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CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

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TO: All Medicare Advantage Organizations, PACE Organizations, Medicare-Medicaid Plans, Section 1833 Cost Contractors and Section 1876 Cost Contractors, and Demonstrations

FROM: Jennifer Harlow /s/
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SUBJECT: Guidance regarding Encounter Data Submission - Edit 98300 – "Exact Inpatient Duplicate"

This memo provides information regarding submission of inpatient encounter data records (EDRs) and edit 98300 and guidance on how to avoid experiencing this edit. CMS provides technical assistance to the plan community in a variety of ways, including targeted phone calls and responding to specific individual inquiries. Through these various discussions with plans, CMS has heard of concerns about "Edit 98300 – Exact Inpatient Duplicate." The reasons for these concerns are varied, and include plans attempting to resubmit an inpatient EDR, but with a change in diagnoses.

Over the past several months, CMS has analyzed Edit 98300 – "Exact Inpatient Duplicate," and considered the inquiries received. Below, we provide guidance on how to respond to this edit.

Background

CMS implemented a duplicate record check for inpatient records in September 2015 in order to improve data integrity by preventing the occurrence of duplicate inpatient EDRs in the MA Encounter Data System.

- Edit 98300 is a header-level edit on institutional inpatient EDRs with the Type of Bill field equal to 11X, 18X, 21X, or 41X.
- This edit does not apply to chart review records.
- For original EDRs the edit logic looks for a match on a previously accepted inpatient EDR on the following 4 data elements: HICN, Dates of Service (from and thru), Billing Provider NPI, and Type of Bill.
- This edit does not apply to replacement or void EDRs (in other words, claim frequency code = 7 or 8, respectively).

Guidance

The following approaches are options for how to avoid edit 98300 for inpatient EDRs:

(1) MAOs may wait to submit an inpatient EDR until an inpatient hospital stay has been fully adjudicated in the plans' systems.

(2) If an MAO has submitted an inpatient EDR and would like to make changes to any of the data elements on the record, the MAO can do one of two things:

   a. Void the original EDR by submitting a new record with claim frequency code = '8' and submit another original encounter or
   b. Submit a replacement EDR with a claim frequency code = '7'.

Since the EDR is a report to CMS from the MAO, and not a provider claim, the MAO should use the appropriate value for the claim frequency code on the EDR, even if it differs from the claim frequency code of the claim submitted to the MAO by the provider.

Below is guidance for situations when an MAO would like to make changes to the diagnosis codes on a previously submitted and accepted inpatient EDR, but not other aspects of the data related to the encounter.

(3) The MAO may follow the guidance in (2) or

(4) The MAO may use a chart review record to add diagnoses to the EDR or use a linked chart review record to delete diagnoses from the EDR.

Please send questions to EncounterData@cms.hhs.gov