Frequently Asked Questions (FAQs) About Medicare Advantage Organizations' (MAOs) Encounter Data Submission and Processing

Contents

I. Submission Deadlines

I.1. What is the cutoff time for RAPS and EDS submission deadlines?

All risk adjustment data (Risk Adjustment Processing System Data and Encounter Data System Data) that will be included in risk score runs need to be submitted by 8pm ET of the deadline for submission date that is relevant to the specific risk score run. For example, for the payment year 2019 final risk score run, the deadline for submission was January 31, 2020 and all risk adjustment data should have been submitted by 8:00 PM ET on January 31, 2020. The deadlines for the risk score runs are announced via Health Plan Management System (HPMS) memo on a periodic basis.

Source: CMS HPMS Memo with subject "Deadline for Submitting Risk Adjustment Data for Use in Risk Score Calculation Runs for Payment Years 2019, 2020, and 2021" (May 22, 2019)

I.2. Where can MAOs and other entities find information on submission deadlines and payment dates?

Submission deadlines are released through the Health Plan Management System (HPMS) Memo distribution system. Historically, the submission deadline memos are released periodically throughout the year, and can be located by searching the HPMS memo system using the terms "Deadline for Submitting Risk Adjustment Data". Payment dates are announced monthly through HPMS in the Medicare Advantage Prescription Drug (MARx) Plan Payment Letter.

Source: User Group Q&A Documentation from April 27, 2017

I.3. What are the submission timelines and deadlines for PACE?

The submission deadlines for Programs of All-Inclusive Care for the Elderly (PACE) are the same as for all MAOs. Submission deadlines are released through the Health Plan Management System (HPMS) Memo distribution system. Historically, the submission deadline memos are released periodically throughout the year and can be located by searching the HPMS memo system using the terms "Deadline for Submitting Risk Adjustment Data". Payment dates are announced monthly through HPMS in the Medicare Advantage Prescription Drug (MARx) Plan Payment Letter.

Source: User Group Q&A Documentation from February 16, 2017

II. General Submission Questions

II.1. What connectivity options can MAOs and other entities use to submit RAPS and EDS files?

MAOs can use the following options to submit Risk Adjustment Processing System (RAPS) and Encounter Data System (EDS) files:

- Connect:Direct
- Secure File Transfer Protocol (SFTP)
- CMS Enterprise File Transfer

Please check the "Onboarding to Submit and Transfer Files with CMS Systems" section on the Customer Service and Support Center (CSSC) Operations website at www.csscoperations.com for more information.

Source: Encounter Data Submission and Processing Guide. Chapter 4.2.2

II.2. How can MAOs and other entities become certified to submit encounter data?

Please check the "Onboarding to Submit and Transfer Files with CMS Systems" section on the Customer Service and Support Center (CSSC) Operations website at www.csscoperations.com for more information https://www.csscoperations.com/internet/cssc4.nsf/docsCatHome/CSSC%20Operations

Source: User Group Q&A Documentation from April 27, 2017

II.3. Can CMS provide a default NPI for MAOs and other entities to use when submitting unlinked chart review records?

No, CMS does not provide a default National Provider Identifier (NPI) for unlinked chart review records. CMS released clarifying guidance on NPI fields in the December 21, 2017, Health Plan Management System (HPMS) memo "Encounter Data Record Submissions—NPI Submission Guidance—Frequently Asked Questions (FAQ)." This information is also included in Section 3.5.2 of the Encounter Data Submission and Processing Guide. Default NPIs can be used when the provider is considered atypical, when the service was provided outside of the country by a foreign provider, or when a beneficiary submits a claim for member reimbursement.

Source: User Group Q&A Documentation from March 23, 2017

II.4. Should MAOs and other entities submit denied claims for processing?

MAOs and other entities should submit encounter data records for each service or item covered by the plan and provided to an enrollee, regardless of payment status of the claim.

Source: User Group Q&A Documentation from March 23, 2017

II.5. What are the acceptable TOB values for EDS Submissions?

The Encounter Data System (EDS) accepts the following Type of Bill (TOB): 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 28X, 32X, 33X, 34X, 41X, 43X, 71X, 72X, 73X, 74X, 75X, 76X, 77X, 79X, 81X, 82X, 83X, 85X, 89X.

Source: User Group Q&A Documentation from February 16, 2017

Note: TOB value 43X was omitted in the user group slides. TOB value 43X is acceptable for encounter data submissions.

II.6. How is the EDPS ICN assigned?

If an Encounter Data Record (EDR) is accepted, the 277CA will provide the Internal Control Number (ICN) assigned to that encounter. The ICN segment of the 277CA for the accepted encounter will be located in 2200D REF segment, REF01=IK and REF02=ICN. The ICN is a unique 13 - digit number. For more information please review the Encounter Data Submission and Processing Guide.

Source: User Group Webinar on August 15, 2019

II.7. Can the MAO or other entity populate the encounter data record with demographic information related to age, name, and sex that it knows to be correct, or should it only submit data sent to the MAO or other entity by the provider (which might be incorrect)?

The Encounter Data Record (EDR) is a report to CMS from the MAO or other entity about an item or service received by the plan enrollee. The MAO or other entity should populate the EDR with demographic information related to age, name, and sex using data that it knows to be correct, instead of submitting to CMS incorrect data that a provider submitted to the MAO or other entity on a claim for payment.

Source: CMS HPMS Memo with subject "Guidance for Encounter Data Submission" (October 30, 2017)

II.8. CMS guidance allows MAOs and other entities, in certain circumstances, to add modifiers to lines within a record to bypass the line-level duplicate check, when each line represents a unique service. Is it acceptable for MAOs and other entities to modify the encounter on the backend for EDPS submission purposes? Or does the billing provider need to rebill with those modifiers?

Since the Encounter Data Record (EDR) is a report to CMS from the MAO or other entity, and not a provider bill, the MAO or other entity can report data on the EDR that was not submitted by a provider, per CMS guidance. See Tables 1 and 2 below for CMS' guidance on how to bypass the line-level duplicate check in the back-end Encounter Data Processing System (EDPS) when the MAO or other

entity has determined that the lines represent distinct items or services, but will be identified as duplicates by the CMS line-level duplicate logic. The bypass logic described is not intended to be instructions for how providers should bill the MAO or other entity.

MAOs and other entities are permitted to use the CMS-specified procedure code modifiers so that the duplicate logic is bypassed. Another option for preventing a duplicate line rejection is to include the actual payment amount on each line (assuming the actual payment amount for each line differs).

Table 1. EDPS - Data Elements Used to Identify Duplicate Lines (Edit 98325)

Professional/Durable Medical Equipment	Institutional – Outpatient
Beneficiary identifier	Beneficiary identifier
Date of Service	Date of Service
Procedure Code and up to 4 modifiers	Procedure Code and up to 4 modifiers
Paid Amount (2320 AMT02/2430 SVD02)	Paid Amount (2320 AMT02/2430 SVD02)
Billed Amount	Billed Amount
Place of Service (POS)	Type of Bill (TOB)
Rendering Provider NPI	Billing Provider NPI
	Revenue Code

Table 2. EDPS - Data Elements Used in Bypass Logic for Edit 98325

Professional/Durable Medical Equipment	Institutional – Outpatient
59 - Distinct Procedural Service	59 - Distinct Procedural Service
76 - Repeat Procedure by Same Physician	62 - Two Surgeons
77 - Repeat Procedure by Another Physician	66 - Surgical Team
91 - Repeat Clinical Diagnostic Laboratory Test	76 - Repeat Procedure by Same Physician
	77 - Repeat Procedure by Another Physician
	91 - Repeat Clinical Diagnostic Laboratory Test

Note: There is an additional by-pass condition for Ambulatory Surgery Center (ASC) Fee Schedule EDRs: populate the field "Multiple Procedure Discount Indicator" with a value of "1" in order to by-pass the duplicate line edit.

In situations in which none of the data elements included in the Encounter Data System's (EDS') duplicate logic check are changing, but other data elements on a line (edit 98325) or record (edit 98300) may have changed, CMS recommends that the subsequent encounter data record be submitted as a replacement or that the previously submitted and accepted encounter data record be voided and a new original record resubmitted in order to prevent rejection for duplicate submission.

Source: CMS HPMS Memo with subject "Guidance for Encounter Data Submission" (October 30, 2017)

II.9.   If the claim submitted by the provider to the MAO or other entity is still an original claim (for example, the provider needed to submit additional pre-authorization information, but the claim is still considered an original or the MAO or other entity has made claims adjustments in our system, but the provider did not submit a new claim), is it acceptable for the MAO or other entity to modify the claim frequency code of the encounter data record?

Since the Encounter Data Record (EDR) is a report to CMS from the MAO or other entity, the MAO or other entity may report information to CMS that was not provided to the MAO or other entity by the provider, per CMS guidance. In the example provided, the provider has submitted one claim to the MAO or other entity, but the MAO or other entity needs to make an adjustment on the EDR that it has sent to

CMS. The MAO or other entity may adjust its EDR for this encounter, as it is a report to CMS regarding a specific item or service received by the enrollee. We recognize that plans may want to track their data sources for populating an EDR for data integrity purposes, and for these purposes CMS recommends as a best practice that MAOs or other entities track when and why provider supplied information is modified for submission to the Encounter Data System (EDS). Please see the Health Plan Management System (HPMS) memo entitled Guidance regarding Encounter Data Submission - Edit 98300 – "Exact Inpatient Duplicate" released October 4, 2017, for additional information.

Source: CMS HPMS Memo with subject "Guidance for Encounter Data Submission" (October 30, 2017)

II.10. If an MAO or other entity voids an accepted encounter containing rejected lines, and then submits a new, original encounter containing only the previously rejected (now corrected) lines, will the data submitted on the voided encounter be lost?

Yes. Data from a voided encounter will be considered inactive. If an original, accepted encounter containing rejected lines is voided, the submitter should submit a new original encounter to include both previously accepted lines and corrected data for rejected lines.

Source: User Group Q&A Documentation from January 19, 2017

II.11. If the MAO-002 comes back with the encounter accepted but some of the service lines rejected, should we consider the encounter as rejected, requiring a void and replacement of the whole encounter?

If there is no reject edit at the header level and at least one of the lines is accepted, then the record will be accepted. The encounter is valid and does not require a void or a replacement record to be submitted. Diagnoses associated with the rejected lines will not be considered for risk adjustment. In order to resubmit rejected lines, submitters can use the same header information and include only the corrected, previously rejected service lines. NOTE: Submitters should not submit previously accepted lines again, as they will be rejected as duplicates. More information on header and service line rejections for encounter data can be found in Chapter 6 of the Encounter Data Submission and Processing Guide.

Source: MAO Help Desk Inquiry answered in October 2019

III. Voiding and Replacing Records

III.1. Should MAOs and other entities submit subsequent replacement encounters using the ICN of the original encounter or the ICN of the previous replacement encounter?

MAOs and other entities should submit a replacement Encounter Data Record (EDR) using the Internal Control Number (ICN) from the most recently accepted submission for the record. In the example provided in the question, the subsequent replacement EDR should reference the ICN of the previously accepted replacement EDR.

Source: User Group Q&A Documentation from January 19, 2017

III.2. Will MAOs need to resubmit encounters to account for code set updates, or will CMS reprocess those encounters impacted by these updates?

If EDRs were rejected because of the inclusion of codes that are not yet valid or are no longer valid at the time of service, then the MAO would need to resubmit these records.

Source: User Group Q&A Documentation from January 19, 2017

III.3. For replacement and void encounter data, if one of the key data fields is different from the original claim submitted, should the encounter be submitted as an original?

If one of the key fields is different from the original record submitted, MAOs should void the originally accepted record and re-submit as an original record.

Source: User Group Webinar on April 18 2019

IV. Adding and Deleting Diagnoses

IV.1. We need to add or delete diagnoses from an already-submitted encounter data record. Are we allowed to change the diagnoses from what was submitted on the bill, or do we need to have the provider rebill the plan?

Since the Encounter Data Record (EDR) is a report to CMS from the MAO or other entity about an item or service received by the plan enrollee, the MAO or other entity can report to CMS the data they know to be correct relative to the provision of that specific item or health care service being reported. Per CMS guidance, diagnoses reported to CMS for risk adjustment must meet risk adjustment rules, including that they must be supported by the medical record. As with Risk Adjustment Processing System (RAPS), if an MAO or other entity determines that diagnoses need to be deleted because they are not supported by the medical record, there are a number of ways to delete diagnoses from the encounter data system, including chart review delete records, replacing with an EDR with the unsupported diagnoses removed, or voiding an EDR.

Source: CMS HPMS Memo with subject "Guidance for Encounter Data Submission" (October 30, 2017)

IV.2. How can MAOs and other entities delete diagnosis codes from the Encounter Data System (EDS)?

MAOs and other entities can delete diagnoses from encounter data records by submitting void, replacement, or chart review delete records. A void record will delete all diagnoses on the encounter or chart review record that it is linked to; a replacement record will delete any diagnosis code on the original record, but not on the replacement record; and a chart review delete will delete diagnosis codes that are listed on the chart review delete record from the record that the chart review delete is linked to.

Voids and replacements must be submitted as the same type of record as they are trying to replace or void. For example, if a chart review record is being replaced, the replacement record must also be indicated as a chart review. However, a chart review delete may be linked to either an encounter or chart review record.

In all cases a record that is deleting diagnoses must be linked. An unlinked chart review record does not reference the Internal Control Number (ICN) of a previously submitted and accepted record. Because the ICN is not referenced, CMS cannot determine which record the unlinked chart review record would be deleting from. Unlinked chart review records attempting to delete diagnoses will be rejected with edit code 00805 – "Deleted Diagnosis Code Not Allowed." Furthermore, a diagnosis delete record deletes only the diagnoses from the record it is linked to, and not from other records. In other words, for each instance of a diagnosis to be deleted, MAOs or other entities must submit a separate Linked Chart Review Record (CRR) Delete. Additional information is available in Encounter Data Submission and Processing Guide, Chapter 2.3.

Source: User Group Q&A Documentation from April 27, 2017

V. Procedure Codes

V.1. Where can MAOs locate a complete list of CMS-acceptable HCPCS procedure and modifier codes?

MAOs can access a full list of Level II alphanumeric Healthcare Common Procedure Coding System (HCPCS) procedure and modifier codes, their long and short descriptions, and applicable Medicare administrative, coverage and pricing data at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

Source: User Group Q&A Documentation from January 19, 2017

V.2. Will the EDS accept service lines with "S" and "G" procedure codes?

Yes, Encounter Data System (EDS) will accept service lines with "S" and "G" procedure codes. There is a link on the Customer Service and Support Center (CSSC) Operations website that provides a list of the procedure codes that are acceptable for Encounter Data Processing. Under Medicare Advantage Encounter Data and Risk Adjustment Processing System (RAPS) Data click on Edits, and then click on Reference Code Tool.
https://protect2.fireeye.com/url?k=998d10eb-c5d819f8-998d21d4-0cc47adb5650-833c29311b84d7fd&u=https://apps.csscoperations.com/errorcode/ReferenceCodeLookup?method=codeLookup

Source: User Group Q&A Documentation from January 19, 2017

V.3. How should anesthesia claims with procedure code 01996 be submitted?

An edit is triggered if an anesthesia modifier (AA, AD, QK, QS, QX, QY or QZ) is submitted with Procedure Code 01996. If 01996 is submitted with one of these modifiers, the edit states the units or basis of measurement code must be 'MJ'. In order to avoid this edit, MAOs and other entities should not submit anesthesia modifiers with procedure code 01996.

Source: User Group Webinar on June 20, 2019

V.4. How should MAOs report annual wellness visits to CMS?

To the extent that the MAO provides more than one annual wellness visit per year to a beneficiary, the MAO may submit the data to the RAPS and encounter data systems. For risk score calculation all diagnoses that meet risk adjustment criteria are considered. For information on the filtering rules applicable to encounter data, please see the December 22, 2015 HPMS memo with subject line "Final Encounter Data Diagnosis Filtering Logic".

Source: MAO Help Desk Inquiry answered in November 2019

V.5. How should Medicare Advantage plans submit encounters for a supplemental gym membership?

MAOs and other entities should submit encounter data on supplemental services falling outside of the Medicare-covered benefits to the extent that the supplemental services are submitted for payment to the MAO or other entity using the 5010 837 claims format or if the MAO or other entity has sufficient information to create an encounter data record.

Source: MAO Help Desk Inquiry answered in September 2019

V.6. Can MAOs and other entities submit End Stage Renal Disease (ESRD) information on behalf of dialysis centers?

No, MAOs and other entities may not submit information on behalf of dialysis centers. CMS obtains information regarding the start of dialysis and transplant status from reports that dialysis facilities directly submit to CMS.

Source: User Group Q&A Documentation from October 26, 2017

VI. Submitting Beneficiary Data

VI.1. How should submitters identify names containing special characters; for example, a name with the tilde character over the 'n'?

Special characters should be excluded when submitting data to Encounter Data System (EDS).
Source: User Group Q&A Documentation from January 19, 2017

VI.2. Where can we find guidance on how CMS implemented the MBI initiative for RAPS and EDS?

CMS issued Medicare Beneficiary Identifier (MBI) Implementation Guidance on December 22, 2017. Please refer to the December 22, 2017 CMS Health Plan Management System (HPMS) memo, "Updates to the Encounter Data System and Risk Adjustment Suite of Systems to Accommodate the New Medicare Card Project" for guidance on how these systems implemented the MBI initiative. In addition, CMS released two additional HPMS memos on MBI implementation, the December 10, 2018 HPMS memo titled, "Updates to the Risk Adjustment Suite of Systems (RASS) for Delete Transactions using a Beneficiary Identifier" and the September 6, 2019 HPMS memo titled, "Risk Adjustment Suite of Systems (RASS) MBI Related Enhancements."

Source: User Group Q&A Documentation from October 26, 2017

VI.3. Since the transition to the new MBI on April 2, 2018, can MAOs and other entities submit deletions for dates of service (DOS) before April 2, 2018 using the HICN?

Yes. For both the Encounter Data System (EDS) and Risk Adjustment Processing System (RAPS), MAOs and other entities will be able to submit the Health Insurance Claim Number (HICN) on deletes during and after the Medicare Beneficiary Identifier (MBI) transition period. For EDS this can be done for encounter data records and chart review records that were originally submitted using either the HICN or MBI. Effective January 8, 2019, RAPS will accept either the MBI, HICN, or RRB where applicable on delete transactions regardless of which beneficiary identifier was submitted on the original add transaction. For further information, please see the December 22, 2017 CMS Health Plan Management System (HPMS) memo, "Updates to the Encounter Data System and Risk Adjustment Suite of Systems to Accommodate the New Medicare Card Project" and the December 10, 2018 CMS HPMS memo titled, "Updates to the Risk Adjustment Suite of Systems (RASS) for Delete Transactions using a Beneficiary Identifier".

Source: User Group Webinar on January 15, 2019

VI.4. Can a Linked Chart Review Record use either the HICN or MBI when matching to an encounter (if the encounter uses the other beneficiary identifier)?

Yes, as long as the member is the same member, either the Health Insurance Claim Number (HICN) or the Medicare Beneficiary Identifier (MBI) may be reported. For example, if the encounter is submitted with the HICN and the linked Chart Review Record is submitted with the MBI, the linked Chart Review Record will be accepted.

Source: User Group Webinar on June 20, 2019

VI.5. When deleting EDPS data, should plans use the same beneficiary identifiers (i.e. HICN or MBI) used to submit the original data?

Plans may submit either the Medicare Beneficiary Identifier (MBI) or the Health Insurance Claim Number (HICN) on any adjustment, regardless of what identifier was used on the original submission.

Source: User Group Webinar on November 1, 2018

VII. Submitting Chart Review Records

VII.1. Can CMS provide a default procedure code for MAOs and other entities to use when submitting unlinked chart review records?

No, CMS does not provide default procedure codes for MAOs and other entities to use when submitting unlinked chart reviews.

Source: User Group Q&A Documentation from March 23, 2017

VII.2. Are chart review records with default procedure codes and default NPI eligible for risk adjustment?

Yes, at this time, all records with default procedure codes and/or a default National Provider Identifier (NPI), and that have diagnoses that pass the CMS filtering logic, are eligible for risk adjustment.
Source: User Group Q&A Documentation from March 23, 2017

VII.3. Does CMS use diagnosis codes submitted via an unlinked chart review for Risk Adjustment payments?

Yes, CMS does consider diagnosis codes for the risk score calculation that are submitted via unlinked chart reviews, provided the codes pass the filtering logic.
Source: User Group Webinar on January 17, 2019

VII.4. Does a linked chart review delete need a primary diagnosis code?

Yes, however, MAOs should include only the diagnosis codes they want to delete on linked chart review delete records. The primary diagnosis on a chart review is not required to match the primary diagnosis on the encounter it is associated with.
Source: User Group Webinar on April 19, 2018

VII.5. Are there restrictions on the number of chart review delete records submitted to the EDPS?

No. The Encounter Data Processing System (EDPS) has no restrictions related the number of chart review delete records submitted to the Encounter Data System (EDS). Please note that chart review delete records *must* include the Internal Control Number (ICN) of the record from which the delete chart review is deleting diagnoses, or it will be rejected.
Source: User Group Q&A Documentation from January 19, 2017

VII.6. If MAOs submit an unlinked CRR that corresponds to an accepted EDR, will it result in a duplicate error?

The Chart Review Record (CRR) will not be considered a duplicate of a previously accepted Encounter Data Record (EDR). If the CRR is a copy of previously accepted CRR, then the CRR will be considered a duplicate. Please refer to the ED and Risk Adjustment Processing System (RAPS) Webinar Topics Index (user group topics index) for more information on duplicate record processing from prior user group calls.
Source: User Group Webinar on August 15, 2019

VII7. An MAO submitted a CRR Add that was linked to an original EDR. The linked CRR Add was accepted. The MAO then submitted a replacement of the EDR, and it was accepted. Because the linked CRR Add was submitted for the original EDR, will those CRR Add diagnoses now be linked to the replacement EDR?

No, the diagnoses on the Chart Review Record (CRR) Add will not be linked to the replacement Encounter Data Record (EDR). However, the diagnoses on the CRR Add will still be considered for risk adjustment if they pass the CMS filtering logic. The information on a Linked CRR Add is still retained and goes through CMS' filtering process, even if the record that the CRR Add is linked to is voided or replaced.
Source: User Group Webinar on February 21, 2019

VIII. Submission Errors

VIII.1. How do MAOs and other entities access the CMS 5010 CEM Spreadsheet?

To access the CMS 5010 Claim Edits and Enhancement Module (CEM) Edits Spreadsheet, use the following steps:

1.   Click on https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017-Transmittals
2.   Key in '(EDI) Front End Updates' in the 'Filter On' box

3. Select Transmittal #
   - R1806OTN –Version EA20173V01 (Institutional)
   - R1865OTN-Version EB20181V01 (Professional)
   - R1947OTN-Version CE20182V01 (Durable Medical Equipment)
4. Click on the link(s) under 'Downloads' at the bottom of the page.

Source: [Encounter Data Submission and Processing Guide](#)

VIII.2. Can CMS clarify the logic for EDPS error 01405 - Sanctioned Providers?

This edit will be posted on Institutional encounters when the header "from" date of service is within the billing provider or rendering provider's (header only) sanction effective date and the sanction termination date received from Provider Enrollment, Chain, and Ownership System (PECOS). This edit will be posted on Professional encounters when the header "from" date of service is within the billing provider or rendering provider's (header and line) sanction effective date and the sanction termination date received from PECOS.

Source: User Group Q&A Documentation from [April 27, 2017](#)

VIII.3. Will the submission of duplicate diagnosis codes in the same EDR generate EDFES edit 255 - Diagnosis Code?

For Institutional records, Encounter Data Front End System (EDFES) edit 255 will not generate a rejection when the Principal Diagnosis code (qualifier ABK or BK) is duplicated in an Other Diagnosis code (qualifier ABF or BF) on the record. For Professional records, if the Principal Diagnosis code is duplicated on an Other Diagnosis code field, edit 255 does apply and will result in a rejection. When diagnosis codes are duplicated within the Other Diagnosis (ABF or BF) fields within a record, edit 255 does apply to both Institutional and Professional records.

Source: User Group Q&A Documentation from [January 19, 2017](#)

VIII.4. How does CMS determine a diagnosis code's highest level of specificity for a specific beneficiary when generating edit 255 'Diagnosis Code'?

To pass Encounter Data Front End System (EDFES) edits, diagnoses codes must be valid codes for the respective date of service and should be coded to the highest level of specificity, meaning to the maximum number of digits available for the codes, in the valid code set. The edits used are similar to those used in Original Medicare, so you may refer to the CMS Medical Learning Network (MLN) Publications *Medicare Billing: 837P and Form CMS-1500 (October 2016) and Medicare Billing: 837I and CMS Form 1450 (April 2016)*, which provide references to the relevant guidance in the "Medicare Claims Processing Manual" for guidance on coding specificity requirements.

Source: User Group Q&A Documentation from [January 19, 2017](#)

VIII.5. MAOs are receiving EDFES edit 178 "Submitted Charges" when the charges exceed $99,999.00. Can CMS provide a prevention or resolution strategy for this edit?

This edit applies to the header level on Professional records in the Encounter Data Front End System (EDFES). Given the current edit, CMS recommends splitting the Encounter Data Record (EDR) into two separate records. It is important to note that, in order to avoid a duplicate record rejection in the Encounter Data Processing System (EDPS), the submitter should also split the services (e.g., procedure code, modifier, etc.) along with the billed amount across multiple encounters. Assuming the services as well as the amounts are allocated across multiple EDRs, the duplicate edit will not be triggered since the data elements that are checked in the EDPS duplicate logic will differ across the EDRs.

Source: User Group Q&A Documentation from [January 19, 2017](#)

IX. MAO-004 Report

IX.1. How can MAOs submit questions regarding MAO-004 reports that they did not receive, but believe they should have?

MAOs and other entities can submit questions regarding missing MAO-004 Reports to encounterdata@cms.hhs.gov. If asking about specific records versus whole reports, please include the related Internal Control Numbers (ICNs) of the encounter(s) in question. Prior to submitting questions, please verify that reports are not in your established File Transfer Protocol (FTP) mailbox or are not available through the Medicare Advantage Prescription Drug User Interface (MARx UI).

If you believe an Encounter Data Record (EDR) is missing from the MAO-004, please check to make sure the EDR meets the criteria below.

- Does the data in question have a date of service of January 2014 or later?
- Is the encounter data record accepted at the header level by Encounter Data System (EDS), as reported on the MAO-002 report?
- Does the encounter data record pass the CMS published filtering logic for each specific encounter type under consideration– Professional, Outpatient, Inpatient?

If an encounter data record meets these criteria, all diagnoses on the record will be indicated as either allowed or disallowed and will also be designated as add, delete, or blank. Diagnoses marked as allowed and either add or blank are considered eligible for risk adjustment, however, not all eligible diagnoses map to an Hierarchical Condition Category (HCC) in the risk adjustment models.

Source: User Group Q&A Documentation from January 19, 2017

IX.2. When will an accepted encounter diagnosis not display on the MAO-004 Report?

Diagnosis codes on an accepted encounter data record will not be on the MAO-004 report if the encounter data record does not meet the Phase III version 3 MAO-004 production criteria stated in the December 20, 2017 Health Plan Management System (HPMS) memo with subject line "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17".

Source: CMS HPMS Memo with subject "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17" (December 20, 2017)

IX.3. How can MAOs or other entities determine which diagnosis codes are accepted on the Phase III MAO-004 Report?

The MAO-002 report indicates whether an encounter data record has been "Accepted" or "Rejected." The Phase III version 3 MAO-004 report includes diagnoses from almost all of the Encounter Data System (EDS) accepted records. The MAO-004 indicates whether the diagnoses are "Allowed" or "Disallowed" depending on whether they pass the CMS filtering logic. To pass the filtering logic, the diagnosis must be submitted on an encounter data record with an acceptable type of bill and/or Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) code, depending on the type of submission.

Source: CMS HPMS Memo with subject "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17" (December 20, 2017)

IX.4. Will the MAO-004 report reflect diagnosis codes that are not risk adjustment eligible with a "disallowed" flag?

Yes, the MAO-004 report will indicate diagnoses that do not pass the CMS filtering logic with a "D", in the allowed/disallowed flag field, meaning the diagnoses were reported but are disallowed for risk adjustment.

The allowed/disallowed flag field is included to help MAOs or other entities determine which records accepted on the MAO-002 report passed the CMS filtering logic as reported on the MAO-004 report

Source: CMS HPMS Memo with subject "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17" (December 20, 2017)

IX.5. Why would the MAO-004 report list a diagnosis as "disallowed"?

The MAO-004 report will identify diagnoses as "allowed" or "disallowed" to indicate whether or not they are risk adjustment eligible. If diagnoses pass the CMS filtering logic, they are "allowed." Allowed diagnoses are considered eligible for risk adjustment since these are the diagnoses that are run through the model when calculating risk scores. Not all diagnoses that are run through the model will be included in the risk score calculation, since not all diagnoses map to the Hierarchical Condition Category (HCC) in the model. Please refer to the December 20, 2017 CMS Health Plan Management System (HPMS) Memo with subject line, "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17.

Source: CMS HPMS Memo with subject "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17" (December 20, 2017)

IX.6. Will the MAO-004 report contain DME encounter services?

Yes. Durable Medical Equipment (DME) records (payer code 80887) are reported on the MAO-004 report and are filtered in the same way as professional records. If at least one of the accepted lines on the record has a Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) code that is on the list of acceptable CPT/HCPCS codes for filtering, then these records will be reported with an Allowed status and the diagnoses on the record will be considered for risk adjustment.

Source: Help Desk Inquiry answered in June 2018

IX.7. What will display in the Allowed/Disallowed Flag field (#25) of the MAO-004 report when the Allowed/Disallowed Reason Codes field (#27) contains value of "Q"?

Field #25 (Allowed/Disallowed Flag) will be "A" if field #27 (Allowed/Disallowed Reason Codes) is "Q". 'Q'= the diagnoses on the current encounter are now allowed due to Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) quarterly update. This value is only applicable to reprocessed outpatient, professional and Durable Medical Equipment (DME) encounters, not to inpatient encounters.

Source: CMS HPMS Memo with subject "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17" (December 20, 2017)

IX.8. On the MAO-004 Report, does the information in the Additional Diagnosis Codes field (#35) apply to the diagnoses in the Current ICN field (#9) or the diagnoses in the Prior Record ICN field (#13)?

Diagnoses reported in field #35 as add, delete or "blank" reference the diagnoses reported on the submitted encounter (#9). For replacements, voids, and linked chart review deletes, field #35 will also report diagnoses deleted from the prior record that the encounter or chart review is linked to, the Internal Control Number (ICN) listed in field (#13).

Source: User Group Q&A Documentation from March 23, 2017

IX.9. What are the circumstances where a single ICN can have 38 or more diagnoses as defined in field #35 (Additional Diagnosis Codes) of the MAO-004 report layout?

Field #35 has 38 slots because the MAO-004 will report diagnoses deleted from a prior Internal Control Number (ICN). If, for example, an institutional record was submitted with 25 diagnoses and then replaced

with 25 new, unique diagnoses, field #35 would report the 25 diagnoses on the current record as add and the 25 diagnoses removed from the prior record as delete. Since only 38 slots are available, the additional diagnoses would be reported on a second line in the report, with all fields identical to the first line except for the diagnoses and add/delete indicators.

Source: User Group Q&A Documentation from March 23, 2017

IX.10. How does the MAO-004 report include diagnosis codes from both the original and replacement EDRs that are risk eligible?

For the diagnoses reported only on the replacement but not on the original, the MAO-004 will indicate these records as "Add" in the add/delete indicator. All diagnoses reported on both the replacement and the original encounter data record will be reported with a "blank" for the add/delete indicator, signifying that those diagnoses have been reported as "add" before, and all diagnoses on the original encounter data record, but not on the replacement record, will be noted as "Delete" in the add/delete indicator.

Source: CMS HPMS Memo with subject "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-17" (December 20, 2017)

IX.11. Are diagnosis codes submitted on chart review records included in MAO-004 Report data?

Yes, linked and unlinked chart review records used to report supplemental diagnosis codes are reported on the MAO-004 report. Chart review records that delete diagnosis codes are also reported on the MAO-004 report.

Source: User Group Q&A Documentation from January 19, 2017

IX.12. What is the process to request a copy of a previously generated MAO-004 Report?

To access the MAO-004 reports, use the following steps:

1. In Medicare Advantage Prescription Drug User Interface (MARx UI) go to the 'Reports' menu
2. Select 'Monthly' frequency, the 'Start Month/Year' and the 'End Month/Year'
3. On the 'Report/Data File' dropdown select 'Risk Adjustment Eligible Diagnosis Report'
4. Add your 'Contract ID' and hit find
5. Do not specify the file type

The archived reports will populate and become available for download approximately 10-15 mins after requestors log out and log back into MARx.

Please contact the MAPD Help Desk at MAPDhelp@cms.hhs.gov or 1-800-927-8069 for any issues with the MARx UI.

Source: User Group Q&A Documentation from January 19, 2017

IX.13. Are all MAO-002 accepted encounter data records included in MAO-004 reports?

CMS reports almost all MAO-002 accepted records on the Phase III version 3 MAO-004 reports. The very few submissions that are not processed are the instances when CMS cannot determine the intention of the submitter. Diagnoses on these records are also not included in the model run processes.
Source: CMS HPMS memo with subject "Phase III version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016-2017" (December 20, 2017)

IX.14. Why do some diagnoses appear on the MAO-004 reports showing as accepted and allowed, but do not appear on the 2019 Initial payment MOR?

There are a number of reasons why the Hierarchical Condition Category (HCC) for a diagnosis reported as accepted and allowed on the MAO-004 report would not appear on the Initial payment Model Output Report (MOR). A diagnosis code that is added and allowed is considered for risk adjustment and will appear on the MOR. While the MAO-004 reports all diagnosis codes submitted on accepted encounters not all diagnosis codes reported map to a payment HCC. In addition, it is possible that there is a diagnosis that maps to a payment HCC that is higher in a hierarchy and thus a lower severity HCC in the same hierarchy would not be included in the risk score for payment. The MOR reports HCCs after the hierarchies are applied, therefore the lower severity HCC that was excluded for payment will not be reported on the MOR. Please also ensure that the diagnosis was submitted on an encounter with dates of service within the submission window for the [payment year's] Initial and was not deleted by a subsequent replacement or chart review delete.
Source: User Group Webinar on February 21, 2019

X. Monthly Medicaid Status Report

X.1. What is the difference between the Monthly Medicaid Status Report and the Medicaid flag on MMR?

The Monthly Membership Report (MMR) contains payment information for the reported month; the Medicaid data fields on the MMR represent the beneficiary's Medicaid status used to determine dual status for that month. The Monthly Medicaid Status Report provides information on dual status that may be more current than the anchor months in the MMR that are used for payment. The Monthly Medicaid Status Report gives plans a more complete picture of a beneficiary's Medicaid status, which can assist with predicting revenue.
Source: User Group Q&A Documentation from April 27, 2017

X.2. When viewing the monthly Medicaid Status file, if the MMR and the Medicaid status files display different Medicaid status, which file's data should take precedence?

Prior to final reconciliation for a payment year, the Medicaid status on the Monthly Membership Report (MMR) reflects the rolling anchor month's status used in prospective payment, while the monthly Medicaid Status file identifies the most recent monthly Medicaid status information CMS has for the beneficiary. MAOs and other entities can also use the Medicare Advantage Prescription Drug User Interface (MARx UI) to identify a beneficiary's most recent dual status. At final reconciliation, CMS uses the most recent information about a beneficiary's dual status from each payment month and makes payments adjustments if the dual status is updated.
Source: User Group Webinar on April 19, 2018

XI. Risk Adjustment: Filtering and Scores

XI.1. Will CMS publish a list of risk adjustment eligible CPT/HCPCS codes?

The list of eligible Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes used for filtering diagnoses from encounter data records for each service year is available at https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/list_of_codes.html. In addition, risk adjustment information, including evaluation of the CMS-HCC Risk Adjustment Model, model diagnosis codes, Risk Adjustment model software (HCC, RxHCC, ESRD), and information for the relevant payment year, is available at https://www.cms.gov/Medicare/HealthPlans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.
Source: MAO Help Desk Inquiry answered in October 2019

XI.2. Are encounter data records and chart review records with default NPIs for atypical providers considered for risk calculation?

Yes, risk adjustment filtering logic includes diagnoses captured from atypical provider service records (as indicated by the default atypical National Provider Identifier). All risk adjustment filtering logic and requirements remain in effect for atypical providers.

Source: MAO Help Desk Inquiry answered in November 2019

XI.3. How are encounter data submissions incorporated into risk score calculations?

Please refer to the December 22, 2015 CMS Health Plan Management System (HPMS) memo entitled "Final Encounter Data Diagnosis Filtering Logic" related to how CMS will extract risk adjustment eligible diagnoses.

Source: User Group Q&A Documentation from February 16, 2017

XI.4. If an encounter data record meets the requirements for risk adjustment, are all diagnoses on the record considered for risk adjustment?

All diagnoses on the **header** of the encounter data record are considered for risk adjustment, if the diagnoses pass the CMS filtering logic.

Source: User Group Q&A Documentation from March 23, 2017

XI.5. Where are the ICD-10 to HCC mappings located?

The ICD-9 and ICD-10 mappings of diagnoses to model the Hierarchical Condition Category (HCC) and the model software are available on the CMS Risk Adjustment website (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). CMS has also posted the PY2020 initial mappings and model software on that website.

Source: User Group Webinar on June 20, 2019

XI.6. Do Risk Adjustment filtering rules differ between PACE and typical Medicare Advantage plans?

No, the filtering rules are the same for Programs of All-Inclusive Care for the Elderly (PACE) and Medicare Advantage plans.

Source: User Group Q&A Documentation from June 20, 2019

XII. Communicating with CMS

XII.1. How should an MAO Encounter Data Technical Contact ensure they are registered to receive HPMS communications?

Please refer to the following link to check registration to receive notifications via Health Plan Management System (HPMS): https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/UserIDProcess.html

Source: MAO Help Desk Inquiry answered in October 2019

XII.2. How can MAOs securely submit PII or PHI so that CMS may research issues?

To securely submit Personally Identifiable Information (PII) or Personal Health Information (PHI), use the following steps:

1. Contact the MAPD Help Desk at 1-800-927-8069 and request a SNOW Case number be generated for the purpose of submitting a password protected file.

2. Email the password protected file containing the sample data to the MAPD Help Desk (MAPDHelp@cms.hhs.gov).IMPORTANT: Include the SNOW Case number in the 'Subject' line to

enable the Help Desk to pair your email with the SNOW Case. NOTE: In accordance with CMS' Security Policy, the password for encrypted PII/PHI data cannot be emailed to the MAPD Help Desk. Please Call the MAPD Help Desk with the password.

3. Email the Risk Adjustment or Encounter data mailbox with the SNOW Case number and question without the PII/PHI. Please do not submit PII/PHI unless CMS requests you provide specific examples.

Source: User Group Webinar on June 20, 2019

XII.3. Where can MAOs and other entities access the Risk Adjustment for EDS & RAPS User Group materials?

The Risk Adjustment for Encounter Data System (EDS) & Risk Adjustment Processing System (RAPS) User Group materials are available at the Customer Service and Support Center (CSSC) Operations website here: www.csscoperations.com.

XII.4.   Where can MAOs submit questions about RAPS and other risk adjustment issues?

Questions related to risk adjustment or Risk Adjustment Processing System (RAPS) policy should be sent to riskadjustment@cms.hhs.gov. Questions related to risk adjustment operations (data submission, reports, etc.) should be submitted to encounterdata@cms.hhs.gov.