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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, Deputy Director, Medicare Plan Payment Group

SUBJECT: Guidance for Encounter Data Submission

This memo provides guidance and responses to questions from MAOs about information used by MAOs to create encounter data records (EDRs).

Under 42 C.F.R. § 422.310(b), MAOs are required to submit to CMS "the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee." Since an EDR is a report from the MAO to CMS about medical items or services a beneficiary received while enrolled in one of the MAO's plans, all information included on an EDR for an item or encounter must be related to the specific item or encounter about which the EDR is reporting.

CMS requires that organizations submit EDRs using the X12 837 5010 format to fulfill MAO's reporting requirements per 42 CFR 422.310. When populating the 5010, MAOs and other submitters should populate data fields in conformance with CMS submission requirements in order to complete successful submission to CMS's Encounter Data System. We remind MAOs that established risk adjustment rules apply to diagnoses submitted on EDRs that are used for risk adjustment; for instance, these diagnosis codes must be documented in the medical record and must be documented as a result of a face-to-face visit in the data collection period for the payment year.

Below are answers to frequently asked questions about how to populate certain data fields.

Q1. Can the MAO 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 by the provider (which might be incorrect)?

A1. Since the EDR is a report to CMS from the MAO about an item or service received by the plan enrollee, the MAO can 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 on a claim for payment.

Q2. 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?

A2. Since the EDR is a report to CMS from the MAO about an item or service received by the plan enrollee, the plan 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 it must be supported by the medical record. As with RAPS, if a plan 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 an EDR with the unsupported diagnoses removed, and voiding an EDR.

Q3. CMS guidance allows plans, 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 CMS saying that it is acceptable for MAOs to modify the encounter on the backend for EDPS submission purposes? Or does the billing provider need to rebill with those modifiers?

A3. Since the EDR is a report to CMS from the MAO, and not a provider bill, the MAO 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) in cases in which the MAO 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 in this memo is not intended to be instructions for how providers should bill the MAO.

MAOs 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/DME	Institutional – Outpatient
Health Insurance Claim Number (HICN)	Health Insurance Claim Number (HICN)
Date of Service (DOS)	Date of Service (DOS)
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/DME	Institutional – Outpatient
59 - Distinct Procedural Service	59 - Distinct Procedural Service
	62 - Two Surgeons
	66 - Surgical Team
76 - Repeat Procedure by Same Physician	76 - Repeat Procedure by Same Physician
77 - Repeat Procedure by Another Physician	77 - Repeat Procedure by Another Physician
91 - Repeat Clinical Diagnostic Laboratory Test	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.

Q4. In situations in which none of the data elements included in the Encounter Data System's 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.

If the claim submitted by the provider to the plan 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 has made claims adjustments in our system, but the provider did not submit a new claim), is it acceptable for the MAO to modify the claim frequency code of the encounter data record?

A4. Since the EDR is a report to CMS from the MAO, the MAO can report information to CMS that was not provided to the MAO by the provider, per CMS guidance. In the example provided, the provider has only submitted one claim to the MAO, but the MAO needs to make an adjustment on the EDR that it has sent to CMS. The MAO 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 track when and why provider supplied information is modified for submission to the EDS. Please see the HPMS memo entitled Guidance regarding Encounter Data Submission - Edit 98300 – "Exact Inpatient Duplicate" released October 4, 2017, for additional information.