Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
7500 Security Blvd
Baltimore, MD 21244-1850

EDGE Server Business Rules

Version: 5.0
Last Modified: December 2015

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
4.0	April 17, 2015	PPFMG/CCIIO	See Appendix A for details: Section title changed Invalid tables removed Revised rules and clarifications New sections added on enrollments; Enrollment Period Activity Indicators; and incurred claims Rules for subscriber and non-subscriber requirements added Additional duplicate check exemptions added Additional rule examples added Updated Appendix B Reformatted for 508 Compliance
5.0	December 18, 2015	PPFMG/CCIIO	Additional information on Enrollment File Processing Rules, Pharmacy File Processing, Medical File Processing, Supplemental Diagnosis Code File Processing and Risk Adjustment and Reinsurance Calculations, Revised rules and clarifications Added additional examples Additional Rule Examples Added Deleted Appendix C

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 File Processing Tables

Appendix Tables

1. Purpose

The External Data Gathering Environment (EDGE) Server Business Rules (ESBR) document supplements the EDGE server Interface Control Document (ICD) by providing EDGE server file processing rules to facilitate successful submission of enrollment, pharmacy claims, medical claims and supplemental diagnosis code 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 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. The Center for Consumer Information and Insurance Oversight (CCIIO)/Centers for Medicare & Medicaid Services (CMS) serve 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 CMS;

- Minimal transfer of protected health information (PHI) 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 claim information on enrollees from issuers' 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 Registration for Technical Assistance Portal (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 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 issuers EDGE server(s) (45 CFR § 153.720).

Issuers must keep all EDGE server data in an active status in MySQL for three (3) years. Additionally, in accordance with CFR § 153.620 of the Federal Regulation, issuers are required to retain any information requested to support risk adjustment data validation for a period of at least 10 years after the date the data is reported.

3. Introduction to File Processing Business Rules

This document provides guidance to issuers on the business rules that CMS applies to enrollment, pharmacy, medical claims and supplemental diagnoses code files submitted to an issuers 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 issuers business needs for claim and enrollment processing.

The ESBR document provides file processing business rules based on five (5) categories (general rules, enrollment, pharmacy claims, medical claims and supplemental diagnosis files). Medical claims include inpatient and outpatient facility claims and professional medical claims.

Section 4: General File Processing

Section 4 describes the rules pertaining to all file types, including general processing rules, general verification rules and general rules that apply to each eXtensible Markup Language (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 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 6 describes the rules pertaining to EDGE Server Pharmacy Claim Submission (ESPCS) file 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 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 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 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 ESBR.

4. General File Processing

The general file processing section of the ESBR provides context and outlines the basics of file processing on issuers' EDGE servers. These general file processing rules apply to enrollment, pharmacy claims, medical claims and supplemental diagnosis code files.

4.1. General File Structure – XML Levels

Files submitted and produced on the EDGE server are created in 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 Types

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, medical claims and supplemental diagnosis code files are defined in the ICD. Additional terms related to specific business rules are defined in the appropriate file type (enrollment, pharmacy claims, medical claims and supplemental diagnosis files) section.

Table 2: File Processing Definitions

File Processing Term	Definition
Benefit Year	An EDGE server benefit year aligns with the Risk Adjustment and Reinsurance benefit year, which is a calendar year from January 1st through December 31st of the applicable year.
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.

Table 2: File Processing Definitions (continued)

File Processing Term	Definition
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 an EDGE server is registered and provisioned, an issuer will have access to a test and production zone. Issuers may begin testing ESES, ESPCS, ESMCS and ESSFS files for processing before submitting files to the production zone. 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 claims, medical claims and supplemental diagnosis data will be verified and stored for risk adjustment and reinsurance processes. A minimum number of data elements associated with rejected records 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. Issuers should refer to published guidance in the REGTAP Library regarding additional data submission deadlines and other important dates throughout the benefit year.

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 a minimum number of data elements associated with the rejected records are maintained for the purpose of error communication.

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

Issuers should ensure that all final claims, supplemental diagnosis codes and enrollment data, as well as corrections to records, are submitted prior to April 30th following the applicable benefit year. Additional data and corrections to previously submitted and 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 RA or RI 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.

CMS reserves the right to publish data submission timeline requirements and other important dates by which an issuer must complete certain activities. CMS will communicate such requirements in the REGTAP Library and through a variety of outreach activities.

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. 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 four (4) rules 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
Rule 4	A file that fails as the result of an issuer's EDGE server technical limitation (e.g. processing speed or size) will also reject.

Files that fail one (1) or more of the four (4) verification rules will be rejected and no **Job ID** will be created. In addition, files that fail will not be archived. Information about the failure will be communicated in the outbound EDGE Server System Error (SE) Report.

Files that pass all four (4) verification rules 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 in the outbound EDGE Server File Accept-Reject Report (ESFAR). 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	
XML Data Tag Requirement	*All XML data element tags are required. Population of specific data within the data tag is optional for some data elements (i.e. Subscriber ID, claim modifiers, etc.) Refer to the ICD to determine the requirements for each data element.*
Required/ Situational / Not Required	Required – Verifies that a data value, other than a null value, is included with the data tag. Situational – Verifies that under the specified conditions, a data value, other than a null value, is included with the data tag. Not Required – No verification. A null value may be used with the submitted data tag. Please see the ICD for specific edits.
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 common 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 an abridged version of the header level verifications that are performed, as listed in the ICD.*

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 Error Codes (i.e. reject codes) and descriptions are posted in the REGTAP Library. This list will be updated periodically as file processing edits are updated. 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 through an ESFAR.
Rule 5	**Amount Allowed** at the header must be greater than $0. Under regulation, issuers must not submit denied claims. The EDGE server software identifies a $0 **Amount Allowed** as a denied claim and will therefore reject claims with a $0 **Allowed Amount**. Any cost sharing reductions that reduce a claim paid amount should not be included in the reported **Amount Allowed**.

An ESFAR file will be generated upon completion of the header verification process. This outbound data file will include an "A" if the file was accepted or will include an "R" if the file was rejected and 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, 7.6 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 contiguous and 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 published in the REGTAP Library 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, to the issuer 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, 7.6 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 – A 16-digit unique identifier for an insurance plan offered by an issuer, either on or off the Marketplace, under which an insured enrollee is covered. 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 and Supplemental Files

Rule 1	Each pharmacy, medical claim and supplemental diagnosis file must contain at least one (1) plan, but 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 Market 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, to the plan 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 claims, medical claims and supplemental diagnosis files, are further defined in Sections 6.3, 7.6 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 4.6, 4.7 and 4.8) 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

Benefit Year	An EDGE server benefit year aligns with the RA and RI benefit year, which is a calendar year from January 1st through December 31st of the applicable year.
Unique Enrollee ID	The **Unique Enrollee ID** represents a masked identifier for an enrollee; not a medical record number, social security number (SSN), driver's license number or cardholder ID (45 CFR § 153.720). Issuers must establish their own method of de-identifying an **Enrollee ID**. Issuers may use an existing internal ID provided the ID was not used for exchange enrollment transaction or on the enrollee membership card. Issuers must use the same **Unique Enrollee ID** if the enrollee switches plans within the issuer. Issuers who wish to change the **Unique Enrollee ID** from one (1) benefit year to another must consider the rules for cross-year claims for RA and RI. The same **Enrollee ID** must be used from one (1) year to another in order for a cross-year claim to be considered. The EDGE server will treat variations in upper and lower case values in the **Unique Enrollee IDs** as unique individuals. Use of special characters may cause system errors and result in file failure. As such, CMS suggests that issuers only use alpha-numeric characters in the masking of **Unique Enrollee IDs**.
Non-Subscriber/Dependent	A non-subscriber/dependent is an enrollee who is affiliated with another enrollee who has been identified as the subscriber. See the example in Section 5.4 for more clarification.
Subscriber	A subscriber is a designated enrollee used to report a charged premium for the plan included on the enrollment period. A subscriber does not need to be a parent or guardian if the parent or guardian is not enrolled in the plan. See Section 5.4 for more clarification.
Subscriber Indicator	The value "S" indicating an enrollee is the designated subscriber. See the example in Section 5.4 for more clarification.
Subscriber ID	The **Unique Enrollee ID** of the enrollee that is identified in the file as the designated subscriber with an "S" for the **Subscriber Indicator**. See Section 5.4 for specific business rules.

Table 13: Enrollee File Definitions (continued)

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 billed directly to a subscriber. The monthly **Premium Amount** does not necessarily represent the amount billed 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 subscriber enrollee's premium rating requires the issuer to report a new enrollment period for that subscriber. See Section 5.8 for specific business rules.
Enrollment Period Activity Indicator (EPAI)	The EPAI 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, (for additional information and examples of EPAI scenarios, please see the 10/1/15 EDGE Server Enrollment Submission webinar presentation slides, posted in the REGTAP Library).
Market Year	A data field in the plan reference table that indicates the EDGE benefit year during which a linked **Plan ID** is valid.

5.2. General Enrollment File Processing Rules

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

CMS discourages issuers from creating a single enrollment period per month due to the significant increase in processing time of inbound and outbound files. The increase in file processing time also creates the need for issuers to significantly increase storage space.

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. Issuers will need to submit multiple year enrollments. CMS will provide guidance when issuers may stop submitting prior benefit year enrollment data.

Table 14: Enrollment File Processing (continued)

Rule 3	Duplicate **Enrollee IDs** are not permitted. 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** is submitted more than once, 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. *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 will result in the inactivation of all previously submitted records and storage of all newly submitted records. *NOTE: Please refer to the sections that follow for examples.*

Enrollment End Dates

Enrollment Start and End Dates are reported at the enrollment period level. It is important that the Enrollment End Dates are not open-ended, as this can significantly affect enrollment file processing times as well as delay, or cause failure of, the outbound detail report.

Table 15: Coverage End Dates

Rule 1	Issuers should limit the number of coverage years included at the enrollment period level or file failure will likely result. Issuers should not submit an **Enrollment End Date** that exceeds 10 years from the earliest **Enrollment Start Date**. Note: Outbound summary reports will only produce counts for the current year and two (2) years prior.
Rule 2	If an issuer does not have an **Enrollment End Date** for an enrollee, the **Enrollment End Date** may reflect the date the premium period ends.
Rule 3	**Enrollment Start Dates** are verified against the plan reference table. A plan must be loaded in the plan reference table with a market year that is equal to the year of the **Enrollment Start Date** and the **Enrollment Start Date** must be equal to or later than the start date of the plan in the plan reference table.
Rule 4	**Enrollment End Dates** are verified against the plan reference table. If the **Enrollment End Date** is later than the end date in the plan reference table, then the enrollment record will be accepted, but the outbound detail report will include an informational edit indicating the coverage date is outside the plan reference table.

Enrollee File Dependencies

The enrollment period level follows the enrollee level in the XML data file. An enrollee cannot be accepted without a valid enrollment period that passes all verifications; therefore a dependency exists between the enrollee and enrollment period levels.

Table 16: Enrollee File Dependencies

Rule 1	If any data element fails verification at the enrollee level, then the enrollee record and 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 an enrollee has multiple enrollment periods and 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.
Rule 4	If a subscriber record fails, all associated non-subscriber/dependent records will also be rejected. See Section 5.4 for more information.

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.

Issuers should take care to always submit full enrollment files that include all enrollees and enrollment periods.

Table 17: Enrollees No Longer Included on Submission Files

Rule 1	An enrollee or associated enrollment period that is no longer included on a newly submitted file will be inactivated. Inactivated enrollee records and corresponding enrollment periods will no longer be eligible for consideration in the RA or RI programs.

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 (2) 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 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 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. Subscriber and Non-Subscriber Requirements

In enrollment file processing, there are required data elements for a **Unique Enrollee ID** that is identified as a subscriber or a non-subscriber/dependent. A **Unique Enrollee ID** is the masked identifier for an individual enrollee; not a SSN, driver's license number, medical record number or a cardholder ID.

A **Unique Enrollee ID** is either designated as a subscriber or as a non-subscriber/dependent with an associated subscriber on the enrollment period record. **Unique Enrollee IDs** may have one (1) or more designations, so long as that designation is indicated on a unique enrollment period.

Table 20: Subscriber Requirements

Rule 1	A subscriber is an enrollee with a reported billed premium on the enrollment period. A subscriber does not need to be a parent or guardian if the parent or guardian is not enrolled in the plan. If no parent or guardian is enrolled, then a child must be designated as the subscriber. The enrollment period must also include the subscriber's **Premium Amount**.
Rule 2	A subscriber is identified when the **Subscriber Indicator** "S" is present on the enrollment period record and the **Subscriber ID** is null. The "S" indicates that the **Unique Enrollee ID** is the subscriber.
Rule 3	If a parent or guardian is not enrolled and one (1) or more child is enrolled in a plan, then one (1) child must be designated as the subscriber and the other child (or children) will be designated as the non-subscriber/dependent(s).
Rule 4	Premiums must only be reported on the enrollment record for the subscriber and where the "S" is included in the **Subscriber Indicator** field. If the enrollment period is greater than or equal to one (1) month, a **Premium Amount** greater than $0.00 must be reported *Information about premium reporting is included in Section 5.8.*

Example: B33h97 is reported as the subscriber with a monthly premium.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
23	B33h97	1968-01-17	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
24	S		21890KY001000104	2014-01-01	2014-12-31	355.00	003

Note: Not all required data elements are present in this example.

Table 21: Non-Subscriber Requirements

Rule 1	A non-subscriber/dependent is an enrollee that is affiliated with another enrollee who has been identified as the subscriber. The subscriber must be included in the enrollment file with the affiliated non-subscriber/dependent. If the subscriber is not included in the enrollment file, or fails verification and is rejected, the associated non-subscriber(s)/dependent(s) will also be rejected.
Rule 2	A non-subscriber/dependent is identified when the **Subscriber Indicator** is null and the **Subscriber ID** is populated on the enrollment period. The **Subscriber ID** indicates the **Unique Enrollee ID** to whom the non-subscriber/dependent is affiliated under the same plan.
Rule 3	A non-subscriber/dependent enrollment period must include: • **Enrollment Start Dates** and **Enrollment End Dates** that are within the subscriber's enrollment start and end dates. • The same 16-digit **Plan ID** as the subscriber. • The same **Rating Area** as the subscriber.
Rule 4	For a non-subscriber/dependent to be accepted, the subscriber enrollment record must be present in the enrollment file and accepted.

Example: J900w1 is a child reported as the subscriber with their sibling (J900w2) reported as the non-subscriber/dependent.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
4000	J900w1	2010-02-03	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
4001	S		60640IL003000101	2014-01-01	2014-12-31	355.00	001

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
4002	J900w2	2012-09-01	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
4003		J900w1	60640IL003000101	2014-06-01	2014-12-31	0.00	001

Note: Not all required data elements are present in this example.

5.5. Enrollees Covered Under the Same or Different Plans

Enrollees who are enrolled in the same plan for the same time period will be rejected unless they meet the dual coverage criteria outlined in Table 24.

Table 22: Overlapping Enrollment Periods in the Same Plan

Rule 1	If an enrollee has two (2) enrollment periods in the same 16-digit plan and those enrollment periods overlap, both enrollment periods will be rejected.

Example: 1 Overlapping Enrollment in the Same Plan

Unique Enrollee ID M11Kd04 is listed twice as a subscriber in the same plan with overlapping enrollment periods. Both records would be rejected.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
8054	M11Kd04	1977-07-20	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
8055	S		21890KY001000104	2014-01-01	2014-12-31	355.00	003
8056	S		21890KY001000104	2014-06-01	2014-12-31	275.00	003

Overlapping Coverage in a Federally-facilitated Marketplace (FFM) or State based Marketplace (SBM) Plan

Individuals enrolled in a plan offered on the Marketplace, either FFM or SBM, cannot be enrolled in the same plan for the same period of time. Issuers who have received 834 transactions where an individual has overlapping coverage must resolve the discrepancy.

Overlapping Coverage in an Off Marketplace Plan

Individuals enrolled in plans offered outside of the Marketplace may be enrolled in the same plan for the same period of time. In such instances, issuers will need to create a separate enrollment period for the time of overlap and report the appropriate premiums charged for the non-overlapping and overlapping periods.

Example: Overlapping Coverage in an Off Marketplace Plan

Unique Enrollee ID J2ee9R is enrolled in Plan 60640IL007000100 from 1/1 – 6/30 and from 5/1 – 8/30 and they have been charged a $500 premium for both enrollments. In this example, record 926 is the overlapping period where the premium charged is the total amount for both enrollments.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
924	J2ee9R	1964-08-01	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
925	S		60640IL007000100	2014-01-01	2014-04-30	500.00	001
926	S		60640IL007000100	2014-05-01	2014-06-30	1000.00	001
927	S		60640IL007000100	2014-07-01	2014-08-30	500.00	001

Table 23: Overlapping Enrollment Periods in Different Plans

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.

Example: 1 Overlapping Enrollment Periods with Different Plan IDs

Unique Enrollee ID A3pw88R is enrolled as a subscriber in two (2) different plans that have overlapping enrollment periods. This would be accepted.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
1104	A3pw88R	1955-04-11	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
1105	S		21890KY001000104	2014-01-01	2014-12-31	355.00	003
1106	S		30412KY007000103	2014-06-01	2014-12-31	275.00	003

Note: Not all required data elements are present in this example.

Example: 2 Overlapping Enrollment Periods with Different Plan IDs

Unique Enrollee ID Z98uTT0p is a subscriber in one (1) plan and a non-subscriber/dependent of subscriber enrollee 3JeR77ym in another plan with overlapping enrollment periods. This would be accepted.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
1104	Z98uTT0p	1955-04-11	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
1105	S		55121AL001000100	2014-01-01	2014-12-31	410.00	001
1106		3JeR77ym	56931AL002000101	2014-04-01	2014-12-31	0.00	001

Note: Not all required data elements are present in this example.

Dual-covered enrollees will be accepted by the EDGE server.

Table 24: Dual-Coverage of an Individual Enrollee in the Same Plan

Dual-coverage is defined as:

1. A **Unique Enrollee ID** that is both a subscriber and non-subscriber/dependent under the same **Plan ID** under the same issuer.
2. A non-subscriber/dependent that is enrolled under two (2) different enrollee **Subscriber IDs** in the same plan under the same issuer.

Rule 1	For an individual enrollee that is both a subscriber and non-subscriber/dependent under the same plan, issuers must submit one (1) enrollment period indicating the enrollee is a subscriber and a second enrollment period indicating the enrollee is a non-subscriber/dependent. Please refer to the medical claim Section 7.9 (Table 51 – Exceptions to Duplicate Checks) for information on submission of claims for enrollees who are both a subscriber and non-subscriber/dependent.
Rule 2	For an individual enrollee that is a non-subscriber/dependent and is covered under two (2) different enrollee subscribers, issuers must submit one (1) enrollment period for each subscriber to whom the non-subscriber/dependent is associated.

Example: Dual Coverage where a unique enrollee is both a subscriber and non-subscriber/dependent

4KhhT93 is a subscriber and a non-subscriber/dependent of B5Yen67.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
1104	4KhhT93	1945-08-21	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
1105	S		55121AL001000100	2014-01-01	2014-12-31	410.00	001
1106		B5Yen67	55121AL001000100	2014-04-01	2014-12-31	0.00	001

B5Yen67 is also a subscriber and non-subscriber/dependent of 4KhhT93.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
1107	B5Yen67	1942-12-01	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
1108	S		55121AL001000100	2014-04-01	2014-12-31	410.00	001
1109		4KhhT93	55121AL001000100	2014-01-01	2014-12-31	0.00	001

Example: Dual Coverage under two (2) Different Subscribers

Rj001mq8 is a non-subscriber/dependent of both Jtn11xR and W4jb509.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
648131	Rj001mq8	2000-02-04	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
648132		Jtn11xR	74005KS005000703	2014-01-01	2014-12-31	0.00	001
648133		W4bj509	74005KS005000703	2014-04-01	2014-12-31	0.00	001

5.6. Enrollment Period Activity Indicators

The purpose of the **Enrollment Period Activity Indicator** is to track enrollment changes that are pertinent to RA. Specifically, to appropriately calculate the RA 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 RA transfers.

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

The rules pertaining to the **Enrollment Period Activity Indicator** are outlined in **Table 25**.

Table 25: Enrollment Period Activity Indicator Rules

Rule 1	The following rules apply for each **Enrollment Period Activity Indicator (EPAI)**:	
	EPAI Code	**Description**
	021028	Indicates the enrollment period is an **Initial Issuance**. • Used to indicate the initial issuance of a policy during the first year of enrollment in an Affordable Care Act (ACA) compliant, RA covered and/or RI eligible health plan. • Used for the first subscriber enrollment period in a policy. • Used for both subscriber and non-subscriber/dependent enrollment periods. • Subscriber and non-subscriber/dependent enrollment periods with this code trigger an RA Allowable Rating Factor (ARF) age determination based on age at time of the Enrollment Start Date.
	001	Indicates the enrollment period is a **Modification** or change at the subscriber level to an existing policy. • Used for subscriber enrollment periods only. • Will only be accepted if the preceding enrollment period includes a 021028, 021041, or 001 EPAI code. (No gap in coverage may be present.) • Subscriber enrollment periods with this EPAI code will **not** trigger a new RA Allowable Rating Factor (ARF) determination. • This EPAI code should be used to represent the following: o A change in the monthly premium amount. o A change in the subscriber's rating area (if it does not result in the issuance of a new policy). o A change in the 2-digit variant. o The addition of a new member to the subscriber's policy.

Table 25: Enrollment Period Activity Indicator Rules (continued)

	021EC	Indicates the enrollment period is an **Addition** of a new member. • Used for non-subscriber/dependent enrollment periods only. • Indicates a non-subscriber/dependent has been added to a subscriber's policy. • Non-subscriber/dependent enrollment periods with this code trigger an RA Allowable Rating Factor (ARF) age determination based on age at time of the **Enrollment Start Date**. • Whenever this EPAI Code is used to add a new member to the subscriber's policy, there should be a corresponding enrollment period for the subscriber with an EPAI Code 001 indicating a modification to the policy.
	021041	Indicates the enrollment period is a **Renewal** to an existing policy. • Used to indicate policy renewal for continuous enrollment in an ACA compliant, RA covered and/or RI eligible health plan at the 14-digit **Plan ID** level from one benefit year to the next benefit year. • Will only be accepted if the preceding enrollment period includes a 021028, 021041, or 001 EPAI Code. (No gap in coverage may be present.) • Used for subscriber and non-subscriber/dependent enrollment periods. o For a non-subscriber/dependent renewal 021041 to be accepted there must be an accepted renewal 021041 for the same coverage period for the subscriber in the enrollment file. • Used when the enrollment is a renewal of an existing policy. • Subscriber and non-subscriber/dependent enrollment periods with this code trigger an RA Allowable Rating Factor (ARF) age determination based on age at the time of the **Enrollment Start Date**.

EPAI codes acceptable for a *subscriber* enrollment period are:

- 021028 Initial Issuance
- 001 Modification
- 021041 Renewal

Note: If a subscriber's enrollment period uses an EPAI Code 021EC (addition of a new member), then the enrollment period will be rejected.

EPAI codes acceptable for *non-subscriber /dependents* are:

- 021028 Initial Issuance
- 021EC Addition of a New Member
- 021041 Renewal

Note: If a non-subscriber/dependent's enrollment period uses an EPAI Code 001 (modification), then the enrollment period will be rejected.

NOTE: When ending an enrollment period for either a subscriber or non-subscriber/dependent, use the previous Enrollment Period Activity Indicator since the only action is an end to an enrollment period.

5.7. Enrollment Periods Crossing Calendar Years

In the Small Group Market, CMS understands that there may be some enrollment periods that cross calendar years. In this case, enrollment periods that cross calendar years may be split so that one enrollment period reflects the portion of one calendar year enrollment and the next enrollment period reflects the portion of the following calendar year enrollment. Issuers are not required to split the enrollment periods, as it may have an adverse effect as outlined below. The EDGE server software will correctly identify the number of member months in each benefit year if the enrollment periods are not split.

Example:

Subscriber A – DOB 7/15/1984 - Enrolled on 6/1/2014 and had continuous coverage for one (1) year

Before splitting enrollment:

Subscriber A	EPAI	ARF
06/01/2014 – 5/31/2015	021028	Age 29 for 12 months

After splitting enrollment:

Subscriber A	EPAI	ARF
06/01/2014 – 12/31/2014	021028	Age 29 for 6 months
01/01/2015 – 05/31/2015	001	Age 29 for 6 months

Submit the subscriber's following year enrollment period with an EPAI Code of 001 to avoid re-rating. If EPAI Code 021028 is used, re-rating of the enrollee will occur.

For a non-subscriber, there is a potential for re-rating. Issuers should consider the following information before making a decision to split the enrollment periods in this scenario.

If the non-subscriber has a birthday during their coverage in the first year, then their Allowable Rating Factor (ARF) age for RA will be higher when they are re-rated for the second year than it would have been otherwise, this may have an impact on the RA transfer amount.

Non-Subscriber B – DOB 11/1/2005 (Age 9) was added as a dependent October 1, 2014

Before splitting enrollment:

Enrollment Period 1	EPAI	ARF
10/1/2014 – 09/30/2015	021028	Age 8 for 12 months

After splitting enrollment:

Enrollment Period 1	EPAI	ARF
10/01/2014 – 12/31/2014	021028	Age 8 years for 3 months
Enrollment Period 2	EPAI	ARF
01/01/2015 – 09/30/2015	021028	Age 9 years for 9months

EPAI Code 001 is not permitted for non-subscribers; therefore, an EPAI of 021028 would be submitted with the second enrollment period, which triggers an RA Allowable Rating Factor (ARF) age determination based on age at the time of the **Enrollment Start Date**.

5.8. Changes in Premium Amounts

Premium Amounts may vary or change based on a mid-month enrollment or disenrollment, addition or removal of non-subscribers/dependents or a change in the subscriber's plan.

When there is a change in the **Premium Amount**, a new enrollment period must be created for the subscriber as indicated in Table 26.

Table 26: Changes in Premium

Rule 1	If a subscriber has a change in premium, a new enrollment period, reflecting the change, must be submitted.

Example: Change in Premium

Unique Enrollee ID Z98uTT0p is initially enrolled with a premium of $400.00 and then has a change in premium to $425.00 on July 1, 2014.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
660	Z98uTT0p	1977-07-20	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
661	S		55121AL001000100	2014-01-01	2014-06-30	400.00	003
662	S		55121AL001000100	2014-07-01	2014-12-31	425.00	003

For subscribers who have either a partial month or $0 premium, issuers will need to create a distinct enrollment period reflecting this information. Table 27 outlines the rule related to partial month and $0 premiums.

Table 27: Partial Month and $0 Premiums

Rule 1	When a subscriber has either a partial month enrollment period or $0 premium, issuers must create a distinct enrollment period representing the partial month or $0 premium and an enrollment period(s) representing the full month premium charged would also need to be created and submitted. *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.
Rule 2	When a subscriber is not charged a premium for a partial month enrollment, issuers should submit a zero (0) dollar premium. In this circumstance, the enrollment period must reflect the partial month enrollment in order to include a premium of $0.00. Any subscriber enrollment periods that exceed 30 days require a premium greater than $0.00.

Table 27: Partial Month and $0 Premiums (continued)

Rule 3	The RA program prorates premium amounts when less than a full month is used. CMS recommends that issuers submit the full month premium when possible. EDGE server proration calculation: number of days of enrollment divided by 30 days equals the percent of month enrolled; percent of month enrolled is then multiplied by the full monthly premium amount to arrive at the prorated premium. Note: For EDGE server a month is 30 days regardless of the number of days in the actual month. Therefore, the EDGE server will use 30 days for the month when calculating the prorated premium.
Rule 4	If a subscriber is charged a per day premium, issuers should report the monthly premium that is charged by multiplying the per day premium by thirty (30) days regardless of the number of days in a given month.

Example: Zero Month Premiums

Unique Enrollee ID: L7n33p21 is enrolled on February 27, 2014 and is not charged a premium for February.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
5222	L7n33p21	1994-08-11	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
5223	S		11801PA004000102	2014-02-27	2014-02-28	0.00	001
5224	S		11801PA004000102	2014-03-01	2014-12-31	225.00	001

Example: Partial Month Enrollment with a Prorated Premium

Unique Enrollee ID: B8O099w is enrolled on March 15, 2014 and is charged a prorated premium for a partial month enrollment.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Enrollee Gender
910	B8O099w	1994-08-11	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
911	S		02114NY001000103	2014-03-15	2014-03-31	425.00	004
912	S		02114NY001000103	2014-04-01	2014-12-31	425.00	004

Example: Partial Month Enrollment with Per Day Premium

Unique Enrollee ID M13ds00 is enrolled on June 14, 2015 and is charged a per day premium of $14.00/day.

- The enrollee is enrolled for 16 days at $14.00/day for a total Premium Amount billed to the member of $224.00. The issuer should report the monthly total Premium Amount charged for the policy which would be $420.00 ($14.00/day x 30 days).

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Gender
2208	M13ds00	1968-01-17	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
2209	S	null	02114NY001000103	2015-06-14	2015-06-30	420.00	004
2210	S	null	02114NY001000103	2015-07-01	2015-12-31	425.00	004

5.9. Disenrollments

Table 28: Disenrollments

Rule 1	When an enrollee is disenrolled, issuers must continue to submit the enrollee on the enrollment file with an **Enrollment End Date** in order for that enrollee to be considered in RA and RI. CMS will notify issuers when enrollment for a given benefit year no longer needs to be submitted.
Rule 2	If a subscriber is disenrolled and there is an associated non-subscriber/dependent that remains enrolled, then the associated non-subscriber/dependent either must be associated to another subscriber or become a subscriber. If the non-subscriber/dependent is not associated to another subscriber or does not become the subscriber, the non-subscriber/dependent will be rejected.
Rule 3	If an enrollee is retroactively disenrolled and consequently did not have health coverage at all, issuers must not submit this enrollee's records on the enrollment file.

Example: Subscriber M11Kd04 is disenrolled on May 31, 2015 and dependent N22Le05, who was the non-subscriber/dependent of M11Kd04, becomes the subscriber.

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Gender
8500	M11Kd04	1955-04-11	M

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
8501	S	null	02114NY001000103	2015-01-01	2015-05-31	450.00	004

Enrollee Record ID	Unique Enrollee ID	Enrollee DOB	Gender
8502	N22Le05	1958-09-12	F

Enrollment Period Record ID	Subscriber Indicator	Subscriber ID	Plan ID	Enrollment Start Date	Enrollment End Date	Premium	Rating Area
8503	null	M11Kd04	02114NY001000103	2015-01-01	2015-05-31	0.00	004
8504	S	null	02114NY001000103	2015-06-01	2015-12-31	300.00	004

5.10. Mandated Enrollment Coverage

Under circumstances where issuers are required to cover a newborn or other enrollees for a defined period of time, regardless of whether a premium is collected, issuers may submit such enrollees and the incurred claims for consideration in RA and RI.

Table 29: Mandated Enrollment Coverage

Rule 1	Issuers who are required to provide benefits and cover claims for enrollees for a defined amount of time should submit the enrollee details and an enrollment period that reflects the span of coverage that was required under the mandate. The enrollment period should not be limited to dates that claims were incurred.
Rule 2	The enrollment period requirements outlined in the preceding sections also apply to enrollees with mandated coverage.
Rule 3	A **Premium Amount** must be included with the enrollment period. The **Premium Amount** reported for mandated enrollment is the amount that would have been charged had the person been enrolled.
Rule 4	If the issuer is mandated under the Marketplace requirements, or by State law, to cover a newborn, then a separate enrollee and enrollment period record must be created for the baby for the time of mandated coverage, even if the baby is never enrolled in the plan. For example: If mandated coverage is 60 days from the time of birth, then the issuer would submit an enrollee record and a 60 day enrollment period in the same plan that is assigned to the subscriber. By creating the enrollment information, the newborn will get a risk score and any associated claims will be eligible for consideration in risk adjustment and reinsurance.

Table 29: Mandated Enrollment Coverage (continued)

Rule 5	Enrollees inside the Marketplace: • Issuers are required to maintain coverage for an enrollee for three (3) consecutive months if the enrollee has financial assistance. o If the enrollee does not make full payment of all outstanding premiums by the end of the three (3) month grace period, the enrollee is terminated back to the end of the first month of the grace period. ▪ The enrollee receives plan benefit coverage for that one (1) month and the issuer must pay all claims for services rendered during the first month of the grace period. ▪ The issuer is not responsible for payment of claims for services rendered in months two (2) and three (3) of the grace period. • Therefore, for enrollees in Marketplace plans who are receiving financial assistance, issuers should report a single month of enrollment and the claims incurred for that one (1)-month period.
Rule 6	Enrollees outside the Marketplace: • The State determines the grace period. • If there is a State grace period for a non-financial assistance enrollee, the answer lies in whether or not the State requires coverage for a period of time without retroactive termination. o If the enrollee is covered without retroactive termination, then the enrollee is considered to be enrolled through the end of the grace period allowed by the State, even though the issuer did not receive a premium payment. o If State law allows for a grace period and subsequent retroactive termination if the enrollee does not pay all outstanding premiums by the end of the allowed grace period, then the enrollee is not enrolled and claims for services rendered after the retroactive termination date should ultimately be reversed or rejected. • Issuers should only report periods for which the person is considered enrolled, which is ultimately one (1) month in the Marketplace when financial assistance is received, and up to the State law period for members enrolled outside the Marketplace.

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 RI program. Incurred pharmacy claim costs are aggregated with medical costs to determine if an enrollee has met the uniform payment parameters of the RI 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 30: Pharmacy Claims File Definitions

Benefit Year	An EDGE server benefit year aligns with the RA and RI benefit year, which is a calendar year from January 1 through December 31 of the applicable year.
Fill Number	Code identifying whether the prescription is an original (00) or refill (01-999).
Dispensing Status	Indicates if the prescription was a partial fill (P) or completion of a partial fill (C). A null value implies a complete fill.
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 can be a National Drug Code (NDC), National Health Related Item Code (HRI) or the Universal Product Code (UPC).
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 31.

Table 31: 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 eight (8) key data elements used to identify a unique claim for purposes of identifying duplicates and processing void and replacement requests. The eight (8) key elements are: • **Issuer ID** • **Plan 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 32.

Table 32: 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 initial pharmacy file submission will contain pharmacy claims with a **Fill Date** equal to or greater than January 1 of the benefit year being submitted. Subsequent pharmacy claim files should 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 6.5 for information on identification of duplicate claims.
Rule 3	Issuers should plan accordingly to ensure that all claims are corrected and submitted for consideration by April 30th of the following the applicable benefit year. Any new claims, or corrections to rejected claims, will not be accepted after April 30th.
Rule 4	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 receive an Enrollee (Without) Claims Detail (ECD) Report listing active claims that do not have an active enrollee record, as well as enrollees without claims.
Rule 5	The **Claim ID** must be unique for each claim, even when a void or replace is submitted, or the claim will be rejected.
Rule 6	Issuers who process the same pharmacy claim multiple times may choose to submit all versions of the claim, using the void/replace process, or submit only the final version of the claim. • If the final version is submitted, the total allowed and paid amounts should reflect the aggregated amounts of all the individual claims processed.
Rule 7	If any data element fails verification, 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 RI calculation process.
Rule 8	National Provider Identifiers (NPIs) will undergo a checked digit validation algorithm. Information related to the check digit algorithm can be found here: https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/downloads/npicheckdigit.pdf

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 claim files that must pass a required and logical check verification process, as outlined in Table 33.

Table 33: 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 the issuer on the file. The **Total Claims** reported at the issuer level must equal the sum of the total claim records for all plans for the issuer. The **Total Claims** reported at the plan level must equal the sum of the total claim records for the specific plan. 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 **Total Plan Paid Amount for Issuer** at the issuer level. The **Total Plan Paid Amount for Issuer** at the issuer level will be compared to the sum of all **Total Plan Paid Amounts** reported at each plan level. The **Total Plan Paid Amount** at the plan level will be compared to the sum of all **Plan Paid Amounts** for all claims associated with the plan. 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 **Total Plan Paid Amount for Issuer** is $524,500, the file would not be rejected. An informational error 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 Table 34 through Table 37. The rules focus on **Prescription/Service Reference Number**, **Product/Service ID**, **Fill Number**, **Total Allowed Costs** and **Plan Paid Amounts**.

Table 34: 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.* **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**.*

Table 35: Product/Service ID

Rule 1	The **Product/Service ID** can be an NDC, a National Health Related Item Code (HRI) or the Universal Product Code (UPC) for items dispensed at a pharmacy that do not have a National Drug Code (NDC) number, such as diabetic supplies. The HRI or UPC cannot exceed 11-digits.
Rule 2	If multiple **Product/Service IDs** were supplied under a single prescription event, the highest cost **Product/Service ID** should to be submitted. • Issuers may aggregate the costs where multiple **Product/Service IDs** were supplied.

Table 36: Fill Number Rules

Rule 1	Issuers who do not capture a **Fill Number** may choose to default the **Fill Number** to one (1) or sequence the **Fill Number** manually. NOTE: If there are multiple fills with the same **Fill Date**, the claims may be rejected as duplicate if the other key elements are the same.

Table 37: Allowed Costs, Paid Amount and Rebates

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.
Rule 2	The **Total Allowed Cost** must be greater than zero (0.00) except when submitting a void. *REMINDER: In accordance with 45 CFR §153.710(b), denied claims must not be submitted.* • For Dates of Service on or after January 1, 2016, claims for covered services that result in a zero (0.00) dollar allowed cost should be submitted with a default value of $1.00. • For Dates of Service prior to January 1, 2016, claims for covered services that result in a zero (0.00) dollar allowed cost should be submitted with a default value greater than zero (0.00). • For information on allowed costs for capitated services, see Sections 6.9 for Pharmacy and 7.14 for Medical.

6.5. Duplicate Pharmacy Claims

To ensure that there is only one (1) active version of a claim stored in the pharmacy claim table on the EDGE server, duplicate checks are performed. Table 38 and Table 39 outlines the data elements used to identify duplicate claims, exceptions and considerations given to **Dispensing Status**.

Table 38: 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** • **Plan 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 Time

The **Claim Processed Date Time** data element is reported at the claim level and is used to determine the order of processing. Claims that are adjusted multiple times need to be differentiated for appropriate processing. Issuers who do not have a unique **Claim Processed Date Time** should carefully review the rules in Table 39.

Table 39: Claim Processed Date Time Rules

Rule 1	All claims must include a date and time in the **Claim Processed Date Time** field.
Rule 2	If the **Claim Processed Date Time** is not provided or is not unique, all claims with the same **Issuer ID** and claim key will be rejected, as the system will not be able to determine the processing order of the claims. Issuers may create a unique **Claim Processed Date Time** to indicate the correct processing order of each claim.
Rule 3	If multiple versions of the same claim are submitted, due to void or replacement, each claim must include a unique **Claim Processed Date Time**, even if the **Void/Replace Indicator** is present.
Rule 4	When voiding and replacing claims: If the **Claim Processed Date Time** of a submitted void or replacement claim is *equal to or earlier* than the **Claim Processed Date Time** of the most current active version of the claim, then the current active claim will not be inactivated and the submitted void or replacement 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 be inactivated. In addition, the submitted void claim will be stored in the pharmacy claim table as inactive. Additional information on submission of voids is covered in Section 6.7. Additional information on submission of replacements is covered in Section 6.8.

Example: Claim Processing Date Time Rules

The following submission would result in the rejection of the replacement claim since the eight (8) key elements match and the **Claim Processed Date Time** is identical.

Issuer ID: 99999 **Plan ID:** 99112WA001000703

Dispensing Provider ID Qualifier	Dispensing Provider ID	Fill Date	Prescription/ Service Reference Number	Fill Number	Dispensing Status	Void/Replace Indicator	Plan Paid Amount	Claim 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	R	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 final **Plan Paid Amount** and no Replacement indicator)…

Dispensing Provider ID Qualifier	Dispensing Provider ID	Fill Date	Prescription/Service Reference Number	Fill Number	Dispensing Status	Void/ Replace Indicator	Plan Paid Amount	Claim 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 **Claim Processed Date Time**.

Dispensing Provider ID Qualifier	Dispensing Provider ID	Fill Date	Prescription/ Service Reference Number	Fill Number	Dispensing Status	Void/Replace Indicator	Plan Paid Amount	Claim 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	R	1200.00	**2014-06-03T08:30:20**

Note: Any variation in the Claim Processed Date Time will satisfy the requirement.

6.7. Voiding Pharmacy Claims

Pharmacy 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 in the RI calculations.

Table 40: Rules for Voiding Pharmacy Claims

Rule 1	Pharmacy claims submitted with a "V" in the **Void/Replace Indicator** bypass the duplicate check logic.
Rule 2	To void a pharmacy claim a minimum set of data values* are required and will be verified in accordance with the restrictions outlined in the ICD: • **Record ID** • **Claim ID** – should be unique • **Claim Processed Date Time** – must be later than the original claim • **Fill Date** • **Prescription/Service Reference Number** • **Dispensing Provider ID Qualifier** • **Dispensing Provider ID** • **Fill Number** • **Dispensing Status Code** • **Void/Replace Code** – must be "V" Any other data values submitted will also be verified in accordance with the restrictions outlined in the ICD. Any data element that fails the verifications will cause the void to be rejected. *See Appendix Table 22 for a quick reference list of required elements for voiding pharmacy claims.
Rule 3	The **Total Allowed Cost** and **Plan Paid Amount** are not required; however, if included, may be a negative amount.
Rule 4	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.

There are six (6) steps to voiding a previously submitted pharmacy claim.

1	Issuer submits an original claim that is accepted and stored as active.
2	Issuer submits a void.
3	EDGE server identifies a void or replace has been submitted based on the "V" populated in the **Void/Replace Indicator** field.
4	EDGE server uses the eight (8) key elements to find the original claim. (a) If a match is not found, the void claim is rejected. (b) If a match is found, the process continues.
5	EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. (a) If the date time passes, then the original claim will be inactivated. (b) If the date time fails, then the original claim will **not** be inactivated and the void claim is rejected. It is important to note that not all original claims are inactivated when a void is processed. Only when the date time verification passes will the original be inactivated. See Table 39 for **Claim Processed Date Time** information.
6	EDGE server checks the remaining submitted data elements to determine if the void claim should be accepted. (a) If all data elements pass, the new claim is stored as inactive. (b) If one (1) or more data elements fail, then the new claim will **not** be stored and the void claim will be rejected. It is important to note that even if the void is rejected, the original claim remains inactive.

Example: Pharmacy Claims Data Table Before and After Void Submission

NOTE: For this example, assume the eight (8) 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 eight (8) 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.

Table 41: Rules for Replacing Pharmacy Claims

Rule 1	Pharmacy claims submitted with an "R" **Void/Replace Indicator** will bypass the duplicate logic. IMPORTANT: A pharmacy claim cannot be replaced if one (1) of the eight (8) key elements has changed; instead, it must be voided.
Rule 2	To replace a pharmacy claim: • A value of "R" must be present in the **Void/Replace indicator** data field • Issuers must include all data elements on a replacement claim in order for the replacement claim to be evaluated for processing. • The eight (8) key elements must match a stored claim. o The original claim that matches the eight (8) key elements may be active or inactive. • The **Claim ID** must be unique when a replacement claim is submitted.
Rule 3	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. NOTE: Issuers should not submit a negative value for the **Plan Paid Amount** when using the replacement function. The original claim will become inactivated and the replacement claim will be the active claim used in calculating RI payments. Submitting a negative **Plan Paid Amount** will reduce the aggregated costs for an enrollee.
Rule 4	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 RI calculation.

There are six (6) steps to replacing a previously submitted pharmacy claim.

1	Issuer submits an original claim that is accepted and stored as active.
2	Issuer submits a replacement.
3	EDGE server identifies a replace has been submitted based on the "R" populated in the **Void/Replace Indicator** field.
4	EDGE server uses the eight (8) key elements to find the original claim. (c) If a match is not, found the void claim is rejected. (d) If a match is found, the process continues.
5	EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. (c) If the date time passes, then the original claim will be inactivated. (d) If the date time fails, then the original claim will **not** be inactivated and the void claim is rejected. It is important to note that not all original claims are inactivated when a replacement is processed. Only when the date time verification passes will the original be inactivated. See Table 39 for **Claim Processed Date Time** information.
6	EDGE server checks the remaining submitted data elements to determine if the replacement claim should be accepted. (a) If all data elements pass, the new claim is stored as active. (b) If one (1) or more data elements fail, then the new claim will not be stored and the replacement claim will be rejected. It is important to note that even if the replacement is rejected, the original claim remains inactive.

Example: Pharmacy Claims Data Table Before and After Replacement Submission

For this example, assume the eight (8) 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. For information about capitated claims, please refer to 45 CFR §153.710.

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

Table 42: 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.

Table 42: Derived Amounts on Pharmacy Claims (continued)

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. • The **Total Allowed Cost** should equal the **Plan Paid Amount**. ▪ If the **Plan Paid Amount** is $0, submit the enrollee cost sharing amount. If the enrollee cost sharing amount is $0, submit a value of $1.00. 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. • The **Total Allowed Cost** should equal the **Plan Paid Amount**. • If the **Plan Paid Amount** is $0, submit the enrollee cost sharing amount. If the enrollee cost sharing amount is $0, submit a value of $1.00.
Rule 3	Issuers must derive the **Plan Paid Amounts** for capitated services, as described in 45 CFR §153.710. Derived **Paid Amounts** will need to include a value in the **Plan Paid Amount** field and that value must be greater than or equal to $0.

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 RI and RA data, issuers must not limit the submission of claims. All claims for Small Group and Individual plans, both on and off the Marketplace, should be submitted. Software for the RA and RI programs will select all program-specific claims based on program-specific business rules.

CMS recognizes that issuers are not permitted to modify claims submitted by their rendering providers in order to adjudicate those claims. Prior to submission to the EDGE server, some post-adjudication claim data will need to be modified to conform to requirements for data submission to the EDGE server. For example, **Bill Types** will need to be modified, under certain circumstances, and/or the removal or addition of **Service Code Modifiers** may need to be performed. The specific modifications necessary for successful data submission are included in the following sections.

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 43: Medical Claims File Definitions

Benefit Year	An EDGE server benefit year aligns with the RA and RI benefit year, which is a calendar year from January 1 through December 31 of the applicable year.
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 44.

Table 44: 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. Medical Claims Code Sets Sources

Issuers are expected to use current medical code sets as required in 45 CFR Parts 160 and 162 – Health Insurance Reform: Standards for Electronic Transactions. CMS expects issuers to enforce correct coding guidelines with their providers.

- Issuers may not submit local or state codes, home grown codes or foreign codes. If these codes are submitted, the claims will be rejected with an **Error Message** indicating a reference check failure. (See Table 45 for information on handling rejected Service Codes.)
- Submitted codes must be effective on the date that the service was rendered. **Statement Covers From** date is used to verify if the code is valid.) If the code is invalid, outdated or not effective on the date the service was rendered the claim will be rejected with an **Error Message** indicating a reference check failure. (See Table 45 for information on handling rejected Service Codes.)
- CMS will make every effort to update reference tables with new and deleted code information 90 days after the effective date of such changes. For example, codes effective on January 1 will be loaded no later than March 30. CMS will notify issuers when updates will be made through the standard Maintenance Release schedule notification process.
- Service Codes are required for professional claims but are not required for institutional claims, as some institutional services are only reported using Revenue Codes.
    - If at least one (1) RA eligible Service Code (CPT or HCPC) is not present on an institutional outpatient claim the claim will not be selected for RA. Issuers should carefully review the RA claim selection process outlined in the RA presentations published in REGTAP.

The standard code sets and sources used to verify submitted codes during data submission to the EDGE server are listed below:

ICD-9 and ICD-10 Diagnosis Codes

- http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

Healthcare Common Procedure Coding System (HCPC) and HCPC modifiers, as published by CMS

- https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
- https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html

Current Procedural Terminology (CPT) and CPT modifiers, as published by the American Medical Association (AMA)

- Contact the AMA for licensing information

Bill Types, Revenue Codes, Discharge Status Codes, as published by the National Uniform Billing Committee (NUBC)

- Contact the NUBC for licensing information

Place of Service (POS) Codes

- http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

7.3. General Medical Claims File Processing Rules

This subsection illustrates general file processing rules for the ESMCS files in Table 45.

The initial medical claims file submission will contain medical claims with Dates of Service after January 1 of the EDGE benefit year. 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 7.8 for information on identification of duplicate claims.

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.

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 RA and RI.

Issuers should plan accordingly to ensure that all claims are corrected and submitted by April 30 of the benefit year for consideration. Any new claims, or corrections to rejected claims, will not be accepted after April 30.

Table 45: 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** and **Plan ID** reported on the medical claims file should correspond to a **Unique Enrollee ID** and **Plan ID** on the enrollment file. Medical claims for enrollees that are not matched to a **Unique Enrollee ID** and **Plan ID** will be considered orphaned and will not be considered during RA and RI processing. Issuers will receive an Enrollee (Without) Claims Detail (ECD) Report listing active claims that do not have an active enrollee record, as well as enrollees without claims.

Table 45: Medical Claims File Processing General Rules (continued)

Rule 3	Issuers may crosswalk outdated, local or home grown codes, using reasonable methods, to current codes, in order for claims to be successfully submitted and considered for RA and RI. As previously stated, CMS expects issuers to institute correct coding initiatives within their organization and with their provider network in accordance with published regulations. Issuers who believe a Service Code is valid and needs to be added to a reference table should contact their Financial Management (FM) Service Representative and provide details and supporting documentation of the code and effective dates that should be added. Issuers will receive a response to all research into missing codes or invalid dates.
Rule 4	All institutional claims must be submitted to the EDGE server with **Bill Types** ending in xx1, xx7 or xx8. **Bill Type** xx1 may be used for original, replacement or void claim submissions. **Bill Type** xx7 must only be used for replacement claims and the claim record must include the 'R' indicator. (See Section 7.11 for more information) **Bill Type** xx8 must only be used for void claims and the claim record must include the 'V' indicator. (See Section 7.12 for more information)
Rule 5	Issuers will need to assess and alter where appropriate, institutional claims with **Bill Types** that end in a value other than xx1, xx7 or xx8 for submission to the EDGE server. Services adjudicated under most **Bill Types** are eligible for consideration in RA and RI, but will need to be changed to one (1) of the EDGE server acceptable **Bill Types** (i.e. xx1, xx7 or xx8). For more information on modifying **Bill Types** for submission, see Section 7.17.
Rule 6	Issuers may choose to submit all versions of a claim (i.e. an original and then an adjusted claim as a replacement claim) or they may choose to submit the final version of the claim (i.e. the final adjusted claim). Issuers who choose to submit only the final adjusted claim must ensure that the claim adheres to the requirements in the ICD and the ESBR. For example, if only the final adjusted institutional claim is submitted, it must be submitted with a **Bill Type** of xx1 since xx7 is only applicable for replacement claims (see Rule 6).
Rule 7	Institutional inpatient claims with overlapping stays at the same or a different facility, for enrollees in the same plan, will not be accepted, unless they are associated with an enrollee who has dual coverage as defined and outlined in Section 5.5. See Section 7.16 for more information on overlapping stays.
Rule 8	NPI format will undergo a checked digit validation algorithm. Information related to the check digit algorithm can be found here: https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/downloads/npicheckdigit.pdf

7.4. Default and Substitute Values

CMS will permit issuers to substitute a data value or use a default value in limited circumstances. Issuers who wish to substitute values or default values for data elements other than those listed here should contact CMS via their FM Service Representative.

Provider IDs	Issuers may use the Billing and Rendering Provider ID interchangeably.
Place of Service Codes	Issuers may use a default value of 11 if no Place of Service value is available. Issuers should take care when using default values and review the data elements used for duplicate logic to ensure claims are not rejected.
Discharge Status Codes	Issuers may default the **Discharge Status Code** for outpatient institutional claims only to a value of 01.
Statement Covers From and Through Dates and Dates of Service	Issuers may adjust the dates at the claim line or claim header to align so long as the change does not result in a claim being accepted that would otherwise be rejected for another reason (i.e. – modification of the Statement Covers From or To date to bypass the overlapping stay logic for an institutional claim or modification of the Dates of Service to bypass duplicate logic.)
Diagnosis Codes	Issuers may use a default Diagnosis Code for dental and vision services only, as outlined in Section 7.7.

7.5. 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 46: 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 RA or RI 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.

7.6. 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 47.

Table 47: Header, Issuer and Plan Level Total Verifications

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.

7.7. 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 48.

Table 48: 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. Stand alone dental and vision plans are excluded from RA and RI and must not be submitted.
Rule 2	Diagnosis Codes: 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 v700 or v722 if no **Diagnosis Code** is available for services rendered prior to 10-1-2015. For services rendered on or after 10-1-2015 use Z0120 for dental services and Z0100 for vision services.
Rule 3	Place of Service Codes: All professional claims require a **POS Code** value. Issuers may use **POS Code** 11 (office) as a default value, for dental and vision services only, if a **POS Code** is not available.
Rule 4	Service Code Type: Issuers must use Service Code Type of 01 to identify dental services that are submitted with codes that begin with a "D". Dental codes will be rejected for reference check failure if the Service Type Code 01 is not used.
Rule 5	Issuers may remove Service Code Modifiers from dental and vision claims. However, issuers must make sure that this removal does not create duplicate claims.

7.8. Duplicate Medical Claims

To ensure that only one (1) 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 49 and Table 51.

Table 49: 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 50: Duplicate Checks Performed at the Claim Line

Rule 1	Duplicate checks at the claim line level are bypassed if a **Void Indicator** is included on the claim record. Note: Duplicate checks at the line level are still applied if a **Replace Indicator** is present.
Rule 2	Duplicate checks at the claim line level are bypassed for all inpatient stays due to overlapping stay logic. See Section 7.16, Table 58 for more information on overlapping stays.
Rule 3	Duplicate services reported on multiple service lines within a single claim will be accepted with or without an exception modifier. Duplicate services reported on different claims, either within the same file or previously submitted and stored on the claim data table, will be rejected unless they are submitted with an appropriate exception modifier. For more information, see Section 7.9.
Rule 4	The following data elements will be used to determine if a duplicate claim line exists: **For Professional Claims:** • **Plan ID** • **Unique Enrollee ID** • **Rendering Provider Qualifier** • **Rendering Provider ID** • **Date of Service - From and Date of Service - To** • **Service Code** • **Service Code Modifier(s)** • **Place of Service Code** **For Institutional Outpatient Claim** • **Plan ID** • **Unique Enrollee ID** • **Rendering Provider ID Qualifier** • **Rendering Provider ID** • **Bill Type** • **Revenue Code** • **Service Code** • **Service Code Modifier** • **Date of Service - From and Date of Service - To** The following **Revenue (REV) Code/Service Code/Service Code 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 5	**Modifier**, **Revenue Code** and **Service Code** exceptions to the line level duplicate checks exist and are outlined in Section 7.9.

7.9. Exceptions to the Line Level Duplicate Check

There are **Revenue Codes**, **Service Codes** and **Service Code 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, even when the duplicate service is billed on a separate claim. These exceptions are listed in Table 51.

Where duplicate services are identified on different claims, and the issuer has applied their internal operational policies, or other reasonable guidelines, to determine that these duplicate services were valid and eligible for reimbursement, then issuers may use one (1) of the methods outlined in Rules 3 and 4 to submit the claims to bypass the duplicate edits. Claims that may be selected for audit would be adequately supported by documentation of such reasonable determinations.

Table 51: Exceptions to Duplicate Checks at the Claim Line Level

Rule 1	When the following **Service Code Modifier**(s), **Revenue Code**(s) or **Service 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 27 = Multiple Outpatient Hospital E/M Encounters on the Same Date 51 = Multiple Procedures 59 = Distinct Procedural Service 76 = Repeat Procedure or Service by Same Physician 91 = Repeat Clinical Diagnostic Laboratory Test GG = Repeated Mammogram If any of these modifiers are included as one (1) of the four (4) allowable modifier values in a claim line, then the claim line will be accepted. **Revenue Codes** – 0250-0259 (Pharmacy), 0270-0279 (Supplies) and 0631-0637 (Drugs), 0761 (Observation) Immunization Administration –90460 through 90474 For full descriptions, please refer to the official sources listed in Table 45.
Rule 2	Issuers may combine claims so that duplicated services are included under a single **Claim ID**. Issuers should be sure to include all diagnoses, **Service Codes** (where applicable) and aggregate the allowed and paid amounts for the claims being combined. (See Option 1 in the examples that follow.)
Rule 3	Issuers may append an exception **Service Code Modifier** to an adjudicated claim where they have confirmed that the duplicate service is allowable in order for that claim to be accepted by the EDGE server. (See Option 2 in the examples that follow.)

Below are examples of how issuers may submit services performed multiple times for a single Date of Service.

In this scenario, the same service is being rendered multiple times on the same day and the rendering provider did not include one (1) of the exception **Service Code Modifiers**. This claim would be accepted.

Unique Enrollee ID	Claim ID	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Status
B99715	994A		2014-06-04	2014-06-04	60.00	2014-06-30T12:12:00	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Status
1	80061		2014-06-04	2014-06-04	30.00		Accepted
2	80061		2014-06-04	2014-06-04	30.00		Accepted

In this scenario, the same service is being rendered multiple times on the same day, but the two (2) services were reported under two (2) different claims and no modifier was included. The first claim would be accepted, but the second claim would be rejected.

Claim 1

Unique Enrollee ID	Claim ID	Void /Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	1401CL9		2014-11-12	2014-11-12	30.00	2014-12-01T08:01:42	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061		2014-11-12	2014-11-12	30.00		Accepted

Claim 2

Unique Enrollee ID	Claim ID	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	9927RX1		2014-11-12	2014-11-12	30.00	2014-12-15T14:22:04	Rejected due to line failure

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061		2014-11-12	2014-11-12	30.00		Rejected due to duplicate of claim 1401CL9

If an issuer determines that the duplicate service was valid, then the issuer may modify their claim data submission in one (1) of two (2) ways.

Option 1: Replace the prior claim, adding the second claim line and aggregating the two (2) claim lines to get a new **Total Amount Paid** at the header.

Unique Enrollee ID	Claim ID	Void /Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	1401CL9	R	2014-11-12	2014-11-12	60.00	2014-12-15T14:22:04	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061		2014-11-12	2014-11-12	30.00		Accepted
2	80061		2014-11-12	2014-11-12	30.00		Accepted

NOTE: Remember that the date of the replacement claim must be later than the original submission of the claim. Here we are showing the **Claim Processed Date Time** of the replacement claim is the same as the second claim but it can be any date time after the original.

Option 2: Add an exception modifier to the second claim.

Unique Enrollee ID	Claim ID	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Total Amount Paid	Claim Processed Date Time	Claim Status
82xWv1	9927RX1		2014-11-12	2014-11-12	30.00	2014-12-15T14:22:04	Accepted

Line Number	Service Code	Service Modifier	Date of Service	Date of Service	Total Amount Paid	Claim Processed Date Time	Claim Status
1	80061	25	2014-11-12	2014-11-12	30.00		Accepted

7.10. Inclusive Services Not Allowed on the Same Day

Some professional and outpatient institutional claims may be identified as duplicate because the submitted service is part of a more inclusive service submitted on the same day. The inclusive services below are also subject to the exception modifiers (i.e., if a service line had a **Service Code Modifier** 26 and 25, it would be accepted due to **Service Code Modifier** 25 being an exception to the duplicate logic).

Table 52: Inclusive Services Not Allowed on the Same Date

Rule 1	Service Code Modifiers 26 and TC If a stored active claim line includes a **Service Code** with a 26 or TC **Service Code Modifier** and a subsequent claim line is submitted with the same **Service Codes**, and no **Service Code Modifier** and the same dates of service, then the claim would be considered a duplicate. No **Service Code 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 The reverse of this rule applies as well. If no **Service Code Modifier** is submitted and then a claim with a 26 or TC is submitted, the latter will be rejected.

Table 52: Inclusive Services Not Allowed on the Same Date (continued)

Rule 2	Service Code Modifier 50 **Service Code Modifier** 50 indicates a bilateral procedure was performed. Therefore, a **Service Code** billed with a **Service Code Modifier** 50 could not also be billed with an RT or LT **Service Code Modifier** or no **Service Code 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	Service Code Modifier RT/LT **Service Code Modifier** RT/LT indicates that a procedure was performed on either the right or left side. Therefore, a **Service Code** billed with a **Service Code Modifier** of LT or RT could also not be billed with a **Service Code Modifier** 50 or with no **Service Code 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	Service Code Modifier RR, NU, UE **Service Code Modifiers** RR, NU and UE are pricing **Service Code Modifiers** used for Durable Medical Equipment (DME) items to indicate a rental, new purchase or used purchase. If a claim line contains any of these **Service Code Modifiers**, then the same **Service Code** could not be billed with any of the other **Service Code Modifiers** or a blank in the **Service Code Modifier** field for any date within the period billed on the original claim. The EDGE server recognizes a blank modifier, when billed with a DME **Service Code**, to be a purchase (NU Modifier). 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

7.11. 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 53.

Table 53: Claim Processing Date Time Rules

Rule 1	All claims must 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. When submitting the final version of an institutional claim, issuers must be sure the **Bill Type** is accurate. See Table 45, Rules 6 and 7. 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**.
Rule 3	If multiple versions of the same claim are submitted, due to void or replacement, 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	When voiding and replacing claims: If the **Claim Processed Date Time** of a submitted void or replacement claim is *equal to or earlier* than the **Claim Processed Date Time** of the most current active version of the claim, then the current active claim will not be inactivated and the submitted void or replacement 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 be inactivated. In addition, the submitted void claim will be stored in the pharmacy claim table as inactive. Additional information on submission of voids is covered in Section 7.12. Additional information on submission of replacements is covered in Section 7.13.

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	Void / Replace Indicator	Original Claim ID	Total Plan Paid Amount	Processed Date Time
9988776	2014041299256			5000.00	**2014-06-03T00:00:00**
9988776	2014041299277	R	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	Void / Replace Indicator	Original Claim ID	Total Plan Paid Amount	Processed Date Time
9988776	2014041299256			5500.00	**2014-06-03T00:00:00**

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

Issuer ID	Claim ID	Void / Replace Indicator	Original Claim ID	Total Plan Paid Amount	Processed Date Time
9988776	2014041299256			5000.00	**2014-06-03T08:15:10**
9988776	2014041299277	R	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 7.12, Table 54 for more information.

7.12. 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 Indicator** bypass the duplicate check logic and proceed to void processing logic as outlined in Table 54. An example is provided below the table.

Table 54: Void Processing Logic for Medical Claims

Rule 1	Medical claims submitted with a "V" **Void/Replace Indicator** bypass the duplicate check logic.
Rule 2	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 for institutional claims • The **Issuer ID** and **Original Claim ID** must match a stored claim • The **Claim Processed Date Time** must be later than original claim (see Table 51)
Rule 3	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 RI or RA programs.
Rule 4	An issuer may reactivate a claim that has been voided by submitting a new claim, with a new **Claim ID**, or submitting a replacement claim with a **Claim Processed Date Time** that is later than the submitted void.

Table 54: Void Processing Logic for Medical Claims (continued)

Rule 5	The following data elements must be present on a void claim; all other fields may be null. Claim Header • **Record ID** • **Void/Replace Indicator** ("V") • **Claim ID** • **Original Claim ID** • **Claim Processed Date Time** (must be later than claim being voided) Claim Line • **Record ID** • **Claim Line Sequence Number** (may be defaulted to 0 for all lines) The **Total Amount Allowed** and **Total Amount Paid** are not required; if submitted the value can be a negative amount. Any other data values submitted will also be verified in accordance with the restrictions outlined in the ICD. Any data element that fails the verifications will cause the void to be rejected. *See Appendix Table 22 for a quick reference list of required elements for voiding pharmacy claims.

There are six (6) steps to voiding a previously submitted medical claim.

1	Issuer submits an original claim that is accepted and stored as active.
2	Issuer submits a void.
3	EDGE server identifies a void or replace has been submitted based on the "V" populated in the **Void/Replace Indicator** field.
4	EDGE Server uses the Original **Claim ID** to find the original claim. (a) If a match is not found, the void is rejected. (b) If a match is found, the process continues.
5	EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. (a) If the date time passes, then the original claim will be inactivated. (b) If the date time fails, then the original claim will not be inactivated and the void claim is rejected **Important Note: Original claims may be inactivated without a void being accepted.**
6	EDGE server checks the remaining required data elements to determine if the void or replacement claim should be accepted. (a) If all data elements pass, the void claim is stored as inactive. (b) If one (1) or more data elements fail, then the void claim will not be stored and the void claim will be rejected.

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

7.13. 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 55. An example follows the table.

Table 55: Replacement Processing Logic for Medical Claims

Rule 1	A medical claim submitted with an "R" **Void/Replace Indicator** will bypass the duplicate logic when searching for the claim to be replaced. After the original claim is found, that claim will be ignored and the duplicate logic will be applied to any other active claims.
Rule 2	To replace a medical claim: • An "R" must be present in the **Void/Replace Indicator** field. • Issuers must include all required data elements on a replacement claim in order for the replacement claim to be processed. • Issuers may only use **Bill Type** xx1 or xx7 on institutional claims. • The **Issuer ID** and **Original Claim ID** must match a stored claim. o The **Original Claim ID** may be an active or inactive version of a previously submitted and accepted claim.
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	When submitting a replacement claim to account for changes in the **Total Amount Paid**, the original claim and the **Total Amount Paid** 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 Codes**, **Service Codes**, etc. NOTE: Issuers should not submit a negative value for the **Total Amount Paid** when using the replacement function. The original claim will become inactivated and the replacement claim will be the active claim used in calculating RI payments. Submitting a negative **Total Amount Paid** will reduce the aggregated costs for an enrollee.
Rule 5	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 RI calculation.
Rule 6	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.

There are six (6) steps to replacing a previously submitted medical claim.

1	Issuer submits an original claim that is accepted and stored as active.
2	Issuer submits a replacement.
3	EDGE server identifies a replace has been submitted based on the "R" populated in the **Void/Replace Indicator** field.
4	EDGE Server uses the **Original Claim ID** to find the original claim. (c) If a match is not found, the replacement is rejected. (d) If a match is found, the process continues.
5	EDGE server uses the **Claim Processed Date Time** to determine if the original claim should be inactivated. (c) If the date time passes, then the original claim will be inactivated. (d) If the date time fails, then the original claim will not be inactivated and the void claim is rejected **Important Note: Original claims may be inactivated without a replacement being accepted.**
6	EDGE server checks the remaining required data elements to determine if the replacement claim should be accepted. (a) If all data elements pass the replacement claim is stored as active. (b) If one (1) or more data elements fail, then the replacement claim will not be stored and the replacement claim will be rejected.

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

7.14. Derived Amounts on Medical Claims

Issuers will need to derive (or estimate) the Plan **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 Plan **Paid Amount** has been calculated for medical services provided under a capitation arrangement. The issuer will need to calculate the estimated **Plan 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.

Medical claims submitted with a **Derived Amount Indicator** must be reported as outlined in Table 56.

Table 56: 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.

Table 56: Derived Amounts on Medical Claims (continued)

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
	• The Total Amount Allowed should match the Total Amount Paid
	  o If the Total Amount Paid is $0, submit the enrollee cost sharing amount. If the enrollee cost sharing amount is $0, submit $1.00.
	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
	• The Total Amount Allowed should match the Total Amount Paid
	  o If the Total Amount Paid is $0, submit the enrollee cost sharing amount. If the enrollee cost sharing amount is $0, submit $1.00.

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 A Total Amount Allowed should match the Total Amount Paid
	  ▪ If the Total Amount Paid is $0, submit the enrollee cost sharing amount. If the enrollee cost sharing amount is $0, submit $1.00.
	  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"
	  ▪ an **Amount Paid** ≥ $0
	  ▪ a **Total Amount Allowed** ≥ $0

Rule 4	Issuers must derive the **Plan Paid Amounts** for capitated services, as described in 45 CFR §153.710. Derived paid amounts will need to include a value in the **Total Amount Paid** field and that value must be greater than or equal to $0.

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

7.15. Tobacco Cessation Services Covered Under Capitation

Issuers who cover tobacco cessation services under capitated arrangements may submit such services to the EDGE server for consideration.

Table 57: Tobacco Cessation Services

Rule 1	The **Paid Amount** submitted for tobacco cessation services must be a derived amount and not the issuers paid per member per month amount. The **Allowed Amount** may be defaulted to any value equal to or greater than $1.00.
Rule 2	Issuers must submit all required data elements, as outlined in the ICD, including the most current CPT or HCPC Service Codes and Diagnosis Codes published. • For claims with **Statement Covers Through** 09/30/2015, a default ICD-9 **Diagnosis Code** value of 3051 or V1582 can be used. For claims with **Statement Covers From** 10/1/2015 or later, a default ICD-10 **Diagnosis Code** value of F17200 or Z87891 may be used. A default **Service Code** value of G0436, G0437, 99406 or 99407 may be used until such codes are replaced or no longer valid. **NOTE: The current default values for the Diagnosis Codes are applicable to the ICD-10 coding system only**.

Note that tobacco cessation services, which are covered under a fee-for-service arrangement, may also be submitted to the EDGE server in accordance with the requirements outlined in the ICD and throughout this document.

7.16. 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 58 outlines the rules for determining whether an overlapping stay has occurred during an inpatient stay. Examples follow the table.

Table 58: 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.
Rule 3	If an enrollee has dual coverage in the same plan the claims must be combined and submitted as a single claim with all **Diagnosis Codes**, **Service Codes**, **Allowed** and **Paid Amounts**.

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
Previously Accepted Claim	M4jk903	123	12345VA001999901	2014-01-17	**2014-01-22**	Active	
New Claim	M4jk903	456	12345VA001999901	**2014-01-22**	2014-01-25		Accept

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	

7.17. 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 assess and convert, where appropriate, any **Bill Type** with a frequency code other than xx1, xx7 or xx8 for such claims to be considered for RA and RI. Table 54 provides guidance on the **Bill Types** that are permitted. Sections 7.18 and 7.19 explain how issuers may convert interim bills and late charges for submission.

Table 59: 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. The following restrictions are related to the frequency code.
	
	• All **Bill Types** submitted must have a frequency code of 1, 7 or 8.
	  o **Bill Type** xx1 may be used for original, replacement or void claim submissions.
	  o **Bill Type** xx7 must only be used for replacement claims and the claim record must include the R indicator.
	  o **Bill Type** xx8 must only be used for void claims and the claim record must include the "V" indicator.
	
	*Issuers may convert eligible claims with **Bill Types** including a frequency code other than xx1, xx7 or xx8 in order for those claims to be considered for RA and RI (See* Table 60 *for more information).*

Rule 2	Only **Bill Types** which are included in the RA program will be selected at the time the RA calculations are performed. Acceptable RA **Bill Types** are: 111, 117, 131, 137, 711, 717, 761, 767, 771 AND 777. There are no **Bill Type** exclusions for the RI program.
Rule 3	For an institutional claim to be selected for RA, it must have a **Discharge Status Code** other than 30 (still a patient). Issuers may default the **Discharge Status Code** for outpatient institutional claims to 01. For institutional inpatient claims, in circumstances where an enrollee has a **Discharge Status Code** of 30, or the **Discharge Status Code** was not submitted by the Rendering Provider, and the issuer has determined that no additional services will be covered or payments will be made, in accordance with company policies, an issuer may alter the **Discharge Status Code** to 01 for submission to the EDGE server. Please note that if new information becomes available that would change the **Discharge Status,** then a replacement must be submitted. Issuers must apply reasonable judgment and good business practices when determining the final action of any services submitted to the EDGE server.

Table 60: Converting Eligible Claims with Bill Type Frequencies Other than xx1, xx7 or xx8

Rule 1	CMS uses the NUBC as the official source of **Bill Type** frequency descriptions. • **Bill Type** Frequency 0 **–** Non-Payment/Zero* o CMS considers nonpayment or zero (0) claims denied services and therefore not eligible for consideration for RA or RI. • **Bill Type** Frequency 2, 3 and 4 – Interim First, Continuing and Last o Please refer to Section 7.18 on institutional interim billing. • **Bill Type** Frequency 5 – Late Charges (Only) o Please refer to Section 7.19 on late charges. • **Bill Type** Frequency 6 **–** Reserved for National Assignment* o CMS considers any **Bill Type** codes with this description as undefined and therefore not eligible for consideration for RA or RI. • **Bill Type** Frequency 9 - and any Alpha **Bill Type** Frequency * o Services covered and paid under these **Bill Type** frequencies may be eligible for consideration. *If an issuer determines a claim represents a valid paid service that should be included in RA or RI, an issuer may convert the **Bill Type** into an acceptable frequency code (i.e., xx1, xx7 or xx8) for submission. Issuers will need to provide supporting documentation that these claims were paid and, therefore, eligible for consideration should they be selected during audit.

7.18. 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 xx2, xx3 or xx4.
- Outpatient services provided over a long periods of time (e.g. ongoing therapy) are less complex and are usually submitted and adjudicated more frequently (i.e., 30 days or less).

Table 61: 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 xx2, xx3 or xx4 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.

CMS assumes issuers have internal operational policies that define the point in time at which no further action will be taken on claims. CMS believes issuers will apply such policies, or other reasonable guidelines, to determine when all claims have been adjudicated and a stay finalized for submission to the EDGE server. Claims that may be selected for audit would be adequately supported by documentation of such reasonable determinations.

Please note that if new information becomes available that would change the status of the interim bill or the aggregated claim detail, then a replacement must be submitted. Issuers must apply reasonable judgment and good business practices when determining the final action of any services submitted to the EDGE server.

Table 61: Inpatient Interim Bill Rules (continued)

Rule 2	**Inpatient interim bills** Location: Hospital • Issuers must aggregate all interim bills into a final claim and submit with frequency code xx1. • 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 xx1 or xx7. Claims That Cross Benefit Years: Inpatient hospital claims that cross a benefit year must be submitted, in aggregate, in the year when the discharge occurred. Issuers may not split inpatient hospital claims across benefit years. See the examples that follow this table.

Table 61: Inpatient Interim Bill Rules (continued)

Rule 3	**Inpatient interim bills** Location: All locations other than an Inpatient Hospital setting • 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 xx1. o Adjustments must be submitted using the replacement claim process and frequency code xx1 or xx7. • 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 xx1. Adjustments must be submitted using the replacement claim process and frequency code xx1 or xx7. Claims That Cross Benefit Years: Inpatient claims that occur in a setting other than a hospital and cross a benefit year may either be submitted, in aggregate, at the time of discharge (Option 1) or be split (Option 2) across benefit years. Issuers may also combine Options 1 and 2 and submit an aggregated amount for one (1) benefit year and another aggregated amount for the following benefit year. Statement coverage periods and/or dates of service, submitted as an aggregated claim, may be strict (ending on December 31) or may span across benefit years. See the examples that follow this table.
Rule 4	ICD-9 Diagnosis Codes may be cross walked to ICD-10 Diagnosis Codes when submitting the final claim. Or Issuers may submit ICD-9 Diagnosis Codes using the Supplemental Diagnosis file as long as the Dates of Service on the supplemental diagnosis file are before October 1, 2015 and within the **Statement Covers From and Through** dates on the final submitted medical claim. For information on ICD-10 data submission, see the EDGE Server ICD-10 Implementation (10/6/15) presentation, published in the REGTAP Library.

Example of Hospital Inpatient Interim Bill Submission

Example 1: Hospital Inpatient Stay within a Benefit Year

An enrollee was inpatient at a hospital from April 4, 2014 – June 28, 2014. The hospital submitted three (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.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
B99Pn5	123a	112	2014-04-04	2014-04-30	4254	127850.00	2014-05-14T14:50:11
B99Pn5	123b	113	2014-04-04	2014-05-30	4254 6954	221950.00	2014-06-12T22:12:00
B99Pn5	123c	114	2014-04-04	2014-06-28	4254 6954	482339.00	2014-07-17T08:05:52

The full inpatient stay must be submitted as one (1) occurrence, for the entire statement coverage period and include all **Diagnosis Codes** and the aggregated **Total Amount Paid** for the stay with **Bill Type** 111 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
B99Pn5	123c	**111**	**2014-04-04**	**2014-06-28**	**4254 6954**	**482339.00**	2014-07-17T08:05:52

Example 2: Hospital Inpatient Stay Across a Benefit Year

Claims that include dates of service that cross a benefit year (i.e. 12/15/2014 – 1/31/2015) must be submitted as a single claim, at the time of discharge with a **Bill Type** of 111.

An enrollee was inpatient at a hospital from December 15, 2014 – January 31, 2015. The hospital submitted two (2) interim bills. The issuer processed each claim with a final total **Paid Amount** of $235,000.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
J22n54	1412	112	2014-12-15	2015-01-15	82003	165000.00	2015-01-28T08:26:01
J22n54	1601	114	2015-01-16	2015-01-31	82003	70000.00	2015-02-13T17:01:40

The full inpatient must be submitted as one (1) occurrence, for the entire statement coverage period and include all **Diagnosis Codes** and the aggregated **Total Amount Paid** for the stay.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
J22n54	A1601	**111**	**2014-12-15**	**2015-01-31**	**82003**	**235000.00**	2015-02-13T17:01:40

Example of Non-Hospital Inpatient Interim Bill Submission

Example 1: Non-Hospital Inpatient Stay within a Benefit Year

An enrollee was inpatient at a skilled nursing facility from February 1, 2014 – May 15, 2014. The skilled nursing facility submitted four (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.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
G1j8TR7	994A	212	2014-02-01	2014-02-28	25000 5559	165081.00	2014-03-05T11:26:00
G1j8TR7	994B	213	2014-03-01	2014-03-30	25000 5559	165081.00	2014-04-02T12:12:00
G1j8TR7	994C	213	2014-04-01	2014-04/30	25000 5559	165081.00	2014-05-08T09:15:52
G1j8TR7	994D	214	2014-05-01	2014-05-15	25000 5559	82540.00	2014-05-28T16:44:02

Option 1: Issuers may either submit one (1) final claim, for the entire statement coverage period, including all **Diagnoses Codes** and the final total **Paid Amount** with a **Bill Type** frequency of xx1. 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
G1j8TR7	994D	**211**	**2014-02-01**	**2014-05-15**	**25000 5559**	**577783.00**	2014-05-28T16:44:02

Option 2: Issuers may choose to submit each claim, for each interim period, which would only include the statement coverage period, **Diagnoses Codes** and **Paid Amounts** for that interim period. Each individual claim would have to be submitted with a **Bill Type** frequency of xx1. 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
G1j8TR7	994A	**211**	**2014-02-01**	**2014-02-28**	**25000 5559**	**165081.00**	2014-03-05T11:26:00
G1j8TR7	994B	**211**	**2014-03-01**	**2014-03-30**	**25000 5559**	**165081.00**	2014-04-02T12:12:00
G1j8TR7	994C	**211**	**2014-04-01**	**2014-04-01**	**25000 5559**	**165081.00**	2014-05-08T09:15:52
G1j8TR7	994D	**211**	**2014-02-01**	**2014-05-15**	**25000 5559**	**82540.00**	2014-05-28T16:44:02

Non-Hospital Inpatient Stay Across a Benefit Year

Issuers may either submit one (1) final claim (as illustrated in Example 1, Option 1 in the prior section).

Issuers may choose to submit each claim, for each interim period (as illustrated in Example 1, Option 2 in the prior section).

Issuers may choose to combine these approaches and submit an aggregated claim for each benefit year. The claims may be aggregated with a strict benefit year or across a benefit year.

An enrollee was inpatient at Home Health facility from November 15, 2014 through March 10, 2015. The Home Health agency submitted four (4) interim bills. The issuer processed each claim with a final total **Paid Amount** of $608,000. The final claim was processed on March 30, 2015.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	994A	322	2014-11-15	2014-12-14	33520	158700.00	2014-12-28T09:16:04
Ds22Mb	994B	323	2014-12-15	2015-01-14	33520	158700.00	2015-01-20T11:32:00
Ds22Mb	994C	323	2015-01-15	2015-02-14	33520	158700.00	2015-02-18T19:05:52
Ds22Mb	994D	324	201-02-15	2015-03-10	33520 7282	131900.00	2015-03-30T06:24:02

Aggregating Using a Strict Benefit Year

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	141231	**321**	**2014-11-15**	**2014-12-31**	**33520**	**236700.00**	2014-12-31T08:00:00

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	150310	**321**	**2015-01-01**	**2015-03-10**	**33520 7282**	**381300.00**	2015-03-30T06:00:00

Aggregating Across a Benefit Year

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	141231	**321**	**2014-11-15**	**2014-12-14**	**33520**	**158700.00**	2014-12-28T09:16:04

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	150310	**321**	**2014-12-15**	**2015-03-10**	**33520 7282**	**449300.00**	2015-03-30T06:24:02

Table 62: 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 xx2, xx3 or xx4 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 xx1. o Adjustments must be submitted using the replacement claim process and frequency code xx1 or xx7. • Option 2: o Issuers may submit interim claims, after each claim is adjudicated, but must include only the **Paid Amounts** and **Diagnosis Codes** 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 xx1. Adjustments must be submitting using the replacement claim process and frequency code xx1 or xx7. **Claims That Cross Benefit Years:** Outpatient claims that cross a benefit year may either be submitted, in aggregate, at the time of discharge (Option 1) or be split (Option 2) across benefit years. Issuers may also combine Options 1 and 2 and submit an aggregated amount for one (1) benefit year and another aggregated amount for the following benefit year. Statement coverage periods and/or dates of service, submitted as an aggregated claim, may be strict (ending on December 31) or may span across a benefit year. CMS assumes that submission of outpatient services, as outlined in this section, which cross a benefit year are similar in nature, with a common set of **Diagnosis Codes** that is applicable to both benefit years. See the examples that follows this table.

Example of Outpatient Interim Bill Submission

An enrollee had ongoing outpatient physical therapy at a rehab hospital from March 15, 2014 – June 15, 2014. The rehab hospital submitted four (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
W2ll3r	825-01	132	2014-03-15	2014-03-30	8154	10100.00	2014-04-02T09:06:44
W2ll3r	825-02	133	2014-04-01	2014-04-30	8154	20025.00	2014-05-03T14:09:02
W2ll3r	825-03	133	2014-05-01	2014-05-30	8154	20025.00	2014-06-04T07:05:52
W2ll3r	825-04	134	2014-06-01	2014-06-15	8154	10075.00	2014-06-30T15:24:00

Option 1: Issuers may either submit one (1) final claim, for the entire statement coverage period, including all **Diagnoses Codes** and the final **Total Amount Paid**. 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
W2ll3r	825-03	**131**	**2014-03-15**	**2014-06-15**	**8154**	**60225.00**	2014-06-30T15:24:00

Option 2: Issuers may choose to submit each claim, for each interim period, which would only include the statement coverage period, **Diagnoses Codes** and **Total Amount Paid** 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
W2ll3r	825-01	**131**	2014-03-15	2014-03-30	8154	10100.00	2014-04-02T09:06:44
W2ll3r	825-02	**131**	2014-04-01	2014-04-30	8154	20025.00	2014-05-03T14:09:02
W2ll3r	825-03	**131**	2014-05-01	2014-05-30	8154	20025.00	2014-06-04T07:05:52
W2ll3r	825-04	**131**	2014-06-01	2014-06-15	8154	10075.00	2014-06-30T15:24:00

Outpatient Services Across a Benefit Year

Issuers may either submit one (1) final claim (as illustrated in the prior example, Option 1).

Issuers may choose to submit each claim, for each interim period (as illustrated in the prior example, Option 2).

Issuers may choose to combine these approaches and submit an aggregated claim for each benefit year. The claims may be aggregated with a strict benefit year or across a benefit year.

An enrollee was receiving ongoing psychiatric counseling at a community mental health center from November 10, 2014 through February 20, 2015. The mental health center submitted four (4) interim bills. The issuer processed each claim with a final **Total Amount Paid** of $2800. The final claim was processed on February 26, 2015.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2014111	762	2014-11-10	2014-12-13	30928	800.00	2014-12-28T11:20:04
CT6o8n	2014121	763	2014-12-14	2015-01-10	30928	800.00	2015-01-20T06:32:10
CT6o8n	2015011	763	2015-01-11	2015-02-07	30928	800.00	2015-02-18T19:00:00

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2015021	764	2015-02-08	2015-02-20	30928	400.00	2015-02-26T08:14:00

Aggregating using a Strict Benefit Year

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2014999	**761**	**2014-11-10**	**2014-12-31**	**30928**	**1000.00**	2014-12-31T07:00:00

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2015999	**761**	**2015-01-01**	**2015-02-20**	**30928**	**1800.00**	2015-02-28T07:00:00

Aggregating Across a Benefit Year

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2014111	**761**	**2014-11-10**	**2014-12-13**	**30928**	**800.00**	2014-12-28T11:20:04

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
CT6o8n	2015021	**761**	**2014-12-14**	**2015-02-20**	**30928**	**2000.00**	2015-02-26T08:14:00

7.19. Late Charges

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

Late charges are additional medical service charges incurred and submitted under a separate bill by the rendering provider. For example, a hospital that submits a bill for additional drugs or services after the issuer has already adjudicated the first claim.

Table 63: 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** with a frequency code of xx1 or xx7. The methods of submitting late charges are outlined below.
Rule 2	Late charges, associated with an inpatient stay, must be aggregated with the original claim to which they are associated. 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 xx7.
Rule 3	Late charges, associated with an outpatient institutional service, may be aggregated with the original claim to which they are associated with a **Bill Type** of xx1 or xx7, if the claim was previously submitted and accepted, or submit the late charge as a separate claim with **Bill Type** xx1. If issuer submits the late charge and a unique claim, the issuer must be careful to follow the Duplicate Medical Claims rules in Section 7.8 in order not to have claims rejected for duplicates.

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 $806.00 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
Ds22Mb	06011	111	2014-06-15	2014-06-18	54000	26432.00	2014-06-24T11:05:14
Ds22Mb	06011	115	2014-06-15	2014-06-18	54000	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 final claim includes the **Total Amount Paid** for both claims and the **Bill Type** is 111.

Unique Enrollee ID	Claim ID	Bill Type	Statement Covers From	Statement Covers Through	Diagnosis Code(s)	Total Amount Paid	Claim Processed Date Time
Ds22Mb	06011	**111**	**2014-06-15**	**2014-06-18**	**54000**	**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 replacement claim has a **Total Amount Paid** that is the aggregate of the original claim and the late charges and the **Bill Type** is 117.

Unique Enrollee ID	Claim ID	Bill Type	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Diagnosis Code	Total Amount Paid	Claim Processed Date Time
Ds22Mb	06011	111		2014-06-15	2014-06-18	54000	26432.00	2014-06-28T15:19:02

Unique Enrollee ID	Claim ID	Bill Type	Void / Replace Indicator	Statement Covers From	Statement Covers Through	Diagnosis Code	Total Amount Paid	Claim Processed Date Time
Ds22Mb	06011	**117**	**R**	2014-06-15	2014-06-18	54000	**27238.00**	2014-06-24T11:05:14

7.20. 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 Codes** and **Service Codes**). The RA and RI 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 64: Mother and Baby Claims

Rule 1	Issuers should submit mother and baby claims separately as unique 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 RA purposes: RA has separate adult, child and infant RA models and requires assignment to the correct model for an enrollee based on age. If claims are not unbundled, then the RA software code will only produce a risk score for the masked **Unique Enrollee ID** that is successfully matched to an enrollee record.
Rule 4	For RI purposes: All claims are aggregated based on the **Unique Enrollee ID** submitted on the claim. If claims are not unbundled, then claim costs will not be aggregated to each unique enrollee.

7.21. Transportation Claims

Transportation claims are eligible for consideration if they are covered services and issuers incur costs for such services.

Table 65: Transportation Claims

Rule 1	Transportation services are submitted using valid **Service Codes** and **Service Code Modifiers** as required and outlined in prior sections.
Rule 2	If no **Diagnosis Code** is available, issuers may include a **Diagnosis Code** from an associated medical claim that was adjudicated within 30 days of the date of transport.

7.22. Incurred Claims Otherwise Not Adjudicated

CMS recognizes that there are circumstances under which medical service costs were incurred by the insurer, but a provider claim was not adjudicated. For example, an issuer may have a policy where they reimburse members directly for services that would have otherwise been paid to a Rendering Provider. Claims incurred for medical costs that are not otherwise adjudicated are eligible for consideration under the RA and RI programs so long as those costs were incurred by the issuer. CMS assumes that issuers

have performed the necessary due diligence to validate such services were rendered and reimbursement is valid. Issuers will need to follow the guidance provided in the following table.

Table 66: Submitting Claims Otherwise Not Adjudicated

Rule 1	Issuers must include all required data elements and provide data that conforms to all verifications, as outlined in the most current version of the ICD and within the ESBR.
Rule 2	Issuers may use default values that are provided within the ESBR where necessary. All other data must be obtained from issuer sources (i.e. member bill, provider documentation, etc.).
Rule 3	Issuers must retain and make available, documentation that supports such services were validated, authorized and/or rendered should such claims be selected under audit.
Rule 4	For such services to be selected for RI or RA, an enrollment record must exist and claims must meet each program's claim selection criteria.

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, CMS will provide specific business rules for the submission of supplemental **Diagnosis Codes**.

Guidance on Health Assessments:

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:

There are two (2) acceptable sources for supplemental diagnoses, medical record and electronic data interchange (EDI).

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.

Issuers have two (2) options regarding **Supplemental Diagnosis Code** file submission for EDGE server data collection as a result of medical record review.

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 and then submit supplemental diagnoses found on the replacement claim along with the original report's diagnoses.
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.

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.

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 67: 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.

Table 67: Supplemental Diagnosis File Definitions (continued)

Detail Record Processed Date Time	The date and time when the **Supplemental Diagnosis Detail Record** was created by the issuer.
Add/Delete/Void Indicator	**Add Indicator** identifies if a **Supplemental Diagnosis Code** is added. **Delete Indicator** identifies if a previously submitted diagnosis is being deleted. **Void Indicator** identifies if a previously submitted **Supplemental Diagnosis Record** is being 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; • MR for medical record • EDI for electronic data interchange Only one (1) code per supplemental diagnosis.

There are additional supplemental diagnosis file processing terms that are used in the following sections that are defined in Table 68.

Table 68: 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 69.

Supplemental files are incremental files submissions. Each subsequent supplemental diagnosis file should include new diagnoses being added to an original claim, any diagnosis being deleted from an original claim, or any voids of previously submitted supplemental diagnosis records.

Full replacement supplemental diagnosis file submissions will result in records being rejected as duplicates.

More than one (1) supplemental diagnosis code for an original claim may be submitted on a supplemental record.

Table 69: Supplemental Diagnosis Code File Processing General Rules

Rule 1	A **Supplemental Diagnosis Code** must be associated with a paid claim or encounter for services that occurred during an enrollee's period of enrollment in a RA-eligible plan. Diagnosis Codes associated with a denied claim are not eligible for submission. 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.
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	The **Unique Enrollee ID** reported on the **Supplemental Diagnosis Code** file should correspond to a **Unique Enrollee ID** on the enrollment file.
Rule 7	**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 RA processing. Issuers will receive a report listing active **Supplemental Diagnosis Code** files that do not have an active enrollee record.
Rule 8	Issuers should plan accordingly to ensure that all **Supplemental Diagnosis Code** files are corrected and submitted by April 30th of the year following 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 4.6, 4.7, 4.8, and 4.9 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 70.

Table 70: Header, Issuer and Plan Level Total Verifications

Header, Issuer and Plan Level Total Claims, Total Claim Lines and Total Plan Paid	
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 (1) 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 71.

Table 71: Duplicate Checks Performed at the Supplemental File 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 72.

Table 72: 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 reference 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 73.

Table 73: 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 and the **Supplemental Diagnosis Detail Record ID** must be unique. 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 and the **Supplemental Diagnosis Detail Record ID** must be unique.
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 **Statement Covers From** and **Statement Covers Through** 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.

Table 73: Supplemental Diagnosis Code Add and Delete Rules (continued)

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 **Statement Covers From** and **Statement Covers Through** 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 RI or RA.

Similarly, supplemental files include a data element which allows issuers to void a **Supplemental Diagnosis Detail Record** that was previously accepted and stored as active. **Supplemental Diagnosis Detail Records** submitted with a "V" in the **Add/Delete/Void Indicator** data field bypass the duplicate check logic and proceed to void processing logic as outlined in Table 74.

Table 74: 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 Diagnosis Detail Record's Issuer ID** and **Supplemental Diagnosis Detail Record ID** respectively. • The date time stamp on the void must be later than the date time stamp on the original **Supplemental Detail Record ID**. • If these two (2) 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 or equal to the **Detail Record Processed Date Time** of the most current active version, then the submitted **Void** will be rejected and the original **Supplemental Diagnosis Detail Record** will not be inactivated. • 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 RA 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. Risk Adjustment and Reinsurance Calculations

For detailed information on how claims are selected by the Risk Adjustment and Reinsurance Programs for calculations, please refer to the below documents posted in the REGTAP Library:

Risk Adjustment

- Risk Adjustment Presentation Slides Introduction to the Affordable Care Act Risk Adjustment Program
- RA Risk Score Calculation & Reports

IMPORTANT NOTE: issuers should be aware that if a Service Code is not included on an outpatient institutional claim or professional claim, the claim and associated Diagnosis Codes will not be selected for RA.

Reinsurance

Reinsurance (RI) Quick Reference Guide Version 1.0

10. Assistance with Business Rules

Assistance with Business Rules

For assistance with any of the file processing rules outlined in this document or any other questions, please visit REGTAP at **www.REGTAP.info**. The REGTAP Library contains a history of Distributed Data Collection for RI and RA presentation slides and supporting 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 ESBR 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
4.0			Modify	All rules have been updated with rule numbers
4.0			Modify	All tables have been updated with Alt text, full header rows and “null” in blank cells
4.0			Modify	All tables have been updated with titles and placed in a Table of Contents
4.0			Modify	Informational content added
4.0	3		Modify	Added additional file type to introduction
4.0	4.1	Table 1	Modify	Added additional file type and updated file levels
4.0	4.3	Table 2	Modify	Added benefit year to the file processing terms
4.0	4.4		Modify	Informational content revised
4.0	4.5	Table 5	Modify	Additional rule added
4.0	4.6		Modify	Language updated to clarify truncation of areas and publication of timeline for accept/reject codes list
4.0	4.6	Table 6	Modify	Column name updated to Required/Situational/Not Required
4.0	4.7	Table 9	Modify	Language of final status in the header level verification clarified
4.0	4.8	Table 10	Modify	Added contiguous restrictions
4.0	4.10		Modify	Plan ID definition updated

Version	Section	Table	New/Modify/Delete	Description
4.0	5.1	Table 13	Modify	New definitions added
4.0	5.2	Table 14	Modify	New Rules added; current Rules updated for clarification
4.0	5.2		Delete	Removed Table: Overlapping Enrollment Periods and examples
4.0	5.4		Modify	Section title updated; examples tables added to section; and language added for examples
4.0	5.4	Table 20	Modify	Addition of new Rules
4.0	5.4	Table 21	Modify	Table name updated and example updated
4.0	5.4		Removed	Removed Table: Premium Dependencies and Table: Enrollment Period Dependencies
4.0	5.5		New	Added new section with Table 24; Table 23.
4.0	5.6		New	Added new section with Pursuant to 45 C.F.R. 155.705(b)(6)(ii) and 156.285(a)(3), issuers may not vary rates for a qualified employer during the employer's plan year. Therefore, the Federally-facilitated Small Business Health Options Program (FF-SHOP) may apply a new geographic rating factor only upon renewal. If an employer group moves the employer's principal business address to a different geographic **Rating Area** in the same state, the FF-SHOP will re-run the eligibility determination process to verify the employer is still located in the same state. If the employer moved to a different state and continues to opt to offer coverage to all full-time employees through the FF-SHOP in which the employer has a principal business address, the group will lose its eligibility for enrollment in the FF-SHOP in its former state and would have to re-apply to participate in the FF-SHOP in the new state. The rules pertaining to the **Enrollment Period Activity Indicator** are outlined in Table 25.
4.0			Modify	Examples added for changes in premium amount
4.0		Table 27	Modify	Rules updated
4.0			New	New section added
4.0	5.9		New	New section added

Version	Section	Table	New/Modify/Delete	Description
4.0	6.1	Table 30	Modify	New definitions added and current definitions updated
4.0	6.2	Table 32	Modify	Rule updated
4.0	6.4	Table 36	Modify	Rule updated
4.0	6.6	Table 39	Modify	Rule updated
4.00	06.7	Table 40	Modify	Rule updated
4.0	7		Modify	Language update
4.0	7.1	Table 43	Modify	Definition added
4.0	7.2		Modify	New language added
4.0	7.2	Table 45	Modify	New rules added and current Rules updated
4.0	7.7	Table 48	Modify	New Rule added and current Rule updated
4.0	7.8	Table 50	Modify	New Rule added and current Rule updated
4.0	7.9		Modify	Language added
4.0	7.9	Table 53	Modify	Rule updated
4.0	7.10		Modify	Examples added and example tables added
4.0	7.12	Table 54	Modify	Rules updated

Version	Section	Table	New/Modify/Delete	Description
4.0	7.13	Table 55	Modify	Rules updated
4.0	7.14	Table 56	Modify	Rule updated
4.0	7.15	Table 57	New	New table added
4.0	7.16		Modify	Example updated
4.0	7.17		Modify	Language updated
4.0	7.17	Table 59	Modify	Rule removed and current Rule updated
4.0	7.18		Modify	New examples added and new example tables added
4.0	7.18	Table 61	Modify	Rules updated
4.0	7.18	Table 62	Modify	Rule updated
4.0	7.19		Modify	New example tables added
4.0	7.20	Table 64	Modify	Rules updated
4.0	7.21		New	New section added with Table 65
4.0	7.22		New	New section added with Table 66
5.0	1.0		Modify	Language updated
5.0	2.0		Modify	Language updated
5.0	4.1		New	New language added
5.0	4.3		Modify	Language updated
5.0	4.4		Modify	Language updated
5.0	4.4	Table 3	Modify	Description updated
5.0	4.4	Table 4	Modify	New policy statement added
5.0	4.5	Table 5	Modify	Rules updated
5.0	4.6	Table 6	Modify	Verification edits updated
5.0	4.6		Modify	Language added
5.0	4.7	Table 9	New	Rule added
5.0	4.7		Modify	Language added
5.0	4.9	Table 11	Modify	Language added
5.0	4.10	Table 12	Modify	Language added
5.0	5.0		Modify	Language added
5.0	5.1	Table 13	Modify	Definition updated
5.0	5.2		Modify	Language added
5.0	5.2	Table 14	Modify	Rules updated
5.0	5.2		New	Language added
5.0	5.2	Table 15	New	Table added
5.0	5.2	Table 16	New	Rule added
5.0	5.3	Table 18	Modify	Rule updated
5.0	5.4		Modify	Language added
5.0	5.4	Table 20	Modify	Rules updated
5.0	5.4	Table 21	Modify	Rules updated
5.0	5.5		Modify	Language added

Version	Section	Table	New/Modify/Delete	Description
5.0	5.5	Table 22	New	Rules added
5.0	5.5		New	Examples added and language provided
5.0	5.5	Table 23	Modify	Rule updated
5.0	5.5	Table 24	New	Language added
5.0	5.5		Delete	Examples deleted
5.0	5.6		New	Sections added, language added and examples added
5.0	5.7		New	Language added
5.0	5.7	Table 25	New	Rules added
5.0	5.7		New	Examples added
5.0	5.8	Table 27	New	Rules added
5.0	5.8		New	Examples and language added
5.0	5.8		Deleted	Examples deleted
5.0	5.8	Table 28	New	Rules added
5.0	5.9	Table 29	New	Rule added
5.0	6.1	Table 30	Modify	Definition updated
5.0	6.2	Table 32	New/Modify	Rules added and updated
5.0	6.3	Table 33	Modify	Rules updated
5.0	6.4	Table 34	Modify	Rules updated
5.0	6.4	Table 35	New/Modify	Rule added and modified
5.0	6.4	Table 36	Modify	Rule updated
5.0	6.4	Table 37	New	Rules added
5.0	6.6	Table 39	New/Modify	Rules added and updated
5.0	6.6		Modify	Examples updated
5.0	6.7	Table 40	Modify	
5.0	6.7		New	Language added
5.0	6.8	Table 41	Modify	Rules updated
5.0	6.8		New	Language added
5.0	6.9		Modify	Language updated
5.0	6.9	Table 42	Modify	Rules updated
5.0	7.0		Modify	Language added
5.0	7.2		New	Section added
5.0	7.2		Deleted	Language deleted
5.0	7.3	Table 45	Modify	Rules updated and rules deleted
5.0	7.4		New	Rules added
5.0	7.7	Table 48	New/Modify	Rules updated and added
5.0	7.9		New	Language added
5.0	7.9	Table 51	Delete	Rule deleted
5.0	7.9		Delete	Language deleted
5.0	7.11	Table 53	Modify	Rules updated
5.0	7.12	Table 54	Add/Modify	Rules updated and added
5.0	7.12		New	Example added

Version	Section	Table	New/Modify/Delete	Description
5.0	7.13	Table 55	Modify/Delete	Rules updated and deleted
5.0	7.13		New	Example added
5.0	7.14		Delete	Language deleted
5.0	7.14	Table 56	Modify	Rules updated
5.0	7.16		New	Rule added
5.0	7.16	Table 58	Modify	Rule updated
5.0	7.17	Table 59	Modify	Rule updated
5.0	7.17	Table 61	New	Rule added
5.0	7.19		New	New language added
5.0	7.19	Table 63	Modify	Rules updated
5.0	8.0		Delete	Language deleted
5.0	8.0		New	Language added
5.0	8.1	Table 67	New	Definitions added
5.0	8.2		New	Language added
5.0	8.3		Modify	Language updated
5.0	8.4	Table 71	Modify	Table updated
5.0	8.6	Table 73	Modify	Rules updated
5.0	8.7		New	Language added
5.0	8.7	Table 74	Modify	Rules updated
5.0	9.0		New	Section added
5.0	Appendix C		Deleted	Appendix deleted

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
CEFR	EDGE Server Claim and Enrollee Frequency Report
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
ECD	Enrollee (Without) Claims Detail
ECS	Enrollee (Without) Claims Summary
EDGE	External Data Gathering Environment
ES	EDGE Server
ESDMCE	EDGE Server Detail Medical Claim Error Report for Medical Submission
ESDPCE	EDGE Server Detail Pharmacy Claim Error Report for Pharmacy Submission
ESDEE	EDGE Server Detail Enrollment Error Report for Enrollment Submission
ESDSFE	EDGE Server Detail Supplemental Diagnosis File Error Report
ESES	EDGE Server Enrollment Submission
ESFAR	EDGE Server File Accept-Reject Report for Enrollee, Medical and Pharmacy Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental Diagnosis File Submission
ESSEFE	EDGE Server Detail Supplemental Diagnosis File Error Report
ESSMFE	EDGE Server Summary Medical Claim File Accept-Reject Error Report
ESSPFE	EDGE Server Summary Pharmacy Claim File Accept-Reject Error Report
ESSSFE	EDGE Server Summary Supplemental Diagnosis File Accept-Reject Error Report
FDEEAF	Frequency by Data Element for Enrollment Accepted Files Report
FDEPAF	Frequency by Data Element for Pharmacy Accepted Files Report
FDEMAF	Frequency by Data Element for Medical Accepted Files Report
FDESAF	Frequency by Data Element for Supplemental Accepted Files Report
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

Acronym	Term
RA	Risk Adjustment
RACSD	Risk Adjustment Claim Selection Detail Report
RACSS	Risk Adjustment Claim Selection Summary Report
RADVPS	Risk Adjustment Data Validation Population Summary Statistics Report
RARSD	RA Risk Score Detail Report
RARSS	Risk Adjustment Risk Score Summary Report
RATEE	Risk Adjustment Transfer Elements Extract
RAUF	Risk Adjustment User Fee
REV Code	Revenue Code
RI	Reinsurance
RIDE	Reinsurance Detail Enrollee Report
RISR	Reinsurance Summary Report
RxC	Pharmacy Claim
SE	EDGE Server System Error Report
SFTP	Secure File Transfer Protocol
SSH	Secure Shell
SSL	Secure Socket Layer
UI	User Interface
XML	eXtensible Markup Language
XSD	XML Schema Definition