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EDGE Server Business Rules

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Revision History

Version	Date	Organization/Point of Contact	Description of Changes
1.0	May 8, 2013	PPFMG/CCIIO/CMS/HHS	Baseline
1.0	May 22, 2013	PPFMG/CCIIO/CMS/HHS	Addition of pharmacy and medical claims file information
2.0	May 27, 2014	PPFMG/CCIIO/CMS/HHS	Revised rules and clarifications See Appendix A for details Reformatted for 508 Compliance
3.0	August 11, 2014	PPFMG/CCIIO/CMS/HHS	Addition of supplemental diagnosis file (ESSFS) information Updated Appendix B See Appendix A for details Reformatted for 508 Compliance

TABLE OF CONTENTS

List of Tables

General File Processing Tables

Enrollment File Processing Tables

Pharmacy Claims File Processing Tables

Medical Claims File Processing Tables

Supplemental Diagnosis Code Tables

Appendix Tables

1. Purpose

The External Data Gathering Environment (EDGE) Server Business Rules document supplements the EDGE Server Interface Control Document (ICD) by providing EDGE server file processing rules to facilitate successful submission of enrollment, pharmacy claim and medical claim files.

2. Overview

As part of the Affordable Care Act (ACA), two (2) programs were identified to mitigate the impact of adverse selection of plans and provide stability for issuers. States will have the option to operate the following programs themselves or to have the Department of Health and Human Services (HHS) operate the programs on their behalf.

- Section 1343 of the ACA created the Risk Adjustment (RA) program, to better spread the financial risk borne by health insurance issuers, in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. Under the Risk Adjustment program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered individual and small group market plans, irrespective of whether they are a part of the Marketplace, will submit risk adjustment data (claims and enrollee data) that will be used to determine individual-level risk scores, plan average actuarial risk and associated payments and charges.

  Section 1341 of the ACA establishes the Reinsurance (RI) program as a temporary three-year program that commences in 2014. Reinsurance provides funds to issuers that incur high costs for claims in the individual market. In accordance with 45 CFR 153.230, reinsurance payments are based on a coinsurance rate or proportion of an issuer's claims costs that are above an attachment point and below a reinsurance cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for reinsurance payments, while the reinsurance cap is the dollar limit at which point an issuer is no longer eligible for reinsurance payments. The attachment point, coinsurance rate, and reinsurance cap are calculated based on an issuer's total costs for an individual enrollee in a given calendar year. Individual market plans, irrespective of whether they are part of the Marketplace, will submit reinsurance data (claims and enrollee data) that will be used to determine if an individual market plan issuer is eligible for reinsurance.

The Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf) grants HHS the authority to collect data from issuers when HHS is operating risk adjustment on behalf of a State. The HHS Notice of Benefit and Payment Parameters for 2014, Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf) grants HHS the authority to collect data for reinsurance. HHS will use a distributed data collection approach to collect this data for both the Reinsurance and Risk Adjustment programs. CCIIO/CMS serves as the HHS facilitating entity to implement the data collection approach for these HHS-operated programs. It was determined, during initial evaluation of the possible models, that a distributed data collection model would prove most effective for the collection and processing of the data received from the issuers. Specifically, the distributed data collection model would ensure:

- Issuer proprietary data would remain resident within the issuer environment and would not be transmitted to the Centers for Medicare & Medicaid Services (CMS);
- Minimal transfer of protected health information to decrease privacy and data security risks; and
- Standardization of business processes, timing and rules.

- Issuers in states where HHS is operating an RA and/or RI program are required to submit enrollment, pharmaceutical claims and medical claims information on enrollees from their proprietary systems to an issuer distributed data collection server (also known as "EDGE server"). An EDGE server will run HHS-developed software designed to verify submitted data and execute the RA and RI processes.

- Issuers have the option to own, operate and maintain an EDGE server or have a third-party entity (vendor) host an EDGE server. Issuers, or third-party entities on their behalf, may establish either an Amazon Cloud EDGE server or an EDGE server in their own environment. The technical specifications and details regarding these options will be made available through webinars and user groups and published in the REGTAP Library. Under either option, issuers will load the necessary software to perform file processing, risk adjustment and reinsurance. The data elements required are outlined in the Interface Control Document (ICD) published in the REGTAP Library.

An EDGE server will store detailed claims data, detailed file processing metrics and detailed and summary reports. Only plan summarized data, file processing metrics and summary reports will be sent back to CMS. CMS will utilize the same data collection method for risk adjustment and reinsurance, thereby limiting the data collection burden on issuers, or submitters on their behalf. The HHS Notice of Benefit and Payment Parameters for 2014, published on March 11, 2013, finalized the requirement (45 CFR § 153.700) that issuers will need to establish dedicated secure data environments (EDGE server) when HHS is operating either program on behalf of a State, for CMS to access claims and enrollment information and run CMS developed software. In addition, the rule requires issuers to use a "masked enrollee identification number" when loading enrollee-level plan enrollment data, enrollee claims data and enrollee encounter data to their EDGE server(s) (45 CFR § 153.720).

3. Introduction to File Processing Business Rules

This document provides guidance to issuers on the business rules that CMS applies to enrollment files and claims files submitted to an issuer's EDGE server. The rules governing the submission of data to an issuer's EDGE server under these HHS-operated programs are not intended to change standard billing practices currently being followed by providers who submit claims to issuers for payment processing. Issuers retain the right to develop and communicate with providers the policies and procedures that support the business needs for claim processing.

The EDGE Server Business Rules document provides file processing business rules based on four (4) categories (general rules, enrollment, pharmacy claims and medical claims). Medical claims include inpatient and outpatient facility claims and physician medical claims.

Section 4: General File Processing

Section four (4) describes the rules pertaining to all file types, including general processing rules, general verification rules and general rules that apply to each XML segment (i.e., header, issuer and plan) within a file. This section does not replace the specifics outlined in the ICD.

Section 5: Enrollment File Processing Rules

Section five (5) describes the rules pertaining to EDGE Server Enrollment Submission (ESES) file processing rules, including enrollment file term definitions, enrollment file specific rules that apply to each XML segment (i.e., header and issuer) within a file, enrollee/subscriber ID dependencies and premium changes. This section does not replace the specifics outlined in the ICD.

Section 6: Pharmacy File Processing

Section six (6) describes the rules pertaining to EDGE Server Pharmacy Claim Submission (ESPCS) files processing, including pharmacy file term definitions, pharmacy file specific rules that apply to

each XML segment (i.e., header, issuer and plan) within a file, duplicate checks, voiding and replacing claims and derived amounts. This section does not replace the specifics outlined in the ICD.

Section 7: Medical File Processing

Section seven (7) describes the rules pertaining to EDGE Server Medical Claim Submission (ESMCS) file processing, including medical file term definitions, medical file specific rules that apply to each XML segment (i.e., header, issuer and plan) within a file, duplicate checks with exceptions, voiding and replacing claims, derived amounts, processing institutional claims, including interim bills, late charges and mother/baby claims. This section does not replace the specifics outlined in the ICD.

Section 8: Supplemental Diagnosis File Processing

Section eight (8) describes the rules pertaining to EDGE Server Supplemental Diagnosis File Submission (ESSFS) file processing, including definitions, file specific rules that apply to each XML segment (i.e. header, issuer, and plan) within a file, duplicate checks, adds, deletes, and voids. This section does not replace the specifics outlined in the ICD.

Section 9: Assistance with Business Rules

Section nine (9) identifies resources for additional assistance with file processing rules.

Appendices:

The appendices provide revision details, acronyms and examples for additional assistance with any file processing rules outlined within the Business Rules.

4. General File Processing

The general file processing section of the business rules provides context and outlines the basics of file processing on issuer EDGE servers. These general file processing rules apply to enrollment, pharmacy and medical claims files.

4.1. General File Structure – XML Levels

Files submitted and produced on the EDGE server are created in eXtensible Markup Language (XML). XML files are segmented by levels of data. These levels will be referred to throughout this document as header level, issuer level, plan level, enrollee level, enrollment period level, pharmacy claim level, medical header claim level and medical claim line level.

All files have a header and issuer level. The other levels apply to various file types as outlined in Table 1.

Table 1: XML Levels by File Type

File Level	All Files	Enrollee File	Pharmacy Claims File	Medical Claims File	Supplemental Diagnosis File
Header	X	X	X	X	X
Issuer	X	X	X	X	X
Plan			X	X	X
Enrollee		X			
Enrollment Period		X			
Pharmacy Claim			X		
Medical Claim Header				X	
Medical Claim Line				X	
Supplemental Diagnosis File Detail Record					X

4.2. General File Processing Definitions

Below are terms commonly used when describing general file processing on an EDGE server. Terms related to enrollment, pharmacy and medical claims files are defined in the ICD. Additional terms related to specific business rules are defined in the appropriate file type (enrollment, pharmacy claims and medical claims) section.

Table 2: File Processing Definitions

File Processing Term	Definition
File Type Verification	The process of verifying that a file is suitable for processing on an EDGE server. For more information related to file type verification, see section 4.4.
Header Level Verification	The process of verifying the data elements present in the header level of the XML file. The header level is included in all four (4) file types – enrollment, pharmacy, medical, and supplemental diagnosis. For more information related to header level verification, see section 4.6.
Issuer Level Verification	The process of verifying the data elements present in the issuer level of the XML file. The issuer level is included in all four (4) file types – enrollment, pharmacy, medical, and supplemental diagnosis. For more information related to issuer level verification, see section 4.8.
Plan Level Verification	The process of verifying the data elements present in the plan level of the XML file. The plan level is only present in pharmacy, medical, and supplemental diagnosis files. For more information related to plan level verification, see section 4.9.
Enrollee Level Verification	The process of verifying the data elements present in the enrollee level of the XML file. The enrollee level is only present in enrollment files. For more information related to enrollee level verifications, see section 5.3.
Enrollment Period Level Verification	The process of verifying the data elements present in the enrollment period level of the XML file. The enrollment period level is only present in enrollment files. For more information related to enrollee level verifications, see section 5.3.
Pharmacy Claims Level Verification	The process of verifying the data elements present in the pharmacy claim level of the XML file. The pharmacy claim level is only present in pharmacy files. For more information related to pharmacy claim level verifications, see section 6.
Medical Claims Header Verification	The process of verifying the data elements present in the medical claim header level of the XML file. The medical claim header level is only present in medical claim files. For more information related to medical claim header verifications, see section 7.
Medical Claims Line Verification	The process of verifying the data elements present in the medical claim line level of the XML file. The medical claim line level is only present in medical claim files. For more information related to medical claim line verifications, see section 7.
Supplemental Diagnosis File Detail Record Verification	The process of verifying the data elements present in the supplemental diagnosis file detail record level of the XML file. The supplemental diagnosis file detail record level is only present in supplemental diagnosis files. For more information related to supplemental diagnosis file detail record verifications, see section 8.

4.3. General File Processing Rules

Once the file processing software is released, an issuer may begin testing ESES, ESPCS, ESMCS, and ESSFS files for processing. The process that issuers must follow to prepare and submit files is called an extract, transform, and load (ETL) process. Issuers will need to extract the necessary data elements from their proprietary systems, transform those elements into an XML format, and load the file either through the EDGE server user interface (UI) or via a secure file transfer protocol (SFTP).

CMS requires that issuers submit complete and accurate data to the EDGE server. CMS is providing a test zone that will allow issuers to validate that their data extract and submission process works correctly prior to submitting production data to the EDGE server. There is currently no formal test plan that CMS will require an issuer to perform. However, issuers should thoroughly test their ETL process and review the outbound error file reports to identify any issues in their submission process.

Table 3: Processing Zone Descriptions

Processing Zone	Description
Test Zone	The test zone mirrors the tables and software used in the production zone and is available for issuers to test files prior to submission to the production zone. The test zone will always be available for issuers to test files at any time.
Production Zone	The production zone is where accepted enrollment, pharmacy and medical claims data will be verified and stored for risk adjustment and reinsurance processes. Rejected data will be stored for issuer reference and use. Files should be submitted to the production zone no less than quarterly. CMS recommends monthly submissions, but issuers have the option to submit as frequently as their business requires.

Once files are submitted for processing, a file verification process will be performed (described in section 4.4). The first verification step performed against the file type will determine whether the file proceeds to header level verification. Once a file passes the file type verification process a job ID is assigned.

Next, the file moves to the header level verification step. A file that passes all header level verifications is archived. A file that fails any header level verification is rejected and not archived.

Next, files that pass header level verifications continue processing and further verifications are performed against the specific data elements at each level of the XML. At each verification level, required fields are confirmed, face validity is performed, validations against reference tables are conducted and logical edits are applied. Accepted data is stored for use in future processing, while rejected data is maintained for the purpose of error communication.

Finally, after a file has completed processing, outbound files are produced and sent to the issuer. These outbound files include both a detailed report of accepted and rejected records, as well as summary counts. Accepted records are the only records that will proceed to Risk Adjustment and Reinsurance program specific file processing. Therefore, it is very important for issuers to review and reconcile their rejected record reports on a regular basis and resubmit corrections as needed.

Issuers should ensure that all final claims, supplemental diagnosis codes, and enrollment data, as well as corrections to rejected records, are submitted prior to April 30th following the benefit year. Additional data and corrections to rejected records will not be accepted after this date.

CMS will receive outbound data files which are limited to aggregated, summarized data. No individual enrollee level risk adjustment or reinsurance data is provided to CMS.

Rules pertaining to the submission and replacement of enrollment, pharmacy, medical, and supplemental diagnosis files differ and are each illustrated in Table 4.

Table 4: General File Submission and Replacement Rules

Rule 1	Enrollment files are full replacement file submissions and must be submitted no less than quarterly. It is recommended that enrollment files be submitted monthly.
Rule 2	Pharmacy claims files are incremental file submissions and must be submitted no less than quarterly. It is recommended that pharmacy claims files be submitted monthly.
Rule 3	Medical claims files are incremental file submissions and must be submitted no less than quarterly. It is recommended that medical claims files be submitted monthly.
Rule 4	Supplemental diagnosis files are incremental file submissions and must be submitted no less than quarterly. It is recommended that supplemental diagnosis files be submitted monthly, if an issuer has supplemental diagnosis files to submit.

Rules pertaining to general submission and processing specific to enrollment, pharmacy, medical, and supplemental diagnosis files are further defined in sections 5.2, 6.2, 7.2 and 8.2, respectively.

4.4. File Type Verification Rules

All files submitted to an EDGE server must pass a file verification process. All three (3) conditions must be met for a file to move to file processing.

Table 5: File Type Verification Rules

	File Type Verification Rules
Rule 1	The file must be XML.
Rule 2	The file must include an acceptable file type at the file header level. • Valid file types: E = Enrollment, P = Pharmacy, M = Medical, S = Supplemental Diagnosis
Rule 3	The file must include an acceptable execution zone. • Valid execution zones: T = Test*, P = Production ** Information about testing files prior to submission will be made available in the future.*

Files that fail one (1) or more of the three (3) verifications will be rejected and no **Job ID** will be created. In addition, files that fail will not be archived. Files that pass all three (3) verifications will be assigned a **Job ID** and moved to the file header verification process. If all file header verifications are passed, the file will then be archived. Specific business rules pertaining to file header verification can be found in section 4.5 below.

Notification of success or failure of every submitted file will be communicated. The notification will provide the status of the file and the **Job ID**, if assigned. If the file is rejected, a reason for the rejection will be provided.

4.5. Verification Edits – Required, Face Validity, Reference and Logical

All data elements included on submitted enrollment, pharmacy claims, medical claims and supplemental diagnosis XML files will undergo a variety of verification edits. The ICD outlines the specific verification edits that are applied to each data element.

Table 6: Verification Edits

	Verification Edits
Required	Verifies that the data element is included in the file and populated with something other than a blank value *NOTE: All XML data element tags are required. Population of data within the data tag is optional for some data elements (i.e. subscriber ID, claim modifiers, etc.) Refer to the Logical Checks and Restrictions columns, in the ICD, for each data element for more information.*
Face Validity	Verifies that the data element conforms to the specified data type and restrictions. Please see the ICD for specific edits.
Referential Check	Verifies that the data element value matches a value in the standard reference data table set. Please see the ICD for specific edits.
Logical Check	Verifies that the data value meets the defined business logic. Please see the ICD for specific edits.

File processing on an EDGE server is designed to evaluate as many data elements as possible before rejecting a file or record. Verification edits are performed in two (2) stages. In the first stage, required and face validity verifications are performed. In the second stage, referential and logical checks are performed. Without the former (required and face validity) verifications, the latter (referential and logical) verifications cannot be conducted.

NOTE: *Below is a truncated version of the header level verifications.*

Review the full table in the ICD for all data elements for each file type and the applicable verifications.

Table 7: Verifications for the Header Level

XML Element Names	Business Data Element	Required/ Situational/ Not Required	Face Validity	Referential Check	Logical Checks
fileIdentifier	File ID	Required	N	Y	Y (if a file is accepted, each File ID must be unique within an execution zone)
executionZoneCode	Execution Zone	Required	Y	N	N
submissionTypeCode	Report Type	Required	N	Y	N

All data elements will proceed through the required and face validity verifications and a status of accept or reject will be applied to each data element.

Table 8: Verification Edit Rules

Rule 1	Any data element that fails the required or face validity verification step, will not proceed to the referential and logical checks.
Rule 2	Data elements that pass the required and face validity verification step will proceed to the referential and logical checks.
Rule 3	Outbound data files will include the specific reject code(s) and description(s) for each data element that failed verification.

A list of accept and reject codes and descriptions are posted to the REGTAP Library. This list will be updated prior to provisioning. Issuers will receive notification of any changes through the REGTAP system and the Release Management process.

4.6. Header Level Rules for Enrollment, Pharmacy, Medical, and Supplemental Diagnosis Files

All file types – ESES, ESPCS, ESMCS, and ESSFS files – include a file header. The specific data elements, definitions and processing rules are outlined in the ICD.

Table 9: Header Level Rules for All File Types

Rule 1	Data elements at the header level must pass all verifications for the file to be archived and to proceed to the next level of verification.
Rule 2	If any data element fails any header level data element verification, the file will not be archived and the file will be rejected.
Rule 3	**File IDs:** • File IDs must be unique to each file submitted. Duplicate file IDs will be rejected. • A duplicate File ID is defined as an identical File ID previously submitted and accepted to the same execution zone. • If a file was rejected, the same a File ID can be reused.
Rule 4	The final status of the header level verification will be communicated to the submitter.

An outbound header accept/reject data file will be generated upon completion of the header verification process. This outbound data file will provide the specific details of those elements that failed verification and were rejected.

Data elements in the header level that pertain specifically to ESES, ESPCS, ESMCS, and ESSFS files have different verification rules which are defined in sections 5.3, 6.3, 7.4 and 8.3, respectively.

4.7. Record ID Rules

All file types – ESES, ESPCS, ESMCS, ESSFS files – include **Record IDs** which begin at the issuer level of the XML.

A **Record ID** is defined as a unique identifier for each record in a submitted file.

Table 10: Record ID Rules for All File Types

Rule 1	**Record IDs** begin at the issuer level and continue sequentially throughout each subsequent level of the file.
Rule 2	**Record IDs** must be sequential throughout the entire file, with each subsequent record being one (1) greater than the preceding **Record ID**, regardless of the level in the file.
Rule 3	The count of the number of records will be compared to the last **Record ID** in the file.
Rule 4	If the count of the number of records does not equal the reported count at the header level, then the file will be rejected.

See the XML samples provided in the Appendices of the ICD for **Record ID** sequencing.

4.8. Issuer Level Verification Rules

All file types – ESES, ESPCS, ESMCS and ESSFS files – must include an issuer level. All issuer level data elements are defined in the ICD.

Issuer ID – Unique identifier for an insurance issuer assigned through the Health Insurance Oversight System (HIOS).

Table 11: Issuer Level Rules for All File Types

Rule 1	Each file may contain only one (1) issuer.
Rule 2	An issuer record that passes the required and referential checks will only be rejected if a subsequent level in the file completely fails verification. For example, the subsequent level in an enrollment file is the enrollee level. If all enrollees fail for a given issuer, then the issuer record will be rejected.

Rules pertaining to data elements at the issuer level, which are specific to enrollment, pharmacy, medical claims, and supplemental diagnosis files, are defined in sections 5.3, 6.3, 7.4 and 8.3, respectively.

4.9. Plan Level Verification Rules

Only pharmacy, medical claims, and supplemental diagnosis files include a plan level. These rules apply only to those file types. All plan level data elements are defined in the ICD.

Plan ID - Unique identifier for an insurance plan offered by an issuer that the insured member is covered under. The **Plan ID** is issued through HIOS.

*NOTE: Business rules about the **Plan ID** related specifically to enrollment files may be found in section 5.*

Table 12: Plan Level Rules for Pharmacy, Medical Claims, and Supplemental Files

Rule 1	Each pharmacy, medical claim, and supplemental diagnosis file must contain at least one (1) plan, and may contain more than one (1) plan.
Rule 2	Plans are restricted to non-grandfathered small group and individual market plans, both inside and outside the Marketplace. Plans outside the small group and individual markets will be rejected.
Rule 3	A plan that passes the required and referential checks will only be rejected if a subsequent level completely fails verification. For example, the subsequent level in a pharmacy and medical claim file is the claim level. If all claims fail for a given plan, then the plan record would be rejected.

Rules pertaining to data elements at the plan level, which are specific to pharmacy, medical claims, and supplemental diagnosis files, are further defined in sections 6.3, 7.4 and 8.3, respectively.

5. Enrollment File Processing Rules

This section defines the business rules that pertain to enrollment file processing only. This section is not meant to replace the specific verifications outlined in the ICD. Header level, **Record ID** and issuer level rules outlined in this document (sections 5.3, 5.4 and 5.5) apply.

5.1. Enrollee File Definitions

All enrollment file data elements are defined in the ICD. The terms below are repeated here to assist the reader with the specific business rules related to these data elements.

Table 13: Enrollee File Definitions

Unique Enrollee ID	This represents a masked identifier for an enrollee; not a medical record number or cardholder ID (45 CFR § 153.720). The unique enrollee ID may not be an identifier used for any other program or any other purpose. Issuers must use the same **Unique Enrollee ID** if the enrollee switches plans within the issuer.
Subscriber Indicator	Indicates when the enrollee is also the subscriber. A subscriber is defined as an enrollee that is the primary insured party. See the example in Section 5.4 for more clarification.
Subscriber ID	This ID is a **Unique Enrollee ID** that represents the enrollee that is identified as the primary insured party. Example: Enrollee Q2#U4Go and A!5Lu9b are both **Unique Enrollee IDs** and are listed as such on the enrollment file. **Unique Enrollee ID** Q2#U4Go could be used as the **Subscriber ID** affiliated with member A!5Lu9b on the same policy. See Section 5.4 for specific business rules.
Premium Amount	The **Premium Amount** is the monthly total rated premium charged for a subscriber's policy, including the advanced premium tax credit (APTC) amount. The **Premium Amount** may include more than the amount charged directly to a subscriber. The monthly **Premium Amount** does not necessarily represent the amount charged to the subscriber. The **Premium Amount** is only reported on the enrollee record when the enrollee is identified as the subscriber with a subscriber indicator of "S". NOTE: Any change in a specific enrollee's (subscriber or dependent) premium rating requires the issuer to report a new enrollment period. See Section 5.4 for specific business rules.
Enrollment Period Activity Indicator	The indicator explains why the issuer created a specific enrollment period for a specific enrollee. CMS will use effective dates associated with specific indicators to determine the age that the issuer used to rate the enrollee. See Section 5.4 for specific business rules.

5.2. General Enrollment File Processing Rules

This section describes the requirements and general processing rules associated with an enrollment file.

Table 14: Enrollment File Processing

Rule 1	The initial enrollment file will be a cumulative file of all of the issuer's enrollees and enrollment periods.
Rule 2	Subsequent enrollment file submissions must be a COMPLETE REPLACEMENT FILE inclusive of all enrollees and enrollment periods.
Rule 3	A duplicate enrollee is identified when the same **Unique Enrollee ID** is reported, at the enrollee level, by a single issuer multiple times on a single enrollment file submission. If a **Unique Enrollee ID** appears on multiple records, at the enrollee level, within an enrollment file submission for the same issuer, then the first **Unique Enrollee ID** record will be passed to the verification steps and will be accepted or rejected based on the results of the verifications. All subsequent records with the same **Unique Enrollee ID,** at the enrollee level, within the same file will reject for duplication.
Rule 4	Unique enrollment periods representing multiple plan enrollments, for a single **Unique Enrollee ID**, may be submitted under one issuer on the same file. *NOTE: Please refer to the sections that follow for examples on multiple enrollment periods.*
Rule 5	Initial records that successfully pass all verifications at the enrollee and enrollment period level will be stored in an enrollment data table. Subsequent file submissions where an enrollee and/or enrollment period matches a previously accepted enrollee and/or enrollment period will be updated with a "last confirmed date" to limit the amount of data stored in the EDGE server. *NOTE: Please refer to the sections that follow for examples*
Rule 6	If an enrollee does not have an enrollment end date, it is suggested that the enrollment end date reflect the date the premium period ends.

Enrollee File Dependencies

The enrollment period level follows the enrollee level in the XML data file. As an enrollee cannot be accepted without a valid enrollment period that passes all verifications, there exists a dependency relationship between the enrollee and enrollment period levels which are outlined in Table 15.

Table 15: Enrollee File Dependencies

Rule 1	If any data element fails verification at the enrollee level, then all associated enrollment periods for that enrollee will be rejected.
Rule 2	If any data element fails verification at the enrollment period level, then the failed enrollment period record for that enrollee will be rejected.
Rule 3	If all enrollment periods for a given enrollee fail, then the enrollee record will be rejected even if the enrollee record passed all data element verifications.

Enrollees and enrollment periods that pass all verification edits are accepted and stored on the EDGE server in an enrollment data table as active records. When an enrollee or enrollment period change is submitted on an enrollment file, the active enrollee/enrollment period is replaced.

Example: Enrollment File Submission Table Updates

Unique Enrollee ID Q2#U4Go was initially submitted on January 31st to the EDGE server with an enrollment period of 01/01/2014 – 12/31/2014. On February 28th, the enrollment file submission indicated a change to the enrollment period end date. The new enrollment period submitted was 01/01/2014 – 06/30/2014.

The enrollment table would appear as follows:

Example: Q2#U4Go Enrollment Period as of January 31st

Unique Enrollee ID	Enrollment Start Date	Enrollment End Date	Received File Run Date	Last Confirmed	Status
Q2#U4Go	2014-01-01	2014-12-31	2014-01-31	2014-01-31	Active

Example: Q2#U4Go Enrollment Period as of February 28th

Unique Enrollee ID	Enrollment Start Date	Enrollment End Date	Received File Run Date	Last Confirmed	Status
Q2#U4Go	2014-01-01	2014-12-31	2014-01-31	2014-01-31	Inactive
Q2#U4Go	2014-01-01	2014-06-30	2014-02-28	2014-02-28	Active

NOTE: The status as of February 28th; the previous enrollment period was inactivated and the new enrollment period added as active.

NOTE: The Received File Run Date is the date and time when the issuer processed the file for submission and sent the inbound submission to the EDGE server.

Issuers should take care to always submit full enrollment files that include all enrollees and enrollment periods. Every accepted enrollee and enrollment period is stored in the enrollment data table on an EDGE server. When a subsequent file is submitted, the **Unique Enrollee ID** and associated enrollment periods are matched to the stored data table. When a new file is processed, the previously submitted records are confirmed. If an active stored record is not confirmed it will be inactivated as outlined in Table 16.

Table 16: Enrollees No Longer Included on Submission Files

Rule 1	If an enrollee or associated enrollment period is no longer included on the submitted file, then the stored enrollee and/or enrollment period record will be inactivated. Inactivated enrollee records and corresponding enrollment periods will no longer be eligible for consideration in the Risk Adjustment or Reinsurance programs. Issuers will receive outbound reports informing them of the enrollee records that were inactivated.

CMS recognizes that an enrollee may be enrolled in two (2) different plans for the same time period. Therefore, the EDGE server will accept overlapping enrollment periods for a **Unique Enrollee ID** when the **Plan ID** is different.

Table 17: Overlapping Enrollment Periods

Rule 1	If an enrollment file contains two (2) enrollment periods, for the same **Unique Enrollee ID,** with different **Plan IDs**, which overlap, then both enrollment periods will be accepted if they pass all enrollment period verifications. See example for a reference of Overlapping Enrollment Periods With Different Plan IDs.

Example: Overlapping Enrollment Periods with Different Plan IDs

The enrollment table would appear as follows:

Unique Enrollee ID	Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date
Q2#U4Go	23	S		21890KY001000104	2014-01-01	2014-12-31
Q2#U4Go	24		A!5Lu9b	30412KY007000113	2014-06-01	2014-12-31

5.3. Header and Issuer Level Rules Specific to Enrollment Files

The general header, **Record ID** and issuer level rules outlined in sections 5.3, 5.4 and 5.5 apply to all enrollment files.

There are two data elements at the header level specific to enrollment files that must pass a required and logical check verification process as outlined in Table 18.

Table 18: Header Level Total Verifications

Rule 1	The total number of enrollee records reported at the header level must equal the count of the total enrollee records for all issuers on the file. If the reported value does not match the total count, then the file will be rejected.
Rule 2	The total number of enrollment period records reported at the header level must equal the count of the total enrollment period records for all issuers on the file. If the reported value does not match the total count, then the file will be rejected.

As with the header level, the issuer level includes two (2) data elements that require the issuer to report the total number of enrollees and enrollment periods. These data elements also must pass a required and logical check as outlined in Table 19.

Table 19: Issuer Level Total Verifications

Rule 1	The total number of enrollee records reported must equal the count of the total enrollee records for the specific issuer submitted. If the reported value does not match the total count for the specific issuer, then the issuer record will be rejected.
Rule 2	The total number of enrollment period records reported must equal the count of the total enrollment period records for the specific issuer submitted. If the reported value does not match the total count for the specific issuer, then the issuer record will be rejected.

5.4. Enrollee and Subscriber Dependencies

In enrollment file processing there are dependencies between a **Unique Enrollee ID** and an enrollee that is identified as the subscriber. A **Unique Enrollee ID** is the masked identifier for an individual enrollee; not a medical record number or a cardholder ID. A **Subscriber ID** represents a **Unique Enrollee ID** that is identified as the subscriber: Table 20.

Table 20: Enrollee and Subscriber Identification

Rule 1	A subscriber is identified when the **Subscriber Indicator** "S" is present on the enrollee record and the **Subscriber ID** is null. This indicates that the **Unique Enrollee ID** is the subscriber. Example: **Unique Enrollee ID** Q2#U4Go is submitted with o a **Subscriber Indicator** = S and o a **Subscriber ID** = [empty tag] **Premium Amount** = $350.00
Rule 2	An enrollee that is NOT the subscriber is identified when the **Subscriber Indicator** is null and the **Subscriber ID** is populated. The **Subscriber ID** indicates the **Unique Enrollee ID** that represents the subscriber for the enrollment period. Example: **Unique Enrollee ID** A!5Lu9b is submitted with o a **Subscriber Indicator** = [empty tag] o a **Subscriber ID** = Q2#U4Go **Premium Amount** = 0

Note that the premium reported should only be reported when the enrollee is identified as a subscriber as outlined in Table 21.

Table 21: Premium Dependencies

Rule 1	Premiums must only be reported on the record for the subscriber and where the **Unique Enrollee ID** includes an "S" in the **Subscriber Indicator** field. The **Premium Amount** is the monthly total rated premium charged for a subscriber's policy, including the APTC amount. The **Premium Amount** may include more than the amount charged directly to a subscriber. The monthly **Premium Amount** does not necessarily represent the amount charged to the subscriber. Example: **Unique Enrollee ID** Q2#U4Go is submitted with o **Subscriber Indicator** = S and o **Subscriber ID** = [empty tag] o **Premium Amount** = $355.00

Enrollees that are associated with a subscriber must include enrollment periods that coincide with the subscriber enrollee enrollment periods as outlined in Table 22.

Table 22: Enrollment Period Dependencies

Rule 1	A **Unique Enrollee ID** that does NOT represent the subscriber must have enrollment periods that begin and end within the subscriber's enrollee record. Example: If **Unique Enrollee ID** A!5Lu9b is submitted with: o a **Subscriber Indicator** = [empty tag] and o a **Subscriber ID** = Q2#U4Go o with enrollment periods 2014-06-01 – 2014-12-31, Then, the **Subscriber ID** Q2#U4Go, with o a **Subscriber Indicator** = S and o a **Subscriber ID** = [empty tag], must be submitted with o an enrollment period with an enrollment begin date equal or prior to 2014-06-01 and an enrollment end date after or equal to 2014-12-31.

The purpose of the **Enrollment Period Activity Indicator** is to track enrollment changes that are pertinent to risk adjustment. Specifically, to appropriately calculate the geographic cost factor (GCF) for risk adjustment transfers, CMS needs to know each enrollee's age at the time of initial policy issuance and policy renewal for the determination of allowable rating factor (ARF). CMS also needs information about other enrollment changes to calculate the correct enrollee inputs at the rating area level for risk adjustment transfers.

Although the **Enrollment Period Activity Indicator** codes CMS is using for EDGE server enrollment files are also used for the 834 enrollment transaction, CMS is using four (4) codes to capture information pertinent to risk adjustment. The 834 enrollment and maintenance process is separate from the EDGE server enrollment file.

The rules pertaining to the **Enrollment Period Activity Indicator** are outlined in Table 23.

Table 23: Enrollment Period Activity Indicator Rules

Rule 1	The following rules apply for each **Enrollment Period Activity Indicator**: • 21028: This code is used to indicate an initial issuance of a policy for a specific enrollee. • 021EC: This code is used to indicate the addition of a new enrollee (e.g. new dependent) for a specific enrollee. This code does not apply to the subscriber. • 021041: This code is used to indicate a renewal of an existing policy for the next benefit year for a specific enrollee. • 001: This code is used to indicate a modification of an existing policy. This code is related to any event that changed an enrollment period attribute except ending an enrollment period (see *NOTE* below). This code only applies to the subscriber. *NOTE: When ending an enrollment period, use the previous **Enrollment Period Activity Indicator** since the only action is an end to an enrollment period. Appendix C provides examples of how **Enrollment Period Activity Indicators** should be submitted.*

5.5. Changes in Premium Amounts

Enrollment End Dates

Enrollment end dates may change based on a number of activities, such as a change in premium amount, a mid-month disenrollment or a change in the enrollees plan.

The EDGE server will accept open ended enrollment periods. However, CMS recommends using premium amount effective dates when developing enrollment period end dates.

When there is a change in the premium amount, a new enrollment period must be created for the enrollee as indicated in Table 24.

Table 24: Changes in Premium

Rule 1	If a subscriber has a change in premium, a new enrollment period must be submitted. Example 1: A subscriber renewed and had a decrease in their monthly premium. Enrollment period 1: 2014-01-01 – 2014-12-31 with a $355.00 premium Enrollment period 2: 2015-01-01 – 2015-12-31 with a $340.00 premium

Enrollees, who have either a partial month or $0 premium, will need to have two (2) enrollment periods. One (1) enrollment period will be through the end of the full-month prior to the partial month. The second period will be for the partial month. Table 25 outlines the rule related to partial month and $0 premiums.

Table 25: Partial Month and $0 Premiums

Rule 1	Issuers must create a distinct enrollment period when an enrollee has either a partial month or $0 premium. An enrollment period for the full month premium rate effective the end of the month and an enrollment period for the partial month or $0 premium. Example (partial month): An enrollee was initially submitted on January 31st to the EDGE server with an enrollment period of 2014-01-01 – 2014-12-31 and has a monthly premium of $230.00. The first enrollment file would appear as follows: Enrollment period 1: 2014-01-01 – 2014-12-31 with a $230.00 premium This enrollee was then terminated on April 12th 2014. The next enrollment file to the EDGE server would include 2 enrollment periods for this enrollee. Enrollment period 1: 2014-01-01 – 2014-03-31 with a $230.00 premium Enrollment period 2: 2014-04-01 – 2014-04-12 with a $212.00 premium* *The method of calculating and reporting a partial month premium should be based on how the issuer sets rates and charges premiums; therefore, a partial month premium could be a partial premium charged, a full premium charged or $0. Example ($0 premium): An enrollee was enrolled on January 21st through December 31, 2014. The first enrollment period would appear as follows: Enrollment period 1: 2014-01-21 – 2014-01-31 with a $0.00 premium The second enrollment period would appear as follows: Enrollment period 2: 2014-02-01 – 2014-12-31 with a $230.00 premium

This concludes the business rules for enrollment files. The following section outlines the rules for pharmacy claims file processing.

6. Pharmacy File Processing

Pharmacy claims are only applicable to the Reinsurance program. Incurred pharmacy claims costs are aggregated with medical costs to determine if an enrollee has met the uniform payment parameters of the reinsurance program. Unlike the enrollment file, pharmacy files are **NOT** complete replacements.

6.1. Pharmacy Claims File Definitions

All pharmacy claims file data elements are defined in the ICD. The terms below are repeated here to assist the reader with the specific business rules related to these data elements.

Table 26: Pharmacy Claims File Definitions

Fill Number	Code identifying whether the prescription is an original (00) or refill (01-99).
Dispensing Status	Indicates if the prescription was a partial fill (P) or completion of a partial fill (C).
Void/Replace Indicator	Identifies if a previously accepted claim is to be voided or replaced.
Derived Amount Indicator	Indicator used to distinguish between fee-for-service claims and claims covered under capitation.
Product/Service ID	Unique ID of the product or service dispensed. The ID submitted must be a National Drug Code (NDC).
Prescription/Service Reference Number	A unique number assigned by a pharmacy to identify a single dispensing event. A **Prescription/Service Reference Number** does not need to be unique across all pharmacies utilized by an issuer. See section 6.4 for specific business rules.

There are additional claims processing terms that are used in the following sections that are defined in Table 27.

Table 27: Claims Processing Terms and Definitions

Active Claim	A claim that was submitted by an issuer, passed all verification edits and was accepted and stored on the pharmacy claims data table.
Inactive Claim	A previously accepted version of a claim that has been voided or replaced. A claim must have been accepted and stored as active to be changed to inactive.
Orphan / Orphaned	A claim that is in an active status but has no corresponding active enrollee record.
Claim Key	The 7 key data elements used to identify a unique claim for purposes of identifying duplicates and processing void and replacement requests. The 7 key elements are: • **Issuer ID** • **Dispensing Provider ID Qualifier** • **Dispensing Provider ID** • **Fill date** • **Prescription Service Number** • **Fill Number** • **Dispensing Status**

6.2. General Pharmacy Claims File Processing Rules

This subsection illustrates general file processing rules and dependency rules pertaining to the ESPCS in Table 28.

Table 28: Pharmacy Claims File Processing & Dependencies

Rule 1	Only pharmacy claims for enrollees in the individual and small group market, both inside and outside the Marketplace, will be accepted. All other claims will be rejected.
Rule 2	The **Unique Enrollee ID** reported on the pharmacy claims file must correspond to a **Unique Enrollee ID** on the enrollment file. Pharmacy claims for enrollees that are not matched on an enrollment file will be considered orphaned and will not be considered during the reinsurance calculation process. Issuers will periodically receive a report listing active claims that do not have an active enrollee record, as well as enrollees without claims.
Rule 3	The initial pharmacy file submission will contain pharmacy claims with a fill date equal to or greater than January 1, 2014. Subsequent pharmacy claims files will contain any new pharmacy claims processed, any replacements or voids of prior submitted claims, and any resubmissions for corrected records that were previously rejected. Full file submissions will result in claims being rejected as duplicates. See section 6.4 for information on identification of duplicate claims.
Rule 4	If any data element fails verification, then the pharmacy claim is rejected. Pharmacy claims which pass all verification edits are accepted and stored on the EDGE server in a pharmacy claims data table as active records and are eligible for consideration in the reinsurance calculation process.
Rule 5	Issuers should plan accordingly to ensure that all claims are corrected and submitted by April 30th of the benefit year for consideration. Any new claims, or corrections to rejected claims, will not be accepted after April 30th.

6.3. Header, Issuer and Plan Level Rules Specific to Pharmacy Claims Files

The general header, **Record ID**, issuer level and plan level rules outlined in sections 4.6, 4.7, 4.8 and 4.9 apply to all pharmacy claim files.

There are two (2) data elements at the header, issuer and plan levels specific to pharmacy claims files that must pass a required and logical check verification process as outlined in Table 29.

Table 29: Header, Issuer and Plan Level Total Verifications

Rule 1	The **Total Count of Claims** reported at the header level must equal the count of all claim records for all issuers on the file. The **Total Claims** reported at the issuer level must equal the count of the total claim records for the specific issuer submitted. The **Total Claims** reported at the plan level must equal the count of the total claim records for the specific plan submitted. If a reported value at the header, issuer or plan level does not match the total count for the indicated level, then that level and all associated sub-levels will be rejected. Example – If the header level fails and is rejected, then the issuer and plan levels will also be rejected.
Rule 2	The **Total Plan Paid Amount on File** at the header level will be compared to the sum of all total **Plan Paid Amounts** for all issuers in the file. The **Total Plan Paid Amount on File** at the issuer level will be compared to the sum of all total **Plan Paid Amounts** for the specific issuer on the file. The **Total Plan Paid Amount on File** at the plan level will be compared to the sum of all total **Plan Paid Amounts** for the specific plan on the file. If a reported total does not match the associated sum of the level, then the level will not be rejected; however, an informational error message will be produced notifying the submitter of the discrepancy. For example, if the issuer level **Total Plan Paid Amount on File** reported sum is $525,000 but the sum of all issuers total **Plan Paid Amounts** is $524,500, the issuer would not be rejected. An informational edit would be sent to the submitter identifying the discrepancy.

6.4. Data Element Clarifications

This subsection illustrates clarifications of data element rules specific to ESPCS files in Tables 30 through 33. The rules focus on **Prescription/Service Reference Number**, **Product/Service ID**, **Fill Number**, **Total Allowed Costs** and **Plan Paid Amounts** associated with pharmacy rebates.

Table 30: Prescription/Service Reference Number Rules

Rule 1	The **Prescription/Service Reference Number** is assigned by the pharmacy to identify a unique prescription event. Issuers must submit the **Prescription/Service Reference Number** assigned by the pharmacy.* The **Prescription/Service Reference Number** cannot exceed 12 digits but may be less than 12 digits. **Issuers submitting non-retail pharmacy claims, such as staff model plans, will need to create a unique number, up to 12 digits, for the **Prescription/Service Reference Number** on ESPCS.*

Table 31: Product/Service ID

Rule 1	The **Product/Service ID** must be a national drug code (NDC). If multiple NDCs were supplied under a single prescription event, only the highest cost NDC should to be submitted on the pharmacy claim file.

Table 32: Fill Number Rules

Rule 1	Issuers who do not capture a **Fill Number** may choose to default the **Fill Number** to 1 or sequence the **Fill Number** manually. However, if there are multiple fills with the same fill date, the claims will be rejected as duplicate

Table 33: Pharmacy Rebate Rules

Rule 1	**Total Allowed Costs** and **Plan Paid Amounts** are the sum of ingredient cost, dispensing fees and sales tax, where applicable. The reported **Plan Paid Amount** does not need to be adjusted to reflect manufacturer rebates.

6.5. Duplicate Pharmacy Claims

To ensure that there is only one active version of a claim stored in the pharmacy claim table on the EDGE server, duplicate checks are performed. Table 34 and Table 35 outline the data elements used to identify duplicate claims, exceptions and considerations given to **Dispensing Status**.

Table 34: Duplicate Pharmacy Claims Rules

Rule 1	Claims identified as a void or replacement will bypass the duplicate check.
Rule 2	The following data elements are used to determine a duplicate record: • **Issuer ID** • **Dispensing Provider ID Qualifier** • **Dispensing Provider ID** • **Fill date** • **Prescription/ Service Reference Number** • **Fill Number** • **Dispensing Status** If a duplicate claim is identified, the claim will be rejected.

Dispensing Status Exceptions

Depending on the **Dispensing Status** that exists on an active stored claim and a new claim submitted, the new claim may be accepted or rejected as duplicate.

A previously submitted claim must exist as active on the pharmacy data table for the following actions to occur.

Active Claim Dispensing Status	**New Claim Dispensing Status** **Blank***	**New Claim Dispensing Status** **Partial (P) Fill**	**New Claim Dispensing Status** **Completion of a Partial Fill (C)**
Blank*	Reject - Duplicate	Reject - Inconsistent	Reject - Inconsistent
Partial (P) Fill	Reject - Inconsistent	Reject - Duplicate	Accept
Completion (C) of a Partial Fill	Reject - Inconsistent	Accept	Reject - Duplicate

NOTE: A blank implies a single complete fill was performed.

6.6. Claim Processed Date and Time Stamp

The **Claim Processed Date Time** data element is reported at the claim level and is used to determine order of processing. Claims that are adjusted multiple times and submitted on the same pharmacy claim file need to be differentiated for appropriate processing. Issuers who do not capture or populate the time component of the date and time stamp should carefully review the rules in Table 35.

Table 35: Claim Processing Date Time Rules

Rule 1	All claims should include a date and time in the **Claim Processed Date Time** field. Issuers may create the time component to clearly identify the order of processing when submitting multiple claims on a single file or when submitting a void/replace claim.
Rule 2	Issuers who process a claim multiple times in a single day may choose to submit all versions of the claim on a single pharmacy file or only submit the final version of the claim
Rule 3	If multiple versions of the same claim are submitted, they must include the time component of the **Claim Processed Date Time** stamp, even if the **Void/Replace Indicator** is present. If the time component is not provided, all claims with the same **Issuer ID** and claim key will be rejected as the system is not able to determine the processing order of the claims.
Rule 4	If only a final claim is submitted, the **Total Allowed Costs** and **Plan Paid Amount** should reflect the entirety of the costs and amount paid.

Example: Claim Processing Date Time Rules

The following submission would result in rejection of both claims as the 7 key elements match and the **Processed Date Time** is identical.

Issuer ID: 99999

Dispensing Provider ID Qualifier	Dispensing Provider ID	Fill Date	Prescription / Reference Number	Fill Number	Dispensing Status	Plan Paid Amount	Processed Date Time
XX	1234567890	2014-06-02	87654321	1	C	1000.00	**2014-06-03T00:00:00**
XX	1234567890	2014-06-02	87654321	1	C	1200.00	**2014-06-03T00:00:00**

For the claim(s) to be accepted, either the last version of the claim would be submitted by itself (with the total **Plan Paid Amount**)…

Dispensing Provider ID Qualifier	Dispensing Provider ID	Fill Date	Prescription / Reference Number	Fill Number	Dispensing Status	Plan Paid Amount	Processed Date Time
XX	1234856789	2014-06-02	87654321	1	C	**1200.00**	**2014-06-03T00:00:00**

…or each would have to include a unique **Processed Date Time**.

Dispensing Provider ID Qualifier	Dispensing Provider ID	Fill Date	Prescription / Reference Number	Fill Number	Dispensing Status	Plan Paid Amount	Processed Date Time
XX	1234567890	2014-06-02	87654321	1	C	1000.00	**2014-06-03T08:30:10**
XX	1234856789	2014-06-02	87654321	1	C	1200.00	**2014-06-03T14:07:39**

6.7. Voiding Pharmacy Claims

Pharmacy claims files include a data element which allows issuers to void claims that were previously submitted and accepted and stored as active. By using the value "V" as the **Void/Replace Indicator**, an issuer can change an active stored claim to an inactive status, thereby removing it from consideration in the Reinsurance program.

Pharmacy claims submitted with a **Void/Replace Indicator** bypass the duplicate check logic and proceed to void processing logic as outlined in Table 36. An example follows the table.

Table 36: Void Processing Logic for Pharmacy Claims

Rule 1	To void a pharmacy claim: • A value of "V" must be present in the **Void/Replace Indicator** data field • The 7 key elements must be present and match a stored active claim
Rule 2	Only the **Void/Replace Indicator** and the 7 key elements undergo verification edits. All other data elements on a void claim, bypass the verification edits. For example**, Unique Enrollee ID** and **Plan Paid Amount** are data elements that may be present on a void claim submission; however, these are not part of the 7 key elements used to match a stored active claim. Therefore, the **Unique Enrollee ID** and **Plan Paid Amount** bypass the verification edits. Issuers may choose to include or exclude the additional data elements, beyond the 7 key elements, when submitting a void for a pharmacy claim.
Rule 3	The EDGE server software will search the pharmacy claim database for a claim that matches the 7 key data elements. If the original claim is not found, then the void will be rejected. If the original claim is found, then the **Claim Processed Date Time** of the submitted void claim will be compared to the **Claim Processed Date Time** of the stored active claim. • If the **Claim Processed Date/Time** of a the submitted void claim is earlier than the **Claim Processed Date/Time** of the most current active version of the claim, then the submitted void claim will be rejected. • If the **Claim Processed Date Time** stamp of the submitted void claim is **later** than the most current active claim, then the current active claim will become inactive. In addition, the submitted void claim will be stored in the pharmacy claim table as inactive.
Rule 4	Once the void is accepted and the stored active claim is changed to an inactive status, the submitted void claim is also stored as inactive.
Rule 5	Once a void claim is submitted and the original claim is changed from active to inactive status, the claim is no longer eligible for consideration in the reinsurance calculation. If the claim was voided in error, the issuer may either resubmit the original claim or submit a replacement claim.

Example: Pharmacy Claims Data Table Before and After Void Submission

NOTE: For this example assume the 7 key elements submitted on all claims are identical for the matching process to occur.

The pharmacy claim data table includes claim RXC555, processed on April, 27, 2014. The claim was accepted and is stored with a status of active.

Issuer ID	Claim ID	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	RXC555		2014-04-27T16:02:20	1735.00	Active

The issuer submits a void on May 2, 2014. The 7 key elements are used to locate the active claim in the data table.

Issuer ID	Claim ID	V/R Indicator	Claim Processed Date Time	Plan Paid Amount
999887	RXC555	V	2014-05-02T06:12:00	1735.00

The previously submitted claim is found and the status changed from active to inactive. In addition, the submitted void is added to the pharmacy claim data table as inactive.

Issuer ID	Claim ID	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	RXC555	V	2014-05-02T06:12:00	1735.00	Inactive
999887	RXC555		2014-04-27T16:02:20	1735.00	Inactive

6.8. Replacing Pharmacy Claims

Pharmacy claims files include a data element which allows issuers to replace claims that were previously submitted and accepted and stored as active. By using the value "R" as the **Void/Replace Indicator**, an issuer can replace a previously submitted claim.

Pharmacy claims submitted with a replace indicator bypass the duplicate check logic and proceed to replacement processing logic as outlined in Table 37.

Table 37: Replacement Processing Logic for Pharmacy Claims

Rule 1	To replace a pharmacy claim: • A value of "R" must be present in the **Void/Replace indicator** data field The 7 key elements must match a stored claim
Rule 2	Issuers must include all data elements on a replacement claim in order for the replacement claim to be processed. • The 7 key elements bypass the verification edits. • The remaining data elements will be verified after the original claim is found.
Rule 3	The EDGE server software will search the stored claims database for a claim that matches the 7 key data elements. If the original claim is not found, the replacement will be rejected. If the original claim is found, the **Claim Processed Date Time** stamp of the submitted replacement claim will be compared to the date/time stamp of the stored claim. • If the **Claim Processed Date Time** of the submitted replacement claim is **earlier** than the **Claim Processed Date Time** of the most current version of the claim, then the replacement claim is rejected. • If the **Claim Processed Date Time** of the submitted replacement claim is **later** than the most current active claim, then the current active claim will become inactive.
Rule 4	Verification edits will be performed on the remaining data elements submitted on replacement claim: • If any verification edit fails, the submitted replacement claim will be rejected. Because the original claim has already been inactivated, there will be no active version of the claim until a valid replacement is submitted. • If all verification edits pass, the submitted replacement claim will be stored as active.
Rule 5	When submitting a replacement claim to account for changes in a **Plan Paid Amount**, the original claim and the **Plan Paid Amount** associated with the original claim will be inactivated. The replacement claim should include all final paid charges for the services.
Rule 6	Once a replacement claim is submitted and the original claim is changed from active to inactive status, the inactive version of the claim is no longer eligible for consideration in the reinsurance calculation.

Example: Pharmacy Claims Data Table Before and After Replacement Submission

For this example, assume the 7 key elements submitted on all claims are identical for the matching process to occur.

The pharmacy claim data table includes the original claim submitted on April 4, 2014 and a replacement of the original claim on April 27, 2014. Upon submission of the replacement the original claim was set to inactive and the new claim was accepted and stored as active.

Issuer ID	Claim ID	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	RXC555	R	2014-04-27T16:02:20	1735.00	Active
999887	RXC555		2014-04-04T07:41:20	1200.00	Inactive

The issuer submits another replacement for claim RXC555 on May 2, 2014. The system will compare the **Claim Processed Date Time** to determine if the new claim is later than the most current active version of the claim.

Issuer ID	Claim ID	V/R Indicator	Claim Processed Date Time	Plan Paid Amount
999887	RXC555	R	2014-05-02T06:12:00	2735.00

The original claim is found and the **Claim Processed Date Time** is compared to the submitted replacement. Since the submitted replacement is later than the most current active claim, the active claim is changed to inactive. Upon verification of all data elements on the replacement claim, the claim is accepted and stored as the new active claim.

Issuer ID	Claim ID	V/R Indicator	Claim Processed Date Time	Plan Paid Amount	Status
999887	RXC555	R	2014-05-02T06:12:00	2735.00	Active
999887	RXC555	R	2014-04-27T16:02:20	1735.00	Inactive
999887	RXC555		2014-04-04T07:41:20	1200.00	Inactive

6.9. Derived Amounts on Pharmacy Claims

Issuers will need to derive (or estimate) a **Plan Paid Amount** for enrollees who received pharmaceutical services under a capitation arrangement. The inbound claim file layout contains a **Derived Amount Indicator** field to identify when the **Plan Paid Amount** has been calculated for dispensed pharmaceuticals provided under a capitation arrangement. The issuer will need to calculate the estimated **Plan Paid Amount** of the pharmaceuticals dispensed, based on the encounter data submitted by the pharmacy. Additional details related to estimating derived amounts will be provided in future guidance.

Pharmacy claims submitted with a **Derived Amount Indicator** must be reported as follows:

Table 38: Derived Amounts on Pharmacy Claims

Rule 1	Acceptable values for the **Derived Amount Indicator**: • Y = pharmaceuticals were dispensed under a capitation arrangement and the **Plan Paid Amount** is a derived value • N = pharmaceuticals dispensed are covered under fee for service and the **Plan Paid Amount** is the actual amount paid for the service
Rule 2	When the value "Y" is reported in the **Derived Amount Indicator** field: • The **Paid Date** field may be empty or populated with the date of claim adjudication. • The **Plan Paid Amount** must be ≥$0 When the value "N" or a null value is reported in the **Derived Amount Indicator** field: • The **Paid Date** field must be populated • The **Plan Paid Amount** must be ≥ $0
Rule 3	Issuers who are deriving Plan Paid Amounts for capitated services will need to include a value in the **Total Allowed Cost** field and that value must be greater than $0. The **Total Allowed Cost** does not need to be a derived value. Issuers may choose a default value (ex: 0.01, 1.00, etc.) for the **Total Allowed Cost**.

This concludes the business rules for pharmacy claims files. The following section outlines the rules for medical claims file processing.

7. Medical File Processing

Medical claims include all institutional inpatient and outpatient services and all professional claims. Since an EDGE server is used to collect both reinsurance and risk adjustment data, issuers must not filter claims. Software for the Risk Adjustment and Reinsurance programs will select all program specific claims based on program specific business rules. Unlike the enrollment file, medical claim files are NOT complete replacements, but rather incremental file submissions. Each subsequent claim file should include new claims processed and any replacements or voids of prior submitted and accepted claims. Full replacement claims file submissions will result in claims being rejected as duplicates.

7.1. Medical Claims File Definitions

All medical claims file data elements are defined in the EDGE server ICD. Medical claims include inpatient and outpatient facility claims, as well as professional claims. The terms below are repeated here to assist the reader with the specific business rules related to these data elements.

Table 39: Medical Claims File Definitions

Claim ID	A unique number generated by the issuer adjudication system to uniquely identify the transaction. The issuer adjudicated **Claim ID** may be de-identified by the issuer, if they choose.
Original Claim ID	A **Claim ID** previously submitted, accepted and stored on the EDGE server medical claims data table. This data element is only populated when the Void/Replace indicator is populated.
Void/Replace Indicator	Identifies if a previously accepted claim is to be voided or replaced.
Derived Amount Indicator	Indicator used to distinguish between fee-for-service claims and medical services/encounters provided under capitation. If the indicator is populated, then the **Amount Paid** data element must be calculated using the issuers derived amount methodology.

There are additional claims processing terms that are used in the following sections that are defined in Table 40.

Table 40: Claims Processing Terms and Definitions

Active Claim	A claim that was submitted by an issuer, passed all verification edits and was accepted and stored on the medical claims data table.
Inactive Claim	A previously accepted version of a claim that has been voided or replaced. A claim must have been accepted and stored as active to be changed to inactive.
Orphan / Orphaned	A claim that is in an active status but has no corresponding active enrollee record.

7.2. General Medical Claims File Processing Rules

This subsection illustrates general file processing rules for the ESMCS files in Table 41.

Table 41: Medical Claims File Processing General Rules

Rule 1	Only medical claims for enrollees in the individual and small group market, both inside and outside the Marketplace, will be accepted. All other claims will be rejected.
Rule 2	The **Unique Enrollee ID** reported on the medical claims file should correspond to a **Unique Enrollee ID** on the enrollment file.
Rule 3	Medical claims for enrollees that are not matched to a **Unique Enrollee ID** will be considered orphaned and will not be considered during risk adjustment and reinsurance processing. Issuers will periodically receive a report listing active claims that do not have an active enrollee record, as well as enrollees without claims.

Rule 4	The initial medical claims file submission will contain medical claims with dates of service after January 1, 2014. Subsequent medical claim files will contain new medical claims processed, replacements or voids of prior accepted claims, and any resubmissions of previously rejected claims. ***IMPORTANT:*** *Full file submissions will result in claims being rejected as duplicates*. See section 7.6 for information on identification of duplicate claims.
Rule 5	Medical claims which pass all verification edits are accepted and stored on the EDGE server in a medical claim data table as **active** records and will be considered for risk adjustment and reinsurance.
Rule 6	**Bill Types** xx0, xx2, xx3, xx4, xx5, xx6 and xx9 must not be submitted. All claims must be submitted with **Bill Type** xx1, xx7 or xx8. Bill Type xx1 may be used for original, replacement or void claim submissions. Bill Type xx7 will be used for replacement claims and the claim record must include the R indicator. Bill Type xx8 will be used for void claims and the claim record must include the V indicator. See the following sections for more information: - 7.10 regarding submission of a void - 7.11 regarding submission of a replacement claim - 7.15 regarding how to submit interim bills - 7.16 regarding how to submit late charges
Rule 7	All **Place of Service Codes**, for professional claims, will be accepted for general EDGE server file processing.
Rule 8	Institutional claims with overlapping stays at the same or a different facility, for enrollees in the same plan, will not be accepted. See section 7.13 for more information.
Rule 9	In an effort to provide the most complete and accurate reporting of accepted and rejected records in a claim file and the reasons for rejection, the file processing software will apply the verification rules to all claim lines submitted with a valid claim header.
Rule 10	Issuers should plan accordingly to ensure that all claims are corrected and submitted by April 30th of the benefit year for consideration. Any new claims, or corrections to rejected claims, will not be accepted after April 30th.

7.3. Claim Header and Claim Line Dependencies

The claim line level follows the claim header level in the XML data file. A claim header cannot be accepted without all claim lines passing all data element verifications.

Table 42: Claim Header and Claim Line Dependencies

Rule 1	If any data element fails verification at the claim header level, then all associated claim lines will be rejected.
Rule 2	If any claim line fails, then the entire claim record will be rejected.
Rule 3	If a claim is rejected, then the entire claim and all associated claim lines must be resubmitted to be considered for Risk Adjustment or Reinsurance program specific file processing.
Rule 4	Dates of service reported at the claim line level must be within the Statement Coverage dates at the header or the claim will be rejected.

7.4. Header, Issuer and Plan Level Rules Specific to Medical Claims Files

The general header, **Record ID** and issuer level rules outlined in sections 5.3 and 5.4 apply to all medical claim files.

In addition, three (3) summary total data elements at the header, issuer and plan levels specific to medical claims files must pass a required and logical check verification process as outlined in Table 43.

Table 43: Header, Issuer and Plan Level Total Verifications

	Header, Issuer and Plan Level Total Claims, Total Claim Lines and Total Plan Paid Amount
Rule 1	The **Total Claims** reported at the header level must equal the count of all claim records for *all issuers and plans* on the file. The **Total Claims** reported at the issuer level must equal the count of all records for the specific *issuer* submitted. The **Total Claims** reported at the plan level must equal the count of all claim records for the specific *plan* submitted. If the **Total Claims** at the header, issuer or plan level does not match the **Total Claims** for the indicated level, then that level and all associated sub-levels will be rejected. Example: IF the header level fails and is rejected, THEN the issuer and plan levels will also be rejected.
Rule 2	The **Total Claim Lines** reported at the header level must equal the count of all claim line records for *all issuers and plans* on the file. The **Total Claim Lines** reported at the issuer level must equal the count of all the claim line records for the specific *issuer* submitted. The **Total Claim Lines** reported at the plan level must equal the count of all the claim line records for the specific *plan* submitted. If the **Total Claim Lines** at the header, issuer or plan level does not match the **Total Claim Lines** for the indicated level, then that level and all associated sub-levels will be rejected. Example: IF the header level fails and is rejected, THEN the issuer and plan levels will also be rejected.
Rule 3	The **Total Plan Paid Amount on File** at the header level will be compared to the sum of all plan paid amounts for all *issuers and plans* in the file. The **Total Plan Paid Amount for Issuer** at the issuer level will be compared to the sum of all plan paid amounts for the specific *issuer* on the file. The **Total Plan Paid Amount** at the plan level will be compared to the sum of all plan paid amounts for the specific *plan* on the file. If a reported total does not match the associated sum of the level, then the level will **not** be rejected; however, an informational error message will be produced notifying the submitter of the discrepancy. Example: If the **Total Plan Paid Amount for Issuer** is $525,000, but the sum of the all the issuer's plan paid amounts is $524,500, the file would not be rejected. An informational edit would be sent to the submitter identifying the discrepancy.

7.5. Dental and Vision Claims

This subsection illustrates rules pertaining to dental and vision claims included on the ESMCS files and the required data elements necessary for their inclusion in Table 44.

Table 44: Dental and Vision Claims

Rule 1	Dental and vision claims included under major medical will be accepted and must be submitted on the medical claim file.
Rule 2	All dental and vision claims covered under major medical and submitted on the medical claim file require a valid diagnosis code. Claims without a valid diagnosis code will not be accepted. Issuers may use v70.0 if no diagnosis code is available.
Rule 3	Stand-alone dental and vision services are excluded from risk adjustment and reinsurance and must not be submitted.

7.6. Duplicate Medical Claims

To ensure that only one version of an active claim is stored on the EDGE server, duplicate claim checks will be performed. There are two (2) types of duplicate checks performed – claim header level duplicates and line level duplicates. These are outlined in Table 45 and Table 47.

Table 45: Duplicate Checks Performed at the Claim Header

Rule 1	Duplicate checks at the claim header level are bypassed if a **Void/Replace Indicator** is included on the claim record.
Rule 2	For those claims that do not have a **Void/ Replace Indicator** a duplicate check will be performed using the **Issuer ID** and the **Claim ID** reported at the claim header level. If the **Issuer ID** and **Claim ID** match a stored active claim in the medical claims data table, then the new claim and all associated claim lines will be rejected.

Table 46: Duplicate checks Performed at the Claim Line

Rule 1	Duplicate checks at the claim line level are bypassed if a **Void/ Replace Indicator** is included on the claim record.
Rule 2	Duplicate checks at the claim line level are bypassed for inpatient stays due to overlapping stay logic. See section 7.13, Table 53 for more information on overlapping stays.
Rule 3	If the submitted claim does not include a **Void/Replace Indicator** and is not an inpatient stay, then the following data elements will be used to determine if a duplicate claim line exists: • **Plan ID** • **Unique Enrollee ID** • **Rendering Provider ID** • **Date of Service From and Date of Service To** • **Revenue Code (if applicable)** • **Service Code** • **Service Code Modifier(s)** The following **Revenue (REV) Code** / **CPT/HCPCS/ Modifier(s)** combinations will be used to determine a duplicate: If there is a stored active claim line with a **Revenue Code** and no **Service Code**, then do not accept any other lines with that same **Revenue Code**, and no **Service Code with the same Date of Service From** and **Date of Service To**. If there is a stored active claim line with a **Revenue Code** and a **Service Code** without a modifier, then do not accept any other lines with the same **Revenue Code**, same **Service Code**, without a **Service Code Modifier**, and the same **Date of Service From** and **Date of Service To**. If there is a stored active claim line with a **Revenue Code** and **Service Code** with a **Service Code Modifier**, then do not accept any other lines with the same **Revenue Code**, same **Service Code**, same **Service Code Modifier**, and same **Date of Service From** and **Date of Service To**.
Rule 4	**Modifier**, **Revenue Code** and **CPT/HCPCS** exceptions to the line level duplicate checks exist and are outlined in Table 48.

7.7. Exceptions to the Line Level Duplicate Check

There are revenue codes, CPTs/HCPCS, and modifiers that may be billed multiple times in a single day and therefore would be exempt from the duplicate checks at the claim line level. These exceptions are listed in Table 48.

Table 47: Exceptions to Duplicate Checks at the Claim Line Level

Rule 1	When the following **Modifier**(s), **Revenue Code**(s) or CPT/HCPCS codes are present, then the duplicate check at the line level will be bypassed. 25 = Separately Identifiable E&M Service by the Same Physician on the Same Day 76 = Repeat Procedure or Service by Same Physician 91 = Repeat Clinical Diagnostic Laboratory Test Revenue Codes – 0250-0259 (Pharmacy), 272 (Supplies) and 0631-0637 (Drugs) Immunization Administration –90460 through 90474

7.8. Inclusive Services Not Allowed on the Same Day

Some services may be identified as duplicate because the submitted service is part of a more inclusive service submitted on the same day.

Table 48: Inclusive Services Not Allowed on the Same Date

Rule 1	Modifiers 26 and TC If a stored active claim line includes a CPT/HCPCS with a 26 or TC and a subsequent claim line is submitted with the same CPT/HCPCS, no modifier, and the same dates of service, then the claim would be considered a duplicate. No modifier implies that both service components, 26 & TC, were performed; therefore, the same service was performed on the same day. Example: Original Claim Dr. Shaw 71020-26 1/15/2014 Accepted New Claim Dr. Shaw 71020 1/15/2014 Reject – Duplicate service
Rule 2	Modifier 50 Modifier 50 indicates a bilateral procedure was performed. Therefore, a CPT/HCPCS code billed with a modifier 50 could not also be billed with an RT or LT modifier or no modifier on the same day. Example: Original Claim Dr. Martin 20610-50 3/1/14 Accepted New Claim Dr. Martin 20610-RT 3/1/14 Reject – Duplicate service
Rule 3	Modifier RT/LT Modifier RT/LT indicates that a procedure was performed on either the right or left side. Therefore, a CPT/HCPCS code billed with a modifier of LT or RT could also not be billed with a modifier 50 or with no modifier on the same day. Example: Original Claim Dr. Clay 20610-RT 1/28/14 Accepted New Claim Dr. Clay 20610 1/28/14 Rejected - Duplicate New Claim Dr. Clay 20610-50 1/28/14 Rejected – Duplicate
Rule 4	Modifier RR, NU, UE Modifiers RR, NU, and UE are pricing modifiers used for DME items to indicate a rental, new purchase or used purchase. If a claim line contains any of these modifiers, then the same code could not be billed with any of the other modifiers or a blank in the modifier field for any date within the period billed on the original claim. Examples: Original Claim Acme Prosthetics E0240-RR 1/1/14 – 1/30/14 Accepted New Claim Acme Prosthetics E0240 1/16/14 Rejected – Rental on file New Claim Acme Prosthetics E0240-NU 1/20/14 Rejected – Rental on file New Claim Acme Prosthetics E0240-UE 2/2/14 Accepted (New DOS) Original Claim Shoreline Services K0002 2/2/14 Accepted New Claim Shoreline Services K0002-NU 2/2/14 Rejected – Possible Dup New Claim Shoreline Services K0002-RR 2/2/14 – 2/18/14 Rejected – Possible Dup

7.9. Claim Processed Date Time

The **Claim Processed Date Time** data element is reported at the claim header level and is used to determine order of processing. Claims that are adjusted multiple times and submitted on the same or subsequent medical claim file need to be differentiated for appropriate processing.

Issuers who do not capture or populate the time component of the **Claim Processed Date Time** should carefully review the rules in Table 49.

Table 49: Claim Processing Date Time Rules

Rule 1	All claims should include a date and time in the **Claim Processed Date Time** field. Issuers may create the time component to clearly identify the order of processing when submitting multiple claims on a single file or when submitting a void/replace claim.
Rule 2	Issuers who process a claim multiple times in a single day may choose to submit all versions of the claim on a single medical claim file or only submit the final version of the claim.
Rule 3	If multiple versions of the same claim are submitted, then each claim must include a unique time component of the **Claim Processed Date Time**, even if the **Void/Replace Indicator** is included. If the time component of the **Claim Processed Date Time** is not provided, or is not unique, then all claims with the same **Issuer ID** and **Claim ID** will be rejected as the system is unable to identify the processing order of the claims.
Rule 4	If only a final claim is submitted, then the claim must include all **Diagnoses Codes** and report the **Total Amount Allowed** and **Total Amount Paid**.

Example: Claim Processing Date Time Rules

The following submission would result in rejection of both claims as the Issuer ID and Claim ID match and the **Processed Date Time** is identical.

Issuer ID	Claim ID	Original Claim ID	Total Plan Paid Amount	Processed Date Time
9988776	2014041299256		5000.00	**2014-06-03T00:00:00**
9988776	2014041299277	2014041299256	5500.00	**2014-06-03T00:00:00**

For the claim(s) to be accepted, either the last version of the claim would be submitted by itself (with the **Total Plan Paid Amount**)…

Issuer ID	Claim ID	Original Claim ID	Total Plan Paid Amount	Processed Date Time
9988776	2014041299277		**5500.00**	**2014-06-03T00:00:00**

...or each would have to include a unique **Processed Date Time**.

Issuer ID	Claim ID	Original Claim ID	Total Plan Paid Amount	Processed Date Time
9988776	2014041299256		5000.00	**2014-06-03T08:15:10**
9988776	2014041299277	2014041299256	5500.00	**2014-06-03T13:44:52**

In addition, the **Claim Processed Date Time** is used to identify the order of processing when void and replacement claims are submitted on different dates. See Section 7.10, Table 50 for more information.

7.10. Voiding Medical Claims

Medical claim files include a data element which allows issuers to void claims that were previously submitted and accepted and stored as active. By using the value "V" as the **Void/Replace Indicator**, an issuer can change an active stored claim to an inactive status, thereby removing it from consideration for reinsurance or risk adjustment.

Medical claims submitted with a **Void/Replace Indicator** bypass the duplicate check logic and proceed to void processing logic as outlined in Table 50. An example is provided below the table.

Table 50: Void Processing Logic for Medical Claims

Rule 1	To void a medical claim: • A"V" must be present in the **Void/Replace Indicator** field • Issuers may only use bill type xx1 or xx8. • The **Issuer ID** and **Original Claim ID** must match a stored claim
Rule 2	Only the **Void/Replace Indicator**, **Issuer ID, Claim ID, Original Claim ID** and **Claim Processed Date Time** undergo verification edits. All other data elements on a void claim bypass the verification edits. Issuers may choose to include or exclude the additional data elements when submitting a void. Example: **Diagnosis Code** and **Total Amount Paid** are data elements that would be present on a claim submission. Because these data elements are not used to match a stored claim during the void process, the **Diagnosis Code** and **Total Amount Paid** data elements are not necessary.
Rule 3	Any previously submitted claim, for the service being voided, may be used as the **Original Claim ID**. If multiple claim IDs exist on the stored medical claim table, either in an active or inactive status, then the **Original Claim ID** and **Claim Processed Date Time** will be used to identify the claim that needs to be voided.

Rule 4	The EDGE server software will search the claim database for a claim that matches the **Issuer ID** and **Original Claim ID**. If the original claim is not found the void will be rejected. If the original claim is found, the **Claim Processed Date Time** of the submitted void claim will be compared to the **Claim Processed Date Time** of the most current active stored claim. • If the **Claim Processed Date Time** of the submitted void claim is *earlier* than the **Claim Processed Date Time** of the most current active version of the claim, then the submitted void will be rejected. • If the **Claim Processed Date Time** of the submitted void claim is *later* than the **Claim Processed Date Time** of the most current active version of the claim, then the void will be accepted and the active claim will be changed to inactive.
Rule 5	Once the void is accepted and the stored active claim is changed to an inactive status, the submitted void claim is also stored as inactive
Rule 6	Once a void claim is submitted and the original claim is changed from active to inactive status, the claim is no longer eligible for consideration in the reinsurance or risk adjustment program.
Rule 7	An issuer may reactivate a claim that has been voided by submitting a new claim or submitting a replacement claim.

Example: Medical Claims Data Table Before and After Void Submission

The medical claim data table includes claim 123, processed on February, 27, 2014. The claim was accepted and is stored with a status of active.

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
999887	123			2014-02-27T16:02:20	720	735.00	Active

The issuer submits a void on March 2, 2014. The Original Claim ID is used to locate the active claim in the data table.

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount
999887	123	123	V	2014-03-02T10:01:50	720	735.00

The original claim is found and the status changed from active to inactive. In addition, the submitted void is added to the claim data table as inactive.

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
999887	123	123	V	2014-03-02T10:01:50	720	735.00	Inactive
999887	123			2014-02-27T16:02:20	720	735.00	Inactive

7.11. Replacing Medical Claims

Medical claim files include a data element which allows issuers to replace claims that were previously submitted and accepted and stored. By using the value "R" as the **Void/Replace Indicator**, an issuer can change an active stored claim to an inactive status, and replace the inactive claim with a new version.

Medical claims submitted with a replace indicator bypass the duplicate check logic and proceed to replacement processing logic as outlined in Table 51. An example follows the table.

Table 51: Replacement Processing Logic for Medical Claims

Rule 1	To replace a medical claim: • An "R" must be present in the **Void/Replace Indicator** field. • Issuers may only use bill type xx1 or xx7. • The **Issuer ID** and **Original Claim ID** must match a stored claim - The **Original Claim ID** may be an active or inactive version of a previously submitted and accepted claim.
Rule 2	Issuers must include all data elements on a replacement claim in order for the replacement claim to be processed. • The **Issuer ID** and **Original Claim ID** elements bypass the verification edits. The remaining data elements will be verified after the original claim is found.
Rule 3	Any previously submitted claim ID, for the service being replaced, may be used as the **Original Claim ID**. If multiple claim IDs exist on the stored medical claims table, either in an active or inactive status, then the **Original Claim ID** and **Claim Processed Date Time** will be used to identify the claim that needs to be replaced.

Rule 4	The EDGE server software will search the stored claims database for a claim that matches the **Issuer ID** and **Original Claim ID**. If the original claim is not found, the replacement will be rejected. If the original claim is found, the **Claim Processed Date Time** of the replacement claim will be compared to the **Claim Processed Date Time** of the stored active claim. • If the **Claim Processed Date Time** of a the replacement claim is **earlier** than the **Claim Processed Date Time** of the most current active version of the claim, then the replacement claim is rejected. If the **Claim Processed Date Time** of the replacement claim is **later** than the **Claim Processed Date Time** of the most current active version of the claim, then the active claim will be changed to inactive.
Rule 5	Verification edits will be performed on the remaining data elements submitted on replacement claims: • If any verification edit fails, the replacement claim will be rejected. o **IMPORTANT:** Because the original claim has already been inactivated, there will be no active version of the claim until a valid replacement is submitted. If all verification edits pass, the replacement claim will be stored as active.
Rule 6	When submitting a replacement claim to account for changes in paid amounts, the original claim and the paid amounts associated with the original claim will be inactivated. The replacement claim should include all final, aggregated, paid charges for the services, along with all diagnosis, service codes, etc.
Rule 7	Once a replacement claim is submitted and the original claim is changed from active to inactive status, the inactive version of the claim is no longer eligible for consideration in the reinsurance calculation.
Rule 8	If a replacement claim is rejected, issuers may resubmit a corrected version of the replacement claim, in accordance with the rules shown, or submit a new claim without the replace indicator.

Example: Medical Claims Data Table Before and After Replacement Submission

The medical claim data table includes the original claim submitted on January 15, 2014 and a replacement of the original claim on February, 27, 2014. Upon submission of the replacement the original claim was set to inactive and the new claim was accepted and stored as active.

NOTE: A new claim ID (999A1) was used for the replacement claim and referenced the Original Claim ID (999). If a new replacement is needed, either claim ID 999 or 999A1 may be used.

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
12345	999A1	999	R	2014-02-27T16:02:20	720	735.00	Active
12345	999			2014-01-15T11:14:55	720	135.00	Inactive

The issuer submits replacement claim 999A2 on March 2, 2014. Either 999 or 999A1 may be used as the **Original Claim ID**. The system will compare the **Claim Processed Date Time** to determine if the new claim is later than the most current active version of the claim.

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount
12345	999A2	999	R	2014-03-02T10:01:50	720	1735.00

The original claim is found and the **Claim Processed Date Time** is compared to the submitted replacement. Since the submitted replacement is later than the most current active claim, the active claim is changed to inactive. Upon verification of all data elements on the replacement claim, the claim is accepted and stored as the new active claim.

Issuer ID	Claim ID	Original Claim ID	V/R Indicator	Claim Processed Date Time	Diagnosis Code	Total Plan Paid Amount	Status
12345	999A2	999A1	R	2014-03-02T10:01:50	720	1735.00	Active
12345	999A1	999	R	2014-02-27T16:02:20	720	735.00	Inactive
12345	999			2014-01-15T11:14:55	720	135.00	Inactive

7.12. Derived Amounts on Medical Claims

Issuers will need to derive (or estimate) the **Paid Amount**(s) for medical services provided under a capitation arrangement. The inbound claim file layout contains a **Derived Amount Indicator** field to identify when the **Paid Amount** has been calculated for medical services provided under a capitation arrangement. The issuer will need to calculate the estimated paid amounts of the medical services provided, based on the encounter data submitted by the rendering provider for actual services provided. For information about capitated claims, please refer to 45 CFR §153.710. Additional details related to estimating derived amounts will be provided in future guidance.

Medical claims submitted with a **Derived Amount Indicator** must be reported as outlined in Table 52.

Table 52: Derived Amounts on Medical Claims

Rule 1	Acceptable values for the **Derived Amount Indicator**: • Y = medical service provided under a capitation arrangement and the **Total Amount Paid**, at the claim header, is a derived value. • N = medical service covered under fee for service and the **Total Amount Paid,** at the claim header, is the actual amount paid for the service.
Rule 2	At the header level of the claim: When the value "Y" is reported in the **Derived Amount Indicator** field: • The **Date Paid** field may be empty or populated with the date of claim adjudication • The **Total Amount Paid** must be ≥ $0 When the value "N" or a null value is reported in the **Derived Amount Indicator** field: • The **Date Paid** field must be populated • The **Total Amount Paid** must be ≥ $0
Rule 3	IF a medical claim includes both capitated services that have been derived and fee for service items that have paid amounts, at the line level, THEN • the claim header should include: o a **Derived Amount Indicator** value of "Y" and o a **Total Amount Paid** ≥ $0 o The **Date Paid** field may be empty or populated with the date of claim adjudication. • each claim line should include: o for medical services covered under a capitation arrangement ▪ a **Derived Amount Indicator** value of "Y" o for medical services paid under fee for service ▪ a **Derived Amount Indicator** value of "N" o an **Amount Paid** ≥ $0.
Rule 4	Issuers who are deriving **Plan Paid Amounts** for capitated services will need to include a value in the **Total Amount Allowed** field, at the claim header, and that value must be greater than $0. The **Total Amount Allowed** does not need to be a derived value. An issuer reporting capitated services may choose a default value (ex: 0.01, 1.00, etc.) for the **Total Amount Allowed** at the claim header. At the claim line, at least one (1) line must include the same **Amount Allowed** value reported at the claim header; all other **Amount Allowed** values at the claim line level may be reported with a zero (0).

For information about how to derive the **Total Amount Paid** for capitated claims, please refer to 45 CFR §153.710(c).

7.13. Overlapping Stay Logic for Inpatient Claims

A medical claim may not indicate an enrollee was an inpatient at the same or different facility for the same time period except on the date of a transfer or if the **Plan ID** is different.

Table 53 outlines the rules for determining whether an overlapping stay has occurred during an inpatient stay. Examples follow the table.

Table 53: Inpatient Stays on Medical Claims Files

Rule 1	When an inpatient claim is received the following data elements will be used to determine if a similar claim is on the medical claim data table in an active status. • **Unique Enrollee ID** • **Statement Covers From** • **Statement Covers Through** • **Plan ID**
Rule 2	Any active inpatient claim with a date equal to or between the **Statement Covers From** and **Statement Covers Through** will be identified. If the **Statement Covers From** date or the **Statement Covers Through** date is the only date that overlaps, then the new claim is accepted. If any date between the **Statement Covers From** and **Statement Covers Through** date overlaps, then the **Plan ID** will be compared. • If the **Plan ID** on the new claim is different than the **Plan ID** of the active claim, the new claim will be accepted. • If the **Plan ID** on the new claim is the same as the **Plan ID** of the active claim, the new claim will be rejected.

Examples of inpatient overlapping stays

In Example 1 only the Statement Covers Through on Claim 123 overlaps the Statement Covers From on Claim 456. This would pass the overlapping stay logic and be accepted.

	Unique Enrollee ID	Claim ID	Plan ID	Statement Covers From	Statement Covers Through	Status	Accept/ Reject
New Claim	M4#@1	456	12345VA001999901	**2014-01-22**	2014-01-25		Accept
Previously Accepted Claim	M4#@1	123	12345VA001999901	2014-01-17	**2014-01-22**	Active	

In Example 2 the Statement Covers From on Claim 456 is between the statement coverage dates on claim 123 and the enrollee is in the same plan. Therefore, claim 456 would fail the overlapping stay logic and be rejected.

Example 2: Inpatient Overlapping Stays – Multiple Days Overlap with Same Plan ID – Reject:

Unique Enrollee ID	Claim ID	Plan ID	Statement Covers From	Statement Covers Through	Status	Accept /Reject
B99!n5	456	98765VA001999901	**2014-03-20**	**2014-03-25**		Reject
B99!n5	123	98765VA001999901	**2014-03-15**	**2014-03-28**	Active	

In Example 3 the statement coverage dates on Claim 456 are the same as the statement coverage dates on claim 123 but the enrollee is in a different plan. Therefore, claim 456 would pass the overlapping stay logic and be accepted.

Example 3: Inpatient Overlapping Stays – Multiple Days Overlap with Different Plan ID – Accept:

Unique Enrollee ID	Claim ID	Plan ID	Statement Covers From	Statement Covers Through	Status	Accept /Reject
B99!n5	456	**12345VA001999901**	**2014-03-15**	**2014-03-28**		Accept
B99!n5	123	**98765VA001999901**	**2014-03-15**	**2014-03-28**	Active	

7.14. Institutional Bill Types

All institutional claims submitted on a medical claim file must include a **Bill Type**. However, to streamline file processing, only a subset of **Bill Types** will be accepted. Issuers must convert any bill type with a frequency code of xx2, xx3, xx4, xx6 or xx9 for such claims to be considered for risk adjustment and reinsurance. Table 54 provides guidance on the **Bill Types** that are permitted. Sections 7.15 and 7.16 explain how issuers may modify interim bills and late charges for submission.

Table 54: Institutional Bill Types

Rule 1	The first digit of the **Bill Type** indicates the type of facility in which a service was performed. There are no exclusions – all facility types will be accepted.
	The second digit of the **Bill Type** indicates the bill classification. There are no exclusions – all classifications will be accepted.
	The third digit of the **Bill Type** indicates frequency. There are restrictions related to the frequency code.
	• All **Bill Types** submitted must have a frequency code of 1, 7 or 8.
	  • Bill Type xx1 may be used for original, replacement or void claim submissions.
	  • Bill Type xx7 should be used for replacement claims and the claim record must include the R indicator.
	  • Bill Type xx8 should be used for void claims and the claim record must include the V indicator.
	• **Issuers may convert bill types with a frequency code of 2, 3, 4, 5, 6 or 9.**

Rule 2	Issuers who process claims with: • **Bill Types** ending with a frequency code of 0 should not submit these claims because they are related to nonpayment or services not covered by the issuer and therefore would be excluded from consideration in risk adjustment and reinsurance. • **Bill Types** ending in 2, 3 or 4 - please refer to Section 7.15 on institutional interim billing. • **Bill Types** ending in 5 - please refer to Section 7.16 on late charges. • **Bill Types** ending in 6 or 9 - please assess these claims and apply either frequency code 1 or 7 based on the processing rules outlined in this document.
Rule 3	**Bill Types** which are excluded from the risk adjustment program will be filtered at the time the risk adjustment calculations are performed. There are no bill type exclusions for the Reinsurance program.

7.15. Institutional Interim Billing

For the purposes of EDGE server medical claim file processing, CMS has established the following rules related to inpatient and outpatient interim bills received and processed by issuers. These rules were established to streamline EDGE server file processing related to interim bills which are complex and span long periods of time.

The following assumptions were used to determine the rules related to institutional interim bills.

- An interim bill is used to report ongoing inpatient care.
- An interim bill is used to report inpatient stays that exceed 30 days.

- Inpatient stays that exceed 30 days are typically submitted to issuers, by providers, with **Bill Type** frequency codes of 2, 3 or 4.
- Outpatient services provided over a long periods of time (e.g. ongoing therapy) are less complex and are usually submitted and adjudicated more frequently (30 days or less).

Table 55: Inpatient Interim Bill Rules

Rule 1	Inpatient interim bills with frequency codes xx2, xx3 and xx4 must not be submitted on the medical claim file to the EDGE server. Claims with **Bill Types** ending in 2, 3 or 4 must be converted to bill types ending in 1 or the claim will be rejected. The method of converting inpatient interim bills is outlined below.
Rule 2	**Inpatient interim bills** Location: Hospital • Issuers must aggregate all interim bills into a final claim and submit with frequency code 1. • Aggregated claims must include all paid charges and header diagnosis codes for the entire length of stay. • Adjustments to aggregated interim claims must be submitted using the replacement claim process and frequency code 1 or 7. See the examples that follow this table.
Rule 3	**Inpatient interim bills** Location: Skilled nursing facility or other long-term care facility • Option 1: o Issuers may aggregate interim bills and include all paid charges and header diagnosis codes for the duration of the stay. o Aggregated claims must be submitted with a **Bill Type** frequency code of 1. o Adjustments must be submitted using the replacement claim process and frequency code 1 or 7. • Option 2: o Issuers may submit interim claims, after each claim is adjudicated, but must only include the paid amounts and diagnoses associated with the interim period. o Interim claims must have **Statement Coverage From** and **Statement Coverage Through** periods that reflect the interim period only, otherwise, subsequent claims may be rejected as duplicates. o Interim claims must be submitted with a **Bill Type** frequency code of 1. Adjustments must be submitted using the replacement claim process and frequency code 1 or 7. See the examples that follow this table.

Examples of Inpatient Interim Bill Submission

In Example 1 an enrollee was inpatient at a hospital from April 4, 2014 – June 28, 2014. The hospital submitted 3 interim bills. The issuer processed each claim with a final total paid amount of $482,339. The final claim was processed on July 17, 2014.

Example 1: Inpatient Interim Bill Submission – Hospital:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	123a	112	2014-04-04	2014-04-30	425.4	127850.00	2014-05-14T14:50:11
B99!n5	123b	113	2014-04-04	2014-05-30	425.4 695.4	221950.00	2014-06-12T22:12:00
B99!n5	123c	114	2014-04-04	2014-06-28	425.4 695.4	482339.00	2014-07-17T08:05:52

The full inpatient stay should be submitted as one (1) occurrence, for the entire statement coverage period, and include all diagnoses and the aggregated total amount paid for the stay. The claim would be submitted as shown.

Example 1: (cont.): Inpatient Interim Bill Submission – Hospital:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	123C	**111**	**2014-04-04**	**2014-06-28**	**425.4** **695.4**	**482339.00**	2014-07-17T08:05:52

In Example 2 an enrollee was inpatient at a skilled nursing facility from February 1, 2014 – May 15, 2014. The skilled nursing facility submitted 4 interim bills. The issuer processed each claim with a final total paid amount of $577,783. The final claim was processed on May 28, 2014.

Example 2: Inpatient Interim Bill Submission – Skilled Nursing Facility:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	994A	212	2014-02-01	2014-02-28	250.00 555.9 492.8	165081.00	2014-03-05T11:26:00
B99!n5	994B	213	2014-03-01	2014-03-30	250.00 555.9 492.8	165081.00	2014-04-02T12:12:00
B99!n5	994C	213	2014-04-01	2014-04/30	250.00 555.9 492.8	165081.00	2014-05-08T09:15:52
B99!n5	994D	214	2014-05-01	2014-05-15	250.00 555.9 492.8	82540.00	2014-05-28T16:44:02

Issuers may either submit one (1) final claim, for the entire statement coverage period, including all diagnoses and the final total paid amount. The claim would be submitted as shown:

Example 2 (cont.): Inpatient Interim Bill Submission – Skilled Nursing Facility:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	994D	**211**	**2014-02-01**	**2014-05-15**	**250.00 555.9 492.8**	**577783.00**	2014-05-28T16:44:02

Issuers may choose to submit each claim, for each interim period, which would only include the statement coverage period, diagnoses and paid amounts for that interim period. The claims would be submitted as shown:

Example 2 (cont.): Inpatient Interim Bill Submission – Skilled Nursing Facility:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!15	994A	**211**	**2014-02-01**	**2014-02-28**	**250.00 555.9 492.8**	**165081.00**	2014-03-05T11:26:00
B99!15	994B	**211**	**2014-03-01**	**2014-03-30**	**250.00 555.9 492.8**	**165081.00**	2014-04-02T12:12:00
B99!n5	994C	**211**	**2014-04-01**	**2014-04-01**	**250.00 555.9 492.8**	**165081.00**	2014-05-08T09:15:52
B99!n5	994D	**211**	**2014-02-01**	**2014-05-15**	**250.00 555.9 492.8**	**82540.00**	2014-05-28T16:44:02

Table 56: Outpatient Interim Bill Rules

Rule 1	Outpatient interim bills with frequency codes xx2, xx3 and xx4 must not be submitted on the medical claim file to the EDGE server. Claims with **Bill Types** ending in 2, 3 or 4 must be converted to a bill type ending in 1 or the claim will be rejected. The method of submitting outpatient interim bills is outlined below.
Rule 2	**Outpatient interim bills – all locations** • Option 1: o Issuers may aggregate interim bills and include all paid charges and diagnosis codes for the duration of services. o Aggregated claims must be submitted with a **Bill Type** frequency code of 1. o Adjustments must be submitted using the replacement claim process and frequency code 1 or 7. • Option 2: o Issuers may submit interim claims, after each claim is adjudicated, but must include only the paid amounts and diagnoses associated with the interim period. o Interim claims must have **Statement Coverage From** and **Statement Coverage Through** periods that reflect the interim period only, otherwise, subsequent claims may be rejected as duplicates. o Interim claims must be submitted with a **Bill Type** frequency code of 1. Adjustments must be submitting using the replacement claim process and frequency code 1 or 7. See the example that follows this table.

Example of Outpatient Interim Bill Submission

An enrollee had ongoing outpatient physical therapy at rehab hospital from March 15, 2014 – June 15, 2014. The rehab hospital submitted 4 interim bills. The issuer processed each claim with a final total paid amount of $60,225. The final claim was processed on June 30, 2014.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	825-01	132	2014-03-15	2014-03-30	81.54	10100.00	2014-04-02T09:06:44
B99!n5	825-02	133	2014-04-01	2014-04-30	81.54	20025.00	2014-05-03T14:09:02
B99!n5	825-03	133	2014-05-01	2014-05-30	81.54	20025.00	2014-06-04T07:05:52
B99!n5	825-04	134	2014-06-01	2014-06-15	81.54	10075.00	2014-06-30T15:24:00

Issuers may either submit one (1) final claim, for the entire statement coverage period, including all diagnoses and the final total paid amount. The claim would be submitted as shown:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	825-03	**131**	**2014-03-15**	**2014-06-15**	**81.54**	**60225.00**	2014-06-30T15:24:00

Issuers may choose to submit each claim, for each interim period, which would only include the statement coverage period, diagnoses and paid amounts for that interim period. The claims would be submitted as shown:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!15	825-01	**131**	2014-03-15	2014-03-30	81.54	10100.00	2014-04-02T09:06:44
B99!15	825-02	**131**	2014-04-01	2014-04-30	81.54	20025.00	2014-05-03T14:09:02
B99!n5	825-03	**131**	2014-05-01	2014-05-30	81.54	20025.00	2014-06-04T07:05:52
B99!n5	825-04	**131**	2014-06-01	2014-06-15	81.54	10075.00	2014-06-30T15:24:00

7.16. Late Charges

For the purposes of EDGE server medical claim file processing, CMS has established the following rules related to late charge claims received and processed by issuers. These rules were established to streamline EDGE server file processing related to late charges.

Table 57: Late Charge Rules

Rule 1	**Bill Types** with a frequency code of xx5 must not be submitted on the medical claim file to the EDGE server. Claims with **Bill Types** ending in 5 will be rejected unless converted to Bill Type xx1 or xx7. The method of submitting late charges is outlined below.
Rule 2	Late charges must be aggregated with the original claim to which they are associated. The aggregated claim may be submitted with a **Bill Type** frequency of 1 or, if the initial claim was previously submitted and accepted, a new claim would be submitted, using the replacement claim process and a **Bill Type** frequency of 7.

Example of Submission of Late Charges

A claim was processed on June 24, 2014 with a final total paid amount of $26,432. A new claim, with late charges, was submitted on June 28, 2014, and an additional paid amount of $806 was issued.

Example 1: Submission of Late Charges:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	06011	111	2014-06-15	2014-06-18	540.00	26432.00	2014-06-24T11:05:14
B99!n5	06011	115	2014-06-15	2014-06-18	540.00	806.00	2014-06-28T15:19:02

Issuers may either submit one (1) final claim which includes the original claim and the late charge claim. The claim would be submitted as shown:

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99!n5	06011	**111**	**2014-06-15**	**2014-06-18**	**540.00**	**27238.00**	2014-06-28T15:19:02

Issuers may also choose to submit the original claim and then submit an adjustment when the late charges are processed. The claims would be submitted as shown:

Unique Enrollee ID	Claim ID	Bill Type	Void / Replace Indicator	Statement Covers From	Statement Covers Through	DX Code	Total Amount Paid	Claim Processed Date Time
B99!n5	06011	111		2014-06-15	2014-06-18	540.00	26432.00	2014-06-28T15:19:02
B99!n5	06011	**117**	**R**	2014-06-15	2014-06-18	540.00	**27238.00**	2014-06-24T11:05:14

7.17. Mother and Baby Claims

In practice, some hospital claims for childbirth include both the mother's record and the newborn infant's record on the same claim (diagnoses and procedure codes). The Risk Adjustment and Reinsurance programs utilize enrollee-based claims; therefore, mother/baby claims that are bundled would not allow the appropriate attribution of claims based data to the mother and to the infant. We recognize that some states require bundling mother/baby claims for a specific timeframe, so timing related to unbundling claims would be a consideration for issuers.

Table 58: Mother and Baby Claims

Rule 1	Issuers should separately submit mother and baby claims. CMS will not unbundle mother and baby services that are bundled on a single claim. Issuers should adopt and adhere to a consistent policy for unbundling claims.
Rule 2	Diagnosis codes and plan paid amounts are allocated to the unique enrollee ID that appears on the claim submission file.
Rule 3	For reinsurance purposes: Claims costs that remain bundled will count as the mother's claims costs under the reinsurance program.
Rule 4	For risk adjustment purposes: Risk adjustment has separate adult, child, and infant risk adjustment models and requires assignment to the correct model for an enrollee based on age. If claims are not unbundled, then the risk adjustment software code will only produce a risk score for the masked enrollee ID that is successfully matched to an enrollee record.

8. Supplemental Diagnosis Code File Processing

The ACA risk adjustment model predicts annualized plan liability expenditures using age, sex and health status (derived from diagnosis codes). Therefore, capturing all relevant diagnoses is important to the accuracy of risk adjustment. CMS recognizes that there are limited circumstances where relevant diagnoses may be missed or omitted during claim or encounter submission. In cases where diagnosis codes were missed or omitted during data submission, we are providing specific business rules for the submission of supplemental diagnosis codes.

Guidance on Health Assessments:

CMS previously stated that it would provide guidance on the use of health assessments as a source of risk adjustment diagnosis codes. We now clarify that a diagnosis code derived from a health assessment may be used if the diagnosis code (all must be met):

- is supported by medical record documentation and complies with standard coding principles and guidelines;
- is related to medical services performed during the patient visit and is the result of a medical service(s) that resulted in a paid medical claim or reported encounter;
- is the result of medical services performed by a State licensed medical provider; and
- Complies with general medical claim file or supplemental diagnosis file submission business rules (see Section 8.2).

Unacceptable health assessment sources of diagnosis codes for distributed data collection include:

- a patient-reported list of diseases or conditions not related to medical services provided and paid for a patient visit;
- diagnosis codes from medical services that occurred outside the plan enrollment period for the enrollee; and
- diagnosis codes from paid claims or encounters from a period prior to January 1, 2014.

Diagnosis codes from a distributed data collection acceptable health assessment (see requirements above) may be submitted in accordance with the medical claim submission process (if a claim for a paid service or accepted encounter **was not previously submitted and accepted)** or may be submitted in accordance with the supplemental diagnosis code submission process (if a claim **was previously submitted and accepted** on the EDGE server).

Acceptable Sources of Supplemental Diagnoses:

Medical Record: The discovery of a supplemental diagnosis code is the result of medical record review by the issuer subsequent to medical billing or through routine medical record review. The issuer must evaluate all diagnoses on the original claim submitted to the EDGE server and must delete any diagnoses not supported by the medical record.

Issuers should follow their normal business practices to address any discrepancies identified as a result of a medical record review. This means that during the course of a medical record review if diagnosis codes are discovered to be inappropriately included on or excluded from a claim, then corrective action should be taken.

CMS is not asking issuers to change their current business practices. For either option, issuers must document any diagnosis code changes since EDGE server data are subject to audit.

Issuers have two (2) options regarding supplemental diagnosis code file submission for EDGE server data collection as a result of medical record review.	
Option 1	If a supplemental diagnosis code is linked to a claim that was previously submitted and accepted by the EDGE server, then issuers can follow the EDGE server process for voiding a claim or replacing a claim.
Option 2	If a supplemental diagnosis code is linked to a claim that was previously submitted and accepted by the EDGE server, then issuers can use the add/delete process for supplemental diagnosis code file submission.

Electronic Data Interchange (EDI): Diagnosis codes that are received via EDI and exceed the number of diagnosis codes that are accepted by the issuer's claims system. Issuers must submit supplemental diagnoses that were on the submitted claim transaction but truncated in the translator/EDI front-end in the ESSFS.

8.1. Supplemental Diagnosis File Definitions

All supplemental diagnosis file data elements are defined in the EDGE server ICD. The terms below are repeated here to assist the reader with the specific business rules related to these data elements.

Table 59: Supplemental Diagnosis File Definitions

Supplemental Diagnosis Detail Record ID	Unique number generated by the issuer to uniquely identify the supplemental diagnosis transaction.
Original Medical Claim ID	The medical claim ID to which the supplemental claim is linked and was submitted on a previous medical claim file and as accepted by the EDGE server.
Detail Record Processed Date Time	The date and time when the supplemental diagnosis detail record was created by the issuer.
Add/Delete/Void Indicator	Identifies if a supplemental diagnosis code is added; identifies if a previously submitted supplemental diagnosis is deleted; identifies if a previously submitted supplemental diagnosis file is voided.
Original Supplemental Diagnosis Detail Record ID	Identifies the original supplemental diagnosis detail record ID when processing a void.
Date of Service – From	Indicates the first day the service occurred that supports the submission of a supplemental diagnosis.
Date of Service – To	Indicates the last day the service occurred that supports the submission of a supplemental diagnosis.

Supplemental Diagnosis Code Qualifier	Indicates if the diagnosis code is ICD-9-CM or ICD-10-CM.
Supplemental Diagnosis Code	Code value for the diagnosis code; ICD-9-CM or ICD-10-CM.
Supplemental Diagnosis Source	Identifies Diagnosis Source code; ICD-9-C Diagnosis. • MR for medical record • EDI for electronic data interchange Only one code per supplemental diagnosis.

There are additional supplemental diagnosis file processing terms that are used in the following sections that are defined in Table 60.

Table 60: Supplemental Diagnosis File Processing Terms and Definitions

Active Detail Record	A detail record that was submitted by an issuer, passed all verification edits and was accepted and stored on the supplemental diagnosis code file data table.
Inactive Detail Record	A previously accepted version of a detail record that has been voided. A detail record must have been accepted and stored as active to be changed to inactive.
Orphan / Orphaned	A detail record that is in an active status, but has no corresponding active original claim or enrollee record.

8.2. General Supplemental Diagnosis Code File Processing Rules

This subsection illustrates general file processing rules for the ESSFS files in Table 61.

Table 61: Supplemental Diagnosis Code File Processing General Rules

Rule 1	A supplemental diagnosis code must be associated with a claim or encounter for services that occurred during an enrollee's period of enrollment in a risk adjustment eligible plan. Therefore, a supplemental diagnosis must be linked to a previously submitted and accepted EDGE server medical claim.
Rule 2	Submission of a supplemental diagnosis code must be supported by medical record documentation and comply with standard coding principles and guidelines.
Rule 3	The medical service(s) that result in a supplemental diagnosis code must have occurred during the data collection period (January 1 through December 31, 20XX) for a given benefit year and must have occurred no earlier than January 1, 2014.
Rule 4	The submission of a supplemental diagnosis code must include **the Original Medical Claim ID** that was adjudicated and resulted in a paid amount or reported encounter. Diagnosis codes from denied claims are not acceptable.

Rule 5	The submission of a supplemental diagnosis code must include **Service From and To** dates for the service that resulted in the diagnosis code.
Rule 6	Only supplemental diagnosis code files for enrollees in the individual and small group market, both inside and outside the Marketplace, will be accepted.
Rule 7	The **Unique Enrollee ID** reported on the supplemental diagnosis code file should correspond to a **Unique Enrollee ID** on the enrollment file.
Rule 8	Supplemental diagnosis code files for enrollees that are not matched to a **Unique Enrollee ID** will be considered orphaned and will not be considered during risk adjustment processing. Issuers will receive a report listing active supplemental diagnosis code files that do not have an active enrollee record.
Rule 9	Issuers should plan accordingly to ensure that all supplemental diagnosis code files are corrected and submitted by April 30th of the benefit year for consideration. Any new supplemental diagnosis code files, or corrections to rejected files, will not be accepted after April 30th for the benefit year.

8.3. Header, Issuer and Plan Level Rules Specific to Supplemental Diagnosis Code Files

The general header, **Record ID** and issuer level rules outlined in sections 5.3 and 5.4 apply to all supplemental diagnosis code files.

In addition, three (3) summary total data elements at the header, issuer and plan levels specific to supplemental diagnosis code files must pass a required and logical check verification process as outlined in Table 62.

Table 62: Header, Issuer and Plan Level Total Verifications

	Header, Issuer and Plan Level Total Claims, Total Claim Lines and Total Plan Paid Amount
Rule 1	The **Total Detail Records** reported at the header level must equal the count of all detail records for all issuers and plans on the file. The **Total Detail Records** reported at the issuer level must equal the count of all detail records for the specific issuer submitted. The **Total Detail Records** reported at the plan level must equal the count of all detail records for the specific plan submitted. If the **Total Detail Records** at the header, issuer or plan level does not match the **Total Detail Records** for the indicated level, then that level and all associated sub-levels will be rejected. Example: IF the header level fails and is rejected, THEN the issuer and plan levels will also be rejected.

8.4. Duplicate Supplemental Diagnosis Code Detail Records

To ensure that only one version of an active supplemental diagnosis detail record is stored on the EDGE server, duplicate checks will be performed. These checks are outlined in Table 63.

Table 63: Duplicate Checks Performed at the Claim Header

Rule 1	For all Supplemental Diagnosis Detail Records, a duplicate check will be performed using the **Issuer ID** and the **Supplemental Diagnosis Detail Record ID** reported at the detail record level. If the **Issuer ID and Supplemental Diagnosis Detail Record ID** match a stored active Supplemental Diagnosis Detail Record in the Supplemental Diagnosis Detail Record data table, then the new Supplemental Diagnosis Detail Record will be rejected.
Rule 2	If any **Supplemental Diagnosis Code** on a Supplemental Diagnosis Detail Record indicated as a **Delete** does not already exist on the **Original Medical Claim ID** or was removed by a previously accepted **Supplemental Diagnosis File**, then the Supplemental Detail Record is rejected.
Rule 3	If any **Supplemental Diagnosis Code** on a Supplemental Diagnosis Detail Record indicated as an **Add** already exists on the **Original Medical Claim ID** or a previously accepted Supplemental Diagnosis File, then the Supplemental Detail Record is rejected.

8.5. Detail Record Processed Date Time

The **Detail Record Processed Date Time** data element is reported at the detail record level and is used to determine order of processing. Detail records that are adjusted multiple times and submitted on the same or subsequent supplemental diagnosis code file need to be differentiated for appropriate processing.

Issuers who do not capture or populate the time component of the **Detail Record Processed Date Time** should carefully review the rules in Table 64.

Table 64: Detail Record Processed Date Time Rules

Rule 1	All Supplemental Diagnosis Code **Adds, Deletes and Voids** must include a detail record creation date and time in the Detail Record Processed Date Time field. Issuers may create the time component to clearly identify the order of processing when submitting multiple Detail Records in a single Supplemental Diagnosis File or when submitting a **Void**.
Rule 2	Issuers who process a Detail Record multiple times in a single day may choose to submit all versions of the Detail Record in a single Supplemental Diagnosis File or only submit the final version.
Rule 3	If multiple versions of the same Detail Record are submitted, then each Detail Record must include a unique time component for the **Detail Record Processed Date Time**, even if the **Void** indicator is included. If the time component of the **Detail Record Processed Date Time** is not provided, or is not unique, then all Detail Records with the same **Issuer ID** and **Supplemental Diagnosis Detail Record ID** will be rejected as the system is unable to identify the processing order of the records.

8.6. Adding and Deleting Supplemental Diagnosis Codes

When a valid supplemental diagnosis code is discovered subsequent to medical record review or through EDI truncation and is linked to an active **Original Medical Claim** in the EDGE server data tables, then it can be submitted as an **Add** on the detail record of the ESSFS file.

When a diagnosis code that was submitted in error as a result of medical record review and is linked to an active **Original Medical Claim** in the EDGE server data tables, then it can be submitted as a **Delete** on the detail record of the ESSFS file.

Rules for an **Add** or **Delete** are outlined in Table 65.

Table 65: Supplemental Diagnosis Code Add and Delete Rules

Rule 1	To **Add** a supplemental diagnosis to a previously accepted medical claim: • A value of "A" must be present in the **Add/Delete/Void Indicator** data field. To Delete a supplemental diagnosis on a previously submitted medical claim: • A value of "D" must be present in the **Add/Delete/Void Indicator** data field.
Rule 2	Detail Record validation edits will be performed when a supplemental diagnosis is submitted as an **Add**: • The **Date of Service – From** and **Date of Service – To** must be within the service dates at the claim header level on the linked **Original Medical Claim**. • If the diagnosis is not present on the **Original Medical Claim**, then the supplemental diagnosis code will be accepted. • If the diagnosis is present on the **Original Medical Claim**, then the supplemental diagnosis code will be rejected.

Rule 3	Detail Record validation edits will be performed when a supplemental diagnosis is submitted as a **Delete**: • The **Date of Service – From** and **Date of Service – To** must be within the service dates at the claim header level on the linked **Original Medical Claim**. • If the diagnosis is not present on the **Original Medical Claim**, then the deleted supplemental diagnosis code will be rejected. • If the diagnosis is present on the **Original Medical Claim**, then the deleted supplemental diagnosis code will be accepted.

8.7. Voiding Supplemental Diagnosis Code Detail Records

Medical claim files include a data element which allows issuers to void claims that were previously submitted and accepted and stored as active. By using the value "V" as the **Void/Replace Indicator**, an issuer can change an active stored claim to an inactive status, thereby removing it from consideration for reinsurance or risk adjustment.

Medical claims submitted with a **Void/Replace Indicator** bypass the duplicate check logic and proceed to void processing logic as outlined in Table 66. An example is provided below the table.

Table 66: Void Processing Logic for Supplemental Diagnosis Code Detail Records

Rule 1	To **Void** a Supplemental Diagnosis Detail Record previously accepted in a Supplemental Diagnosis File: • A value of "V" must be present in the **Add/Delete/Void Indicator** data field. • The **Issuer ID** and the **Original Supplemental Diagnosis Detail ID** must match a stored Supplemental Detail Record's **Issuer ID** and **Supplemental Diagnosis Detail Record ID** respectively. • If these two conditions are met, then the matched Supplemental Diagnosis Detail Record is inactivated.
Rule 2	Only the **Void** Indicator, **Original Supplemental Diagnosis Detail ID, Supplemental Diagnosis Detail Record ID,** and **Detail Record Processed Date and Time** undergo validation edits. All other data elements on a **Void** bypass edits. Issuers may choose to include or exclude the additional data elements when submitting a **Void**.
Rule 3	The EDGE server software will search Supplemental Diagnosis File database for a record that matches the **Issuer ID** and has a **Supplemental Diagnosis Detail Record ID** that matches the **Original Supplemental Diagnosis Detail ID** on the **Void** record. • If the **Original Supplemental Diagnosis Detail ID** is not matched, then the **Void** will be rejected. • If the **Original Supplemental Diagnosis Detail ID** is found, then the **Detail Record Processed Date Time** of the submitted **Void** will be compared to the **Detail Record Processed Date Time** of the most current active stored record. • If the **Detail Record Processed Date Time** of the submitted **Void** record is earlier than the **Detail Record Processed Date Time** of the most current active version, then the submitted **Void** will be rejected. • If the **Detail Record Processed Date Time** of the submitted **Void** record is later than the **Detail Record Processed Date Time** of the most current active version, then the **Void** will be accepted and the active claim will be changed to inactive.
Rule 4	Once the **Void** is accepted and the stored active record is changed to an inactive status, then the submitted **Void** is also stored as inactive.
Rule 5	Once a **Void** is submitted and the original record is changed from active to inactive status, then the record is no longer eligible for consideration for the risk adjustment program.
Rule 6	An issuer may reactivate a Supplemental Diagnosis Detail Record that has been voided by submitting a new Supplemental Diagnosis Detail Record with a new **Supplemental Diagnosis Detail Record ID**.

9. Assistance with Business Rules

For assistance with any of the file processing rules outlined in this document or any other questions, please go to the Registration Technical Assistance Portal (REGTAP) at **www.REGTAP.info**. REGTAP contains a library of Distributed Data Collection for Reinsurance (RI) and Risk Adjustment (RA) presentation slides and support documents as well as a Frequently Asked Questions (FAQ) database. In addition, registered users may submit questions directly into the Inquiry Tracking and Management System (ITMS) on REGTAP.

Appendix A. EDGE Server Business Rules Revision Details

The following table(s) outlines the changes in each version of the EDGE Server Business Rules document. Excluded from the list are corrections due to typographical errors.

- New = A new section or table was added to the document
- Modify = Content was added or changed in an existing section or table.
- Delete = A section or table, previously included, was deleted.

Appendix Tables 1: EDGE Server Business Rules Revision Details

Version	Section	Table	New/Modify/Delete	Description
			Modify	All rules have been updated with rule numbers
			Modify	All rules tables have been updated with Alt text and full header rows
			Modify	All tables have been updated with titles and placed in a Table of Contents
	3		Modify	Informational content added
	4.4		Modify	Clarification regarding file archiving
	5		Modify	Informational content added
	5.1	Table 14	Modify	Definition of premium
	5.4	Table 21	Modify	Definition of premium
	5.4	Table 23	Modify	Enrollment period activity Indicator updates
	5.5	Table 24	Modify	Definition of premium
	5.5	Table 26	Modify	Note added regarding partial month premiums
	6		Modify	Informational content added
	6.1	Table 26	Modify	Addition of Product/Service ID and Prescription/Service Reference Number definitions
	6.2	Table 28	Modify	Clarification on rule 3 and 4
	6.4		New	New Section added – "Data Element Clarifications"
	6.4	Table 30	New	New table – Prescription/Service Reference Number Rules
	6.4	Table 31	New	New table – Product/Service ID Rules
	6.4	Table 33	New	New table – Pharmacy Rebate Rules

Version	Section	Table	New/Modify/Delete	Description
	6.5		New	Section 6.4 changed to section 6.5 (i.e., Duplicate Pharmacy Claims)
	6.4	Table 32	Modify	Moved note related to fill number to section 6.4
	6.5		Modify	Clarification of dispensing status rules
	6.7	Table 36	Modify	Clarification of void process
	6.8	Table 37	Modify	Clarification of replacement process
	7		Modify	Informational content added
	7.1	Table 39	Modify	Definition of derived amount indicator
	7.2	Table 41	Modify	Clarification on rule 1 and 4 and rule 7 added
	7.2	Table 42	Modify	Rule 3 added
	7.5		New	New section added – "Dental and Vision Claims"
	7.5	Table 45	New	New table – Dental and vision claim rules
	7.14		Modify	Renamed section – Institutional bill types
	7.14	Table 54	New	New table – Institutional bill type rules
	7.15		New	New section added – "Institutional Interim Billing"
	7.15	Table 55	New	New table – Inpatient interim bill rules
	7.15		New	New table – Outpatient interim bill rules
			New	New section added – "Late Charges"
		Table 57	New	New table – Late charges rules
			New	New section added – "Mother and Baby Claims"
		Table 58	New	New table – Mother and baby claims rules
	8		New	New section added for supplemental diagnosis file (ESSFS)
	8.1	Table 59	New	Supplemental Diagnosis File Definitions
	8.1	Table 60	New	Supplemental Diagnosis File Processing Terms and Definitions
	8.2	Table 61	New	Supplemental Diagnosis Code File Processing General Rules
	8.3	Table 62	New	Header, Issuer and Plan Level Total Verifications
	8.4	Table 63	New	Duplicate Checks Performed at the Claim Header
	8.5	Table 64	New	Detail Record Processed Date Time Rules

Version	Section	Table	New/Modify/Delete	Description
	8.6	Table 65	New	Supplemental Diagnosis Code Add and Delete Rules
	8.7	Table 66	New	Void Processing Logic for Supplemental Diagnosis Code Detail Records
	9		Modify	Old Section 8 became Section 9
	Appendix B		Modify	Updated
3.0	5.4		New	Enrollment Period Activity Indicator purpose statement
	5.4	Table 23	Modify	Clarifications regarding Enrollment Period Activity Indicator business rules
	6.9	Table 38	Modify	Updated; New rule added
	7.2	Table 41	Modify	Medical Claims File processing general rules clarified
	7.3	Table 42	Modify	New rule added
	7.11	Table 51	Modify	Rule clarification
	7.12	Table 52	Modify	Updated; New rule added
	7.14	Table 54	Modify	Rule updated

Appendix B. Acronyms

Appendix Tables 2: EDGE Server Business Rules Acronyms

Acronym	Term
ACA	Affordable Care Act of 2010
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS – EDGE Server
CPT/HCPCS	Current Procedural Terminology/Healthcare Common Procedure Coding System
DDC	Distributed Data Collection
EDGE	External Data Gathering Environment
ES	EDGE Server
ESES	EDGE Server Enrollment Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental Diagnosis File Submission
ETL	Extract, Transform and Load
FFM	Federally Facilitated Marketplace
FTP	File Transfer Protocol
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act
HTTP(S)	Hypertext Transfer Protocol (Secure)
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
MC	Medical Claim
NDC	National Drug Code
NPI	National Provider Identifier
PMPM	Per Member Per Month
RA	Risk Adjustment
REV Code	Revenue Code
RI	Reinsurance
RxC	Pharmacy Claim
SFTP	Secure File Transfer Protocol
SSH	Secure Shell
SSL	Secure Socket Layer
UI	User Interface
XML	eXtensible Markup Language
XSD	XML Schema Definition

Appendix C. EDGE Server Enrollment Period Activity Indicator

a. Scenario #1:

Sunshine Health submits their January enrollment file that includes an initial enrollment for Enrollee ABA9651

Appendix Tables 3: Scenario #1 ESES File Header Category Data

Data Element	Issuer Input
File ID	000011112222
Execution Zone	P
Interface Control Release Number	01.00
Run Date	2014-01-31T05:00:00
Report Type	E
Total Number of Enrollee Records	200
Total Number of Enrollment Period Records	250
Enrollment Issuer XML Element	

Appendix Tables 4: Scenario #1 ESES Issuer Category Data

Data Element	Issuer Input
Record ID	1234
Issuer ID	99882
Total Number of Enrollee Records	20
Total Number of Enrollment Period Records	25
Enrollment Enrollee XML Element	

Appendix Tables 5: Scenario #1 ESES Enrollee Category Data

Data Element	Issuer Input
Record ID	1235
Unique Enrollee ID	ABA9651
Enrollee DOB	1971-04-12
Enrollee Gender	M
Enrollment Issuer Profile XML Element	

Appendix Tables 6: Scenario #1 ESES Enrollment Period Category Data

Data Element	Issuer Input
Record ID	1236
Subscriber Indicator	S
Subscriber ID	
Plan ID	12345MD001999901
Enrollment Start Date	2014-01-01
Enrollment End Date	2014-12-31
Enrollment Period Activity	021028
Premium Amount	150.00
Rating Area	020

b. Scenario #2:

Sunshine Health submits their July enrollment file that reflects a new member added to Enrollee ABA9651's policy and increases the premium amount.

Appendix Tables 7: Scenario #2 ESES File Header Category Data

Data Element	Issuer Input
File ID	000011113333
Execution Zone	P
Interface Control Release Number	01.00
Run Date	2014-07-31T05:00:00
Report Type	E
Total Number of Enrollee Records	250
Total Number of Enrollment Period Records	400
Enrollment Issuer XML Element	

Appendix Tables 8: Scenario #2 ESES Issuer Category Data

Data Element	Issuer Input
Record ID	3321
Issuer ID	99882
Total Number of Enrollee Records	100
Total number of Enrollment Period Records	246
Enrollment Enrollee XML Element	

Appendix Tables 9: Scenario #2 ESES Enrollee Category Data (Enrollee ABA9651)

Data Element	Issuer Input
Record ID	3322
Unique Enrollee ID	ABA9651
Enrollee DOB	1971-04-12
Enrollee Gender	M
Enrollment Issuer Profile XML Element	

Appendix Tables 10: Scenario #2 ESES Enrollment Period Category Data (Enrollee ABA9651 Period #1)

Data Element	Issuer Input
Record ID	3323
Subscriber Indicator	S
Subscriber ID	
Plan ID	12345MD001999901
Enrollment Start Date	2014-01-01
Enrollment End Date	2014-06-30
Enrollment Period Activity	021028
Premium Amount	150.00
Rating Area	020

Appendix Tables 11: Scenario #2 ESES Enrollment Period Category Data (Enrollee ABA9651 Period #2)

Data Element	Issuer Input
Record ID	3324
Subscriber Indicator	S
Subscriber ID	
Plan ID	12345MD001999901
Enrollment Start Date	2014-07-01
Enrollment End Date	2014-12-31
Enrollment Period Activity	001
Premium Amount	300.00
Rating Area	020

Appendix Tables 12: Scenario #2 ESES Enrollee Category Data (Enrollee ABA9988)

Data Element	Issuer Input
Record ID	000023
Unique Enrollee ID	ABA9988
Enrollee DOB	1997-09-15
Enrollee Gender	F
Enrollment Issuer Profile XML Element	

Appendix Tables 13: Scenario #2 ESES Enrollment Period Category Data (Enrollee ABA9988 Period #1)

Data Element	Issuer Input
Record ID	000024
Subscriber Indicator	
Subscriber ID	ABA9651
Plan ID	12345MD001999901
Enrollment Start Date	2014-07-01
Enrollment End Date	2014-12-31
Enrollment Period Activity	021EC
Premium Amount	
Rating Area	020

c. Scenario #3:

Sunshine Health submits their October enrollment file that reflects Enrollee ABA9988 has been dropped from the policy and Enrollee ABA9651's policy premium changes again because of the dropped enrollee.

Appendix Tables 14: Scenario #3 ESES File Header Category Data

Data Element	Issuer Input
File ID	000011116777
Execution Zone	P
Interface Control Release Number	01.00
Run Date	2014-10-31T05:30:00
Report Type	E
Total Number of Enrollee Records	255
Total Number of Enrollment Period Records	500
Enrollment Issuer XML Element	

Appendix Tables 15: Scenario #3 ESES Issuer Category Data

Data Element	Issuer Input
Record ID	4588
Issuer ID	99882
Total Number of Enrollee Records	80
Total number of Enrollment Period Records	123
Enrollment Enrollee XML Element	

Appendix Tables 16: Scenario #3 ESES Enrollee Category Data (Enrollee ABA9651)

Data Element	Issuer Input
Record ID	4589
Unique Enrollee ID	ABA9651
Enrollee DOB	1971-04-12
Enrollee Gender	M
Enrollment Issuer Profile XML Element	

Appendix Tables 17: Scenario #3 ESES Enrollment Period Category Data (Enrollee ABA9651 Period #1)

Data Element	Issuer Input
Record ID	4590
Subscriber Indicator	S
Subscriber ID	
Plan ID	12345MD001999901
Enrollment Start Date	2014-01-01
Enrollment End Date	2014-06-30
Enrollment Period Activity	021028
Premium Amount	150.00
Rating Area	020

Appendix Tables 18: Scenario #3 ESES Enrollment Period Category Data (Enrollee ABA9651 Period #2)

Data Element	Issuer Input
Record ID	4591
Subscriber Indicator	S
Subscriber ID	
Plan ID	12345MD001999901
Enrollment Start Date	2014-07-01
Enrollment End Date	2014-09-30
Enrollment Period Activity	001
Premium Amount	300.00
Rating Area	020

Appendix Tables 19: Scenario #3 ESES Enrollment Period Category Data (Enrollee ABA9651 Period #3)

Data Element	Issuer Input
Record ID	4592
Subscriber Indicator	S
Subscriber ID	
Plan ID	12345MD001999901
Enrollment Start Date	2014-10-01
Enrollment End Date	2014-12-31
Enrollment Period Activity	001
Premium Amount	175.00
Rating Area	020

Appendix Tables 20: Scenario #3 ESES Enrollee Category Data (Enrollee ABA9988)

Data Element	Issuer Input
Record ID	0000157
Unique Enrollee ID	ABA9988
Enrollee DOB	1997-09-15
Enrollee Gender	F
Enrollment Issuer Profile XML Element	

Appendix Tables 21: Scenario #3 ESES Enrollment Period Category Data (Enrollee ABA9988 Period #1)

Data Element	Issuer Input
Record ID	0000158
Subscriber Indicator	
Subscriber ID	ABA9651
Plan ID	12345MD001999901
Enrollment Start Date	2014-07-01
Enrollment End Date	2014-09-30
Enrollment Period Activity	021EC
Premium Amount	
Rating Area	020