INTERFACE CONTROL DOCUMENT (ICD) WALKTHROUGH – SUPPLEMENTAL DIAGNOSIS FILE SUBMISSION (ESSFS)

June 19, 2014

Health Insurance Exchange Program Training Series

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Introduction
- Session Guidelines
- Intended Audience
- Purpose
- EDGE Server File Submission Resources Documentation
- Interface Control Document (ICD) Updates
- Submission of Supplemental Diagnoses for RA
- New ESSFS File Type
- Clarification: Submission of Pharmacy Claims Data
- Upcoming Webinars
- Resources
- Closing Remarks

Introduction

- The Distributed Data Collection (DDC) for Reinsurance (RI) and Risk Adjustment (RA) Webinar Series will provide issuers and other entities with program and operational guidance for establishing a distributed data environment to support the RI and RA premium stabilization programs.

Session Guidelines

- This is a ninety-minute webinar session.
- This session will be followed by a one-hour Q&A session on June 24, 2014 from 11:30 a.m. to 12:30 p.m. ET. Registration is open.
- For questions regarding content, submit inquiries to REGTAP.
- For questions regarding logistics and registration, contact the Registrar at: (800) 257-9520.

Intended Audience

- Issuers (Exchange and Non-Exchange)
- Third Party Administrators (TPAs) and Support Vendors

Purpose

- The purpose of this webinar series is to inform issuers about the External Data Gathering Environment (EDGE) server updates to the ICD and the new Supplemental Diagnosis File Submission file type.
- This session will **not** provide details on RI and RA policy or the provisioning timeline.

EDGE Server File Submission Resource Documentation

Review of EDGE Server File Processing

- Data is extracted from issuer proprietary systems, transformed into the necessary EDGE server data formats and loaded to the EDGE server in a process known as Extract, Transform and Load (ETL).
- The EDGE server accepts four XML file types:
  - Enrollment
  - Pharmacy
  - Medical
  - Supplemental Diagnosis

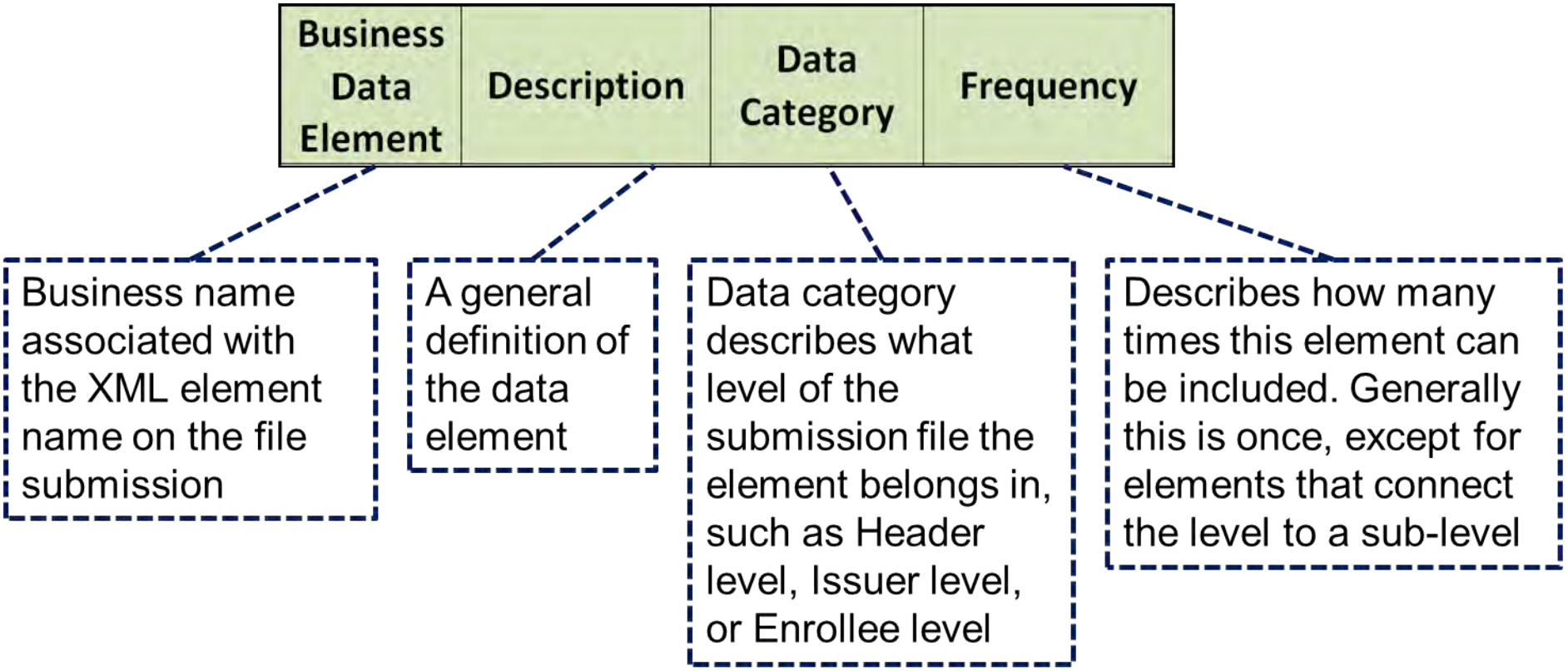
EDGE Server File Submission Resources

- The following resources provide issuers information about the EDGE server file type submissions:
  - ICD
  - ICD Job Aids
  - XSDs (XML Schema Definition)
  - XML (eXtensible Markup Language) examples
  - EDGE Server Business Rules (ESBR), Version 2.0

Interface Control Document (ICD)

- The ICD:
  - Describes the interface requirements for the transmission of information between CMS and an issuer's EDGE server, including the detailed data exchange format and protocols.
  - Interface requirements for the Amazon EDGE server are included in version 02.00.00.
  - Interface requirements for the On-Premise EDGE server will be provided in a future version.
  - IMPORTANT NOTE: The file formats and data elements are the same for either EDGE server option.

ICD Category Data Table Format

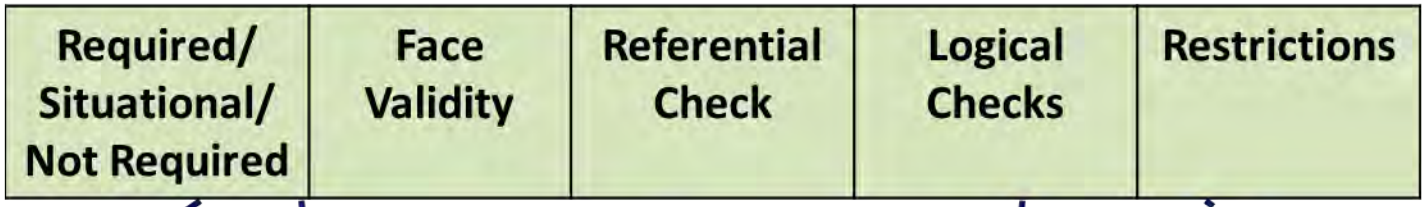


ICD Field Element Characteristics Table Format

The name of the data element used in the XML file. This is the name used when building XML files for submission.

The format of the data entered in this field. Common data types are integer, string (alpha-numeric), date, and decimal (used for dollar amounts, requires decimal place).

ICD Field Element Characteristics Table Format (continued)



Verifies a value is provided for required and situational fields. When a field is "Not Required" a null indicator is still required.

A "Y" in these fields indicates that a verification check is performed against the element. Where a logical verification is performed, a brief description is provided.

Provides a description of the format of the element, such as length, date format or a specific character.

ICD Updates

ICD Updates – Overview

- ICD version 02.00.00 includes, but is not limited to, the following updates:
  - The number of issuers on a single file is restricted.
    - Files may no longer include multiple issuers; only one issuer per file may be submitted on any inbound file.
    - Multiple plans per issuer are still permitted.
  - The “Required” data elements have been redefined as Required, Situational and Not Required.
  - A file naming convention and compression information were added.

ICD Updates - Overview (continued)

- Additional changes to version 02.00.00 include:
  - Minor changes to definitions for the enrollment and pharmacy claim file types
  - Medical claim file logical edit corrections and clarifications
    - Total Allowed Amount and Total Paid Amount Values
  - XSD and XML updates
  - Supplemental diagnosis file specifications
- Issuers should review the ICD in its entirety to identify any other content changes they may find relevant.
  - CMS will publish a detailed document of all changes in the REGTAP library.

Redefining “Required” Elements

- In ICD version 01.00.00, all data elements were identified as “Required”.
- In ICD version 02.00.00 we have provided more clarity by using the following terms:
  - Required: A value must be provided to pass validation.
  - Situational: A value must be provided under pre-defined conditions as indicated.
  - Not Required: Under no condition is a value required to pass validation; however, a value may be provided.
- The XML must include the data tags for all data elements.

File Naming Convention Added

- All submitted files must follow the standard naming convention outlined below. Any files that do not comply will be rejected with an appropriate error message.
- **File Format Mask:**

  <Submitting Entity ID>.<File Type>.D<MMDDYYYY>T<hhmmss>.<Execution Zone>.xml
- **Example File Name:**

  12345.E.D04022014T091533.P.xml

EDGE Server File Compression

The system will support both compressed and uncompressed inbound files. Files can be compressed using gzip or zip compression methods and should be transmitted with the extensions as defined below.

Compression Method	Extension	File Name Example
gzip	.gz	12345.E.D04022014T091533.P.xml.gz
zip	.zip	12345.E.D04022014T091533.P.xml.zip

Medical Claim File Logical Edits

- Statement Covers From and Through at the claim header and Date of Service From and To at the line level must be populated on all claims.
  - For professional claims, issuers may use the Date of Service From and To dates to populate the claim header elements.
  - For institutional claims, issuers may use the most appropriate method, of their choosing, when populating the Date of Service From and To dates.
    - Logical edits will verify that Service From and To dates are within Statement Covers From and Through dates.
    - Review the Business Rules regarding Duplicate Logic when determining your method.

Medical Claim File Logical Edits

- Allowed Amounts
  - The allowed amount at the claim header must always be greater than $0.
  - The allowed amount at the claim line may be equal to or greater than $0.
- Paid Amounts
  - The paid amount at the claim header or claim line may be equal to or greater than $0.

XSD and XML Updates

- New XSDs and XMLs will be provided in the REGTAP library.
- An error was identified in the medical claim file data element “Original Claim ID” and the XML element name has been corrected.
- Prior XML samples included multiple issuers in a single file. The new XML samples include only 1 issuer per file in accordance with the new specifications.

Submission of Supplemental Diagnoses for Risk Adjustment

Why Supplemental Diagnoses?

- The ACA risk adjustment model predicts annualized plan liability expenditures using age, sex and health status (derived from diagnosis codes).
- Collecting all relevant diagnoses is important to the accuracy of Risk Adjustment.
- CMS recognizes that there are limited circumstances for submitting supplemental diagnoses, in cases where diagnosis codes were missed or omitted during data submission.
- We are providing specific business rules to ensure the data quality of supplemental diagnoses.

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 and the issuer must delete any diagnoses not supported by the medical record.
- **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 may submit supplemental diagnoses that were on the submitted claim transaction but truncated in the translator/EDI front-end.

Supplemental Diagnoses – Business Rules

	Description
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.

Business Rules (continued)

	Description
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.

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:
  - 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
  - Complies with general medical claim file or supplemental diagnosis file submission business rules

Health Assessments (continued)

- **Unacceptable** health assessment sources of diagnosis codes include:
  - A patient reported list of diseases or conditions not related to medical services provided and paid for a patient visit
  - Diagnosis codes that occurred outside the plan enrollment period for the enrollee
  - Diagnosis codes from paid claims or encounters from a period prior to January 1, 2014

Health Assessments (continued)

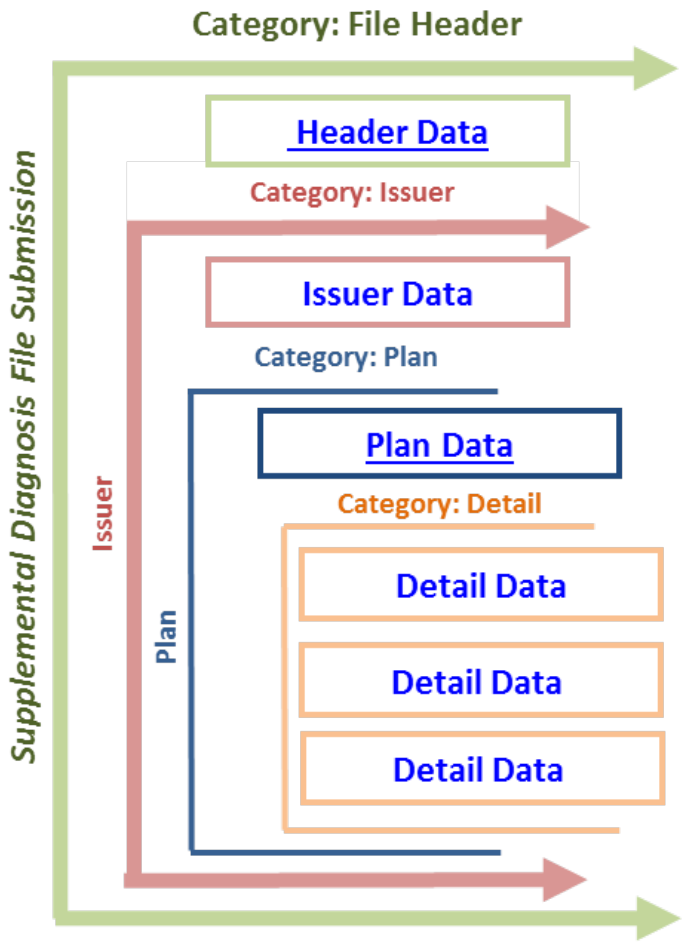
- Diagnosis codes from health assessments that comply with CMS requirements related to data submission may be submitted using the medical claim file submission process if an original medical claim does not exist, or through the supplemental diagnosis submission process if an original claim already exists.

New ESSFS File Type

The ESSFS File Type

- The new ESSFS file type allows issuers to submit supplemental diagnosis information to the EDGE server for consideration in the Risk Adjustment Program.

XML Basic Structure



This graphic illustrates the levels in an XML Supplemental Diagnosis Submission file.

- Header
- Issuer
- Plan
- Detail

ESSFS File Assumptions

- Can only contain information for one issuer, one or more plans within an issuer and one or more detail records within each plan for each issuer
- Must have at least one plan and at least one detail record for that plan included
- Must include a unique enrollee ID that corresponds to a masked unique enrollee ID on the EDGE Server Enrollment Submission (ESES) file

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

Supplemental File Definitions

Data Element	Definition
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 was accepted by the EDGE Server
Detail Record Processed Date Time	The date and time when the supplemental diagnosis detail record was created by issuer
Add/Delete/Void Indicator	Identifies if a supplemental diagnosis code is added; identifies if a previously submitted 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

Supplemental File Definitions

Data Element	Definition
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 the source of the Supplemental Diagnosis • MR for medical record • EDI for electronic data interchange Only one code per supplemental diagnosis

ESSFS - Face Validity Checks

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 face validity verification step will proceed to the referential and logical checks.
Rule 3	The following data elements in the Supplemental Diagnosis File are subject to face validity checks: • Header Level: Execution Zone, Run Date (date check), and Total Detail Records (number check) • Issuer Level: Record ID and Total Detail Records (number check) • Plan Level: Record ID and Total Detail Records (number check) • Detail Record Level: Record ID, Detail Record Processed Date Time (date check), Date of Service – From (date check), and Date of Service – To (date check)

ESSFS – Reference Checks

Rule 1	A plan that passes required and referential checks will only be rejected if a subsequent level completely fails verification. For example, the subsequent level in a Supplemental Diagnosis File is the Detail Record level. If all Detail Records fail for a given plan, then the plan record will be rejected.
Rule 2	The following data elements in the Supplemental Diagnosis File are subject to reference checks: • Header Level: Interface Control Release Number and Record Type • Issuer Level: Issuer ID • Plan Level: Plan ID • Detail Record Level: Add/Delete/Void Indicator, Diagnosis Code Qualifier, Diagnosis Code, and Supplemental Source

ESSFS – Logical Checks

Rule 1	Any data element that fails logical checks will not proceed through file processing.
Rule 2	The following data elements in the Supplemental Diagnosis File are subject to logical checks: • Header Level: File ID, Run Date, and Total Detail Records • Issuer Level: Record ID and Total Detail Records • Plan Level: Record ID and Total Detail Records • Detail Record Level: Record ID, Detail Record Processed Date Time, Original Supplemental Diagnosis Detail ID, Date of Service – From, Date of Service – To, and Supplemental Source

ESSFS – Header, Issuer and Plan Level Edits

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.

ESSFS – Duplicate Checks

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.

ESSFS – Add and Delete Diagnosis Codes

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.

ESSFS – Voiding 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.

ESSFS – Voiding Detail Records (continued)

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.

ESSFS - Detail Record Processing 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.

ESSFS - Reports

- Accept/Reject Report for ESSFS File
- ESSFS Detail Error Report
- ESSFS Accept/Reject Error Report

Clarification: Submission of Pharmacy Claims Data

Q&A: Pharmacy Claims Submission for Edge Server

Q: Do data submission requirements differ for issuers who participate in either the risk adjustment or reinsurance program, and do not participate in both programs?

A: No, regardless of market type (individual or small group) issuers must submit all data types (enrollment, pharmacy, medical and supplemental diagnosis) to the EDGE Server. The common data submission is needed to support payment calculations and ongoing efforts to refine and improve the payment methodology. CMS stated in the 2014 Payment Notice (78 FR 15419) that we intend to continually evaluate how prescription drugs may be incorporated in future HHS risk adjustment models.

Upcoming Webinars

Upcoming Webinars & User Groups

Webinar/User Group Topic	Scheduled Event Date
Supplemental Diagnosis File user group	Tuesday – June 24, 2014
On-Premise EDGE Server	Thursday - June 26, 2014
On-Premise EDGE Server User Group	Tuesday - July 1, 2014

Questions?

To submit questions by phone:

- ❑ dial ‘14’ on your phone’s keypad
- ❑ dial ‘13’ to exit the phone queue

To submit questions by webinar:

- ❑ type your question in the text box under the ‘QA’ tab

Resources

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Resources

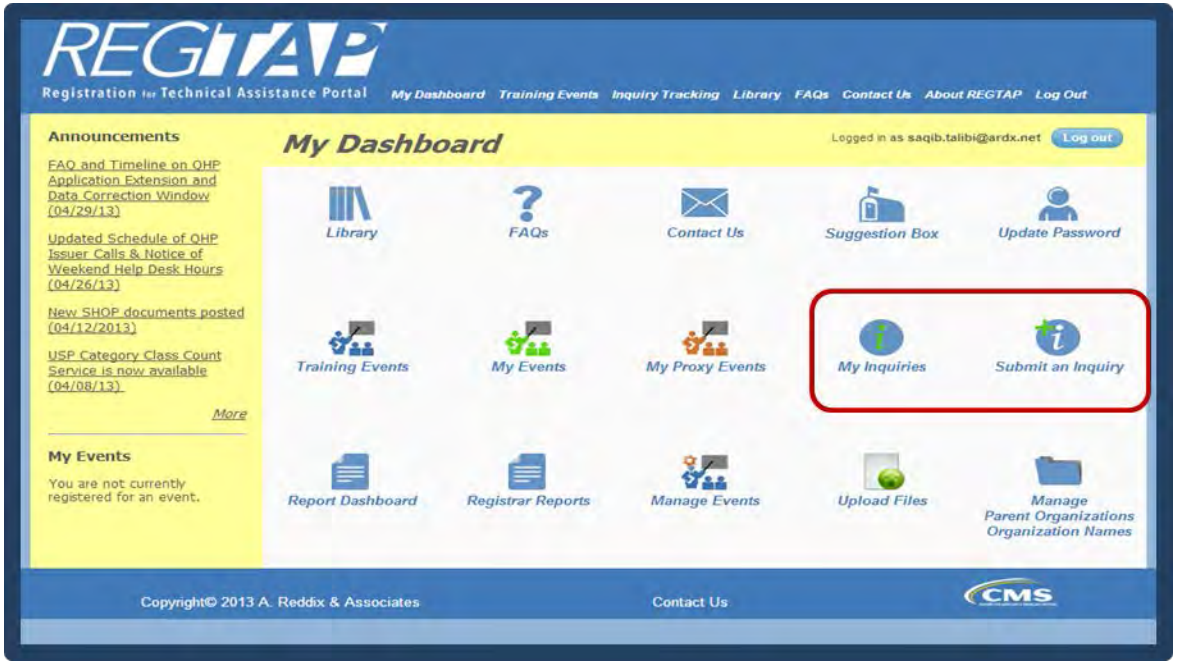
Resource	Link/Contact Information
Center for Consumer Information and Insurance Oversight (CCIIO)	http://cms.gov/cciio/
Registration for Technical Assistance Portal (REGTAP) • Registration • Inquiry Tracking and Management System (ITMS) • Resource Library • Frequently Asked Questions (FAQs)	https://www.REGTAP.info/

Inquiry Tracking and Management System (ITMS)

ITMS is available at http://www.REGTAP.info

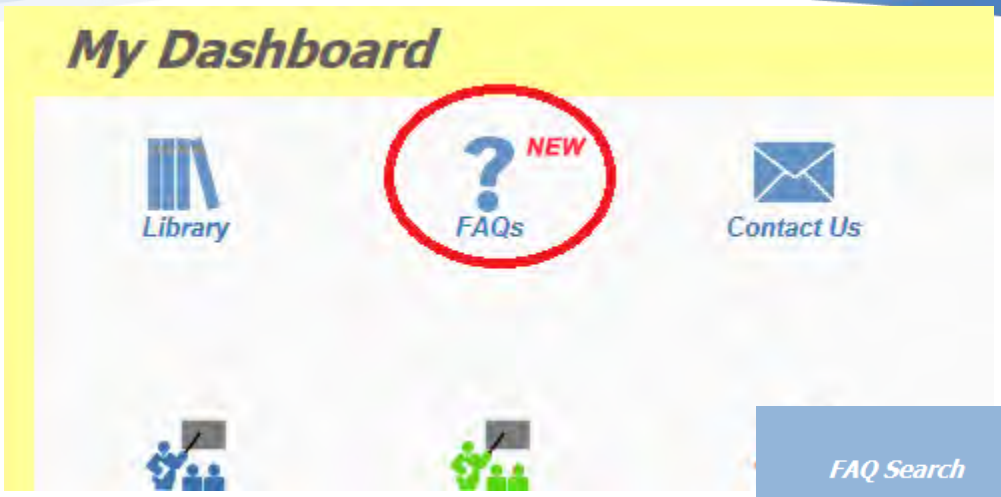
Users can submit questions after the

User Group by selecting "Submit an Inquiry" from My Dashboard.



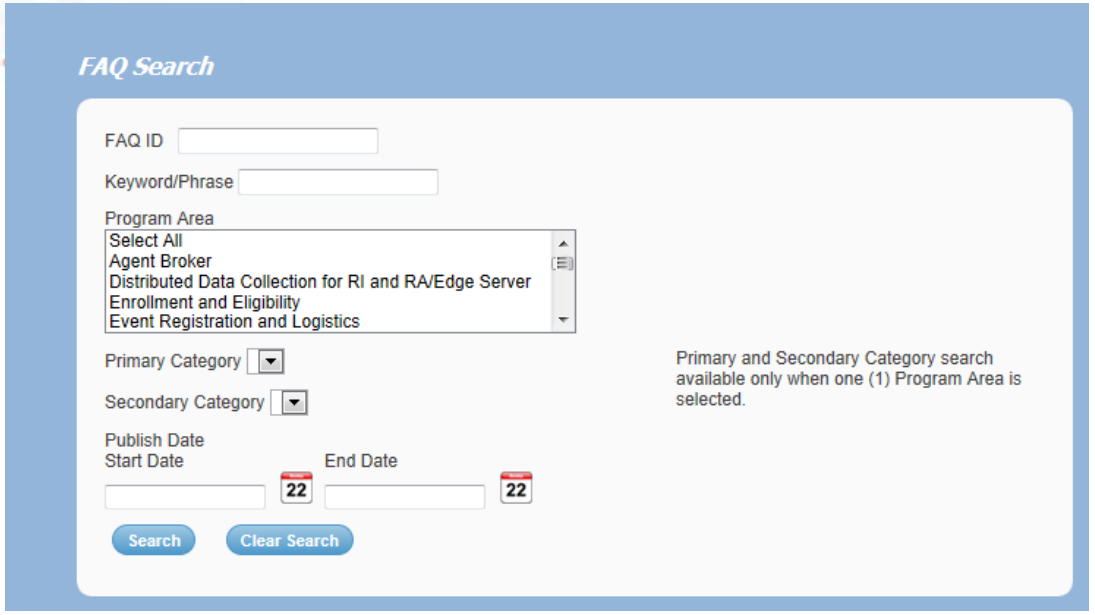
Note: Enter only one (1) question per submission.

FAQ Database on REGTAP



The FAQ Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary categories, and Publish Date.

FAQ Database is available at http://www.REGTAP.info



Closing Remarks