims	NO NPI ON PROVIDER CLAIM	**048**
Default EIN for atypical providers	NO EIN ON PROVIDER CLAIM	**052**
Chart Review Default Procedure Codes	DEFAULT PROCEDURE CODES INCLUDED IN CHART REVIEW	**056**
True COB Default Adjudication Date	DEFAULT TRUE COB PAYMENT ADJUDICATION DATE	**060**

12.0 Tier II Testing

CMS developed the Tier II testing environment to ensure that MAOs and other entities have the opportunity to test a more inclusive sampling of their data. MAOs and other entities that have obtained end-to-end certification may submit Tier II testing data.

CMS encourages MAOs and other entities to utilize the Tier II testing environment when they have questions or issues regarding edits received on EDFES Acknowledgement Reports or MAO-002 Encounter Data Processing Status reports; and when they have new submission scenarios that they wish to test prior to submitting to production.

MAOs and other entities may submit chart review, correct/replace, or void/delete encounters to the Tier II testing environment only when the encounters are linked to previously submitted and accepted encounters in the Tier II testing environment.

Encounter files submitted to the Tier II testing environment must comply with the TR3, CMS Edits Spreadsheet, and the CMS EDS Companion Guides, as well as the following requirements:

- Files must be identified using the Authorization Information Qualifier data element “Additional Data Identification” in the ISA segment (ISA01= 03).
- Files must be identified using the Authorization Information data element to identify the “Tier II indicator” in the ISA segment (ISA02= 8888888888).
- Files must be identified as “Test” in the ISA segment (ISA15=T).
- Submitters may send multiple Contract IDs per file
- Submitters may send multiple files for a Contract ID, as long as each file does not exceed 2,000 encounters per Contract ID
- If any Contract ID on a given file exceeds 2,000 encounters during the processing of the file, the entire file will be returned

As with production encounter data, MAOs and other entities will receive the TA1, 999, and 277CA Acknowledgement Reports and the MAO-002 Reports.

While not required, MAOs and other entities are strongly encouraged to correct errors identified on the reports and resubmit data.

13.0 EDS Acronyms

Table 19 below outlines a list of acronyms that are currently used in EDS documentation, materials, and reports distributed to MAOs and other entities. This list is not all-inclusive and should be considered a living document; as acronyms will be added, as required.

TABLE 19 – EDS ACRONYMS

ACRONYM	DEFINITION
A	
ASC	Ambulatory Surgery Center
C	
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CAS	Claim Adjustment Segments
CC	Condition Code
CCI	Correct Coding Initiative
CCN	Claim Control Number
CEM	Common Edits and Enhancement Module
CMG	Case Mix Group
CMS	Centers for Medicare & Medicaid Services
CORF	Comprehensive Outpatient Rehabilitation Facility
CPO	Care Plan Oversight
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSC	Claim Status Code
CSCC	Claim Status Category Code
CSSC	Customer Service and Support Center
D	
DDRC	Default Data Reason Code
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Carrier
DOB	Date of Birth
DOD	Date of Death
DOS	Date(s) of Service
E	
E & M or E/M	Evaluation and Management
EDDPPS	Encounter Data DME Processing and Pricing Sub-System
EDFES	Encounter Data Front-End System
EDI	Electronic Data Interchange
EDIPPS	Encounter Data Institutional Processing and Pricing Sub-System
EDPPPS	Encounter Data Professional Processing and Pricing Sub-System
EDPS	Encounter Data Processing System
EDS	Encounter Data System
EIC	Entity Identifier Code
EODS	Encounter Operational Data Store
ESRD	End Stage Renal Disease

TABLE 19 – EDS ACRONYMS (CONTINUED)

ACRONYM	DEFINITION
F	
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year
H	
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HICN	Health Information Claim Number
HIPAA	Health Insurance Portability and Accountability Act
HIPPS	Health Insurance Prospective Payment System
I	
ICD-9CM/ICD-10CM	International Classification of Diseases, Clinical Modification (versions 9 and 10
ICN	Interchange Control Number
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
M	
MAC	Medicare Administrative Contractor
MAO	Medicare Advantage Organization
MTP	Multiple Technical Procedure
MUE	Medically Unlikely Edits
N	
NCD	National Coverage Determination
NDC	National Drug Codes
NPI	National Provider Identifier
NCCI	National Correct Coding Initiative
NOC	Not Otherwise Classified
NPPES	National Plan and Provider Enumeration System
O	
OCE	Outpatient Code Editor
OIG	Officer of Inspector General
OPPS	Outpatient Prospective Payment System
P	
PACE	Program for All-Inclusive Care for the Elderly
PHI	Protected Health Information
PIP	Periodic Interim Payment
POA	Present on Admission
POS	Place of Service
PPS	Prospective Payment System

TABLE 19 – EDS ACRONYMS (CONTINUED)

ACRONYM	DEFINITION
R	
RAP	Request for Anticipated Payment
RHC	Rural Health Clinic
RNHCI	Religious Nonmedical Health Care Institution
RPCH	Regional Primary Care Hospital
S	
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SSA	Social Security Administration
T	
TARSC	Technical Assistance Registration Service Center
TCN	Transaction Control Number
TOB	Type of Bill
TOS	Type of Service
TPS	Third Party Submitter
V	
VC	Value Code
Z	
ZIP Code	Zone Improvement Plan Code

REVISION HISTORY

VERSION	DATE	DESCRIPTION OF REVISION
2.1	9/9/2011	Baseline Version
3.0	11/16/2011	Release 1
4.0	12/9/2011	Release 2
5.0	12/20/2011	Release 3
6.0	3/8/2012	Release 4
7.0	5/9/2012	Release 5
8.0	6/22/2012	Release 6
9.0	8/31/2012	Release 7
10.0	9/26/2012	Release 8
11.0	11/2/2012	Release 9
12.0	11/26/2012	Release 10
13.0	12/21/2012	Release 11
14.0	01/21/2013	Release 12
15.0	02/26/2013	Release 13
16.0	03/20/2013	Release 14
17.0	04/15/2013	Release 15
18.0	05/20/2013	Release 16
19.0	06/24/2013	Release 17
20.0	07/25/2013	Release 18
21.0	09/26/2013	Release 19
22.0	10/25/2013	Release 20
23.0	11/22/2013	Release 21
24.0	12/27/2013	Release 22
25.0	01/20/2014	Release 23
26.0	02/21/2014	Release 24
27.0	03/18/2014	Release 25

REVISION HISTORY (CONTINUED)

VERSION	DATE	DESCRIPTION OF REVISION
28.0	04/28/2014	Release 26
29.0	05/30/2014	**Section 13.0, Table 19** – Updated EDS Acronyms table