EDGE Server Planned Release Schedule and Projected Modifications

Issue 4 6/5/15

Introduction

The tables below include details of expected modifications to the External Data Gathering Environment (EDGE) server software through June 2015 and a list of future updates. There is no estimated date of deployment for the future updates. This list is subject to change as reported problems are evaluated and new items are prioritized. The Centers for Medicare & Medicaid Services (CMS) will communicate any changes to the planned release schedule as soon as they become available.

Planned Releases

June 5, 2015 Planned Release

6/5/15 Planned Release	Description
File Processing - Enrollment File	• Subscriber enrollment periods with a Premium Amount of $0 and an Enrollment Start Date between March 1 and March 9 and an Enrollment End Date exactly 31 days from the start date will now be rejected. ○ This change is expected to affect a very small volume of issuers that submitted subscriber enrollment periods meeting the indicated criteria.
File Processing – Medical Claim File	• Total Amount Allowed (‘allowedTotalAmount’) = $0 at the claim header will be rejected.
File Processing – Pharmacy Claim File	• Total Allowed Cost (‘allowedTotalCostAmount’) = $0 will be rejected.
File Processing – Supplemental File	• The system will allow multiple Diagnosis Codes to be submitted under a single supplemental detail record.

Risk Adjustment (RA)	• Claims that include a Service Code will only be evaluated for RA selection if the Service Code Qualifier = 03. (This excludes inpatient hospital claims which are selected regardless of Service Code).
	• The EDGE server RARSD and RARSS reports will be updated to prevent count duplication between the following plan and issuer level XML elements in the reports:
	  ○ meanUniqueDiagnosisPerUtilizers
	  ○ meanUniqueDiagnosisPerRAUtilizers
	  ○ meanUniqueDiagnosisPerRAPaymentHccEnrollee
	  ○ totalUniqueEnrolleePaymentHCCs
	• The EDGE server RARSD and RARSS reports will be updated to include ‘maturity’ in the infant Severity Level (hccSeverity).

June 26, 2015 Planned Release

6/26/15 Planned Release	Description
File Processing – Medical Claim File	• A claim submitted with a UE Modifier and a second claim submitted with no modifier and the data elements used to identify a duplicate (Table 48 in the Business Rules). The second claim should be rejected. • Rejected records that previously generated an Error Code of 3.5.21 and 3.5.10 will be replaced with Error Code 3.4.34 (Void or replace claim must reference an existing Original Claim ID if the Void/Replace Indicator is populated as V or R).
Outbound Reports	• An update to the Enrollee Claims Detail (ECD) and Enrollee Claims Summary (ECS) will be made to only list an enrollee as orphaned if there were no claims associated with that enrollee for any enrollment period. • The EDGE server file processing outbound report XSDs will receive minor updates to restrictions for the following reports: ESFAR, ESDMCE, ESDPCE, ESDEE, ESDSFE, ESSEFE, ESSMFE, ESSPFE, ESSSFE
EDGE Registration User Interface (UI)	• RA and Reinsurance (RI) Payment Reports will be available for download by the Issuer Approver when those reports are produced. CMS will notify issuers when the reports will be made available on the UI.

Future Updates

There will be no estimated date of deployment for the following updates and recommended solutions until the updates can be released to production. Issuers should use the recommended solutions, where noted, to submit data that would otherwise be rejected.

Maintenance Type	Category	Information
Software Processing Improvement	File Processing – Medical and Pharmacy Claims	**Item 1: Multiple versions of a claim in a single claim ingest file** Current Functionality: When more than one (1) original, void or replacement claim is included in a single claim file for ingest, the additional claims in the claim family get rejected. Proposed Improvement: Allow multiple versions of the same claim within a single claim file. Recommended Solution: Issuers should choose one (1) of the following options: • Submit only the last version of the claim and include all Dates of Service, Diagnosis Codes and final Plan Paid Amounts. • Segregate the claims across multiple files so that there is no more than one (1) original, one (1) void and one (1) replace within a single file.

Software Processing Improvement	File Processing – Medical Claims	**Item 1: Duplicate claim lines** Current Functionality: The current conditions are correctly rejected in accordance with the Business Rules, Section 7.6 – Table 48: • Service Code 99199 is reported across multiple claims. • The same Service Code is reported across multiple claims with a $0 allowed amount. Proposed Improvement: Allow the services indicated above to bypass duplicate checks across claims. Recommended Solution: Issuers should follow the guidance provided in Section 7.7 of the Business Rules, Table 49 to bypass the duplicate edits across claims. **Item 2: Dental Claim Service Code Modifiers** Current Functionality: Dental modifiers are not included on the reference table, therefore inclusion of these modifiers result in rejects. Proposed Improvement: Bypass verification edits on modifiers where the Service Code Qualifier is 01 (dental services). Recommended Solution: Issuers should remove dental modifiers from claims. If removal of the modifier would result in a duplicate service across claims, issuers should follow the guidance provided in Section 7.7 of the Business Rules, Table 49 to bypass the duplicate edits across claims.
Software Processing Improvement	File Processing – Pharmacy Claims	**Item 1: Void and Replacement Submissions** Current Functionality: Submitted voids and replacement claims are rejected as duplicate (Error Code 3.5.6) when the same Claim ID is used and one (1) of the eight (8) key elements does not match the original claim. Proposed Improvement: Allow the same Claim ID to be used when changing one (1) of the eight (8) key elements. Recommended Solution: Issuers can only reuse a Claim ID on a void or replacement claim when all eight (8) key elements match the original claim. If an original claim needs to be inactivated and one (1) of the eight (8) key elements has changed, issuers must first submit a void using the original matching eight (8) elements and the updated claim can be submitted as an original claim, but the Claim ID must be different.