February 4, 2025, Submitter Webinar

Claim Versioning

ATTENDEES	
• Lee Spangler, Executive Director	• Devin York, Senior Project Manager
• Joseph Harrison, Data Process Manager	• Jodie Nassar, Data Operations Manager

AGENDA
• Claim Versioning

DISCUSSION TOPICS – Q&A

General

1. General comments from the Center:

The Center thanks everyone for participating in this submitter forum. The answers provided here are our best understanding of the questions submitted. As always, something may get lost in translation. If there needs to be further clarification on any question, please submit a ticket and we can start that dialogue.

Some questions may have been repeated from the last Q&A as they are still pertinent.

Operational

2. Will I be able to explain how my systems work in terms of claim versioning on the survey?

Yes, we intend to provide freeform fields where you can document your concerns. Additionally, the TX-APCD may reach out to discuss your operational constraints if you are unable to align with one of the specified versioning options.

3. We would like to have a generic email address for correspondence, is this possible?

For security concerns, the TX-APCD requires that every account be tied to a specific person. A generic email address would need to be linked to a generic account, which would be a security issue as the

account is passed down through the organization. The TX-APCD contains very sensitive data, and we need to ensure that account activity is auditable.

4. **Does the CDL layout have a separate Scheme Identifier as a field to support multiple scheme submissions? Or does it depend on the conversation we have with your team to use an exact Scheme type?**

Thank you for this feedback. The TX-APCD survey will allow you to document where you have differing schemes per file or submission.

5. **I have a question not directly related to the subject of this meeting. My question is, what is the minimum number of monthly files do we need to submit for testing for CDL v3.0.1—one month, 2 months, or 3 months? Additionally, is a successful test required for each registered Payor Code?**

One would be the minimum. However, once you have a working program subsequent submission over multiple months will provide you with better information regarding the quality of your data.

You should ensure that each unique system/extract process be tested. Please reference Technical Guide (TG) 5.4: Testing guidelines.

Claim Versioning

6. **I do not believe our new vendor for claims processing will fit into these four scenarios. What shall we do?**

For any reason that may not allow you to align with one of these claim version options (vendor issues, system migrations, etc.) please document your concerns in the survey to be provided later. Once we've collected the survey results, we will follow up to discuss your issues.

7. **So, the CDL 3.0.1 is not up to date regarding this guidance?**

That is correct. We intend to harmonize the claim line type codes soon. As you are aware, the CDL is part of the rule-making process and was adopted while our claim versioning research and data-analysis was ongoing.

8. **Several questions: Can you include definition of a 'forward' claim?**

A forward claim is one that has a subsequent version to it.

9. Assuming all references are to 'claim' are at the line level?

Yes. If an entire claim is voided or denied, we will not include it in the production data warehouse.

10. Will the resubmission of the full claim for any lines on the claim that is adjusted 'duplicate' expenses reported to APCD?

We certainly hope not, we are attempting to derive a "final" version of the claim at any point in time to be shown in the production data warehouse. We realize that any "final" version may also be subsequently revised in some manner which will then replace the "final" version in the data warehouse, keeping all raw versions in the raw data files.

11. How should corrected claims be submitted? These are scenarios in which the provider submits a corrected claim, which generates a new claim number, but results in the original claim being reversed with negative values.

The completely revised (corrected) claim should either have: (1) a new claim number with a reference to the former claim, or (2) have the same claim number. If the new claim number refers to the former claim we can link them and be sure we generate a "final" version and/or void the original claim. If it has the same claim number, the versioning methodology applies.

12. The following assumption raises a question for us: "The most recent version of a claim line should not be a backout (except where forward claim is expected, else claim line should be voided.)" Considering the above, there may be a backout that occurs on the last day of a reporting period. If the subsequent claim does not occur until the following month (and therefore included in a separate submission file), this means that the most recent version of a claim line in a single month's report would be a backout. Will the system flag this as an issue or will it allow that instance if it's at the end of a month once it sees the following month has the additional Adjustment line?

The TX-APCD looks across time to identify a "final claim/line", thus if a backout or amendment occurs in a month following the original, we revise the claim in our data warehouse to the most recent "final" version. All monthly versions are kept in the raw data files.

13. Per my prior question, a corrected claim would result in a backout being the final transaction under one claim number, and the corrected claim would be a new claim number.

In this case we would expect to see a reference number to the original claim so we can follow the sequencing.

14. What happens if the original claim comes in one calendar year, and an adjustment comes in a different year, resulting in a completely different claim number being utilized? While the date of service is the same, the claim number is not the same for the original claim and the adjustment claim. Though the comment line of both claims will reference both claim numbers.

We would require the void claim be submitted at its relevant date, and we would link it to the original claim to derive a "final" version. The TX-APCD expects the submission of all adjudicated claims including voided claims. In this scenario, we would expect a reference number to the original claim so that the claims can be linked.

15. The Claim Line Type slide lists only O = Original; B = Back Out; A = Amendment; V = Void. Whereas the CDL lists valid codes: O = Original; V = Void; R = Replacement; B = Back Out; A = Amendment; D = Denial. Where can we find the definition for Replacement? When would the R claim type code be used? No scheme examples use R.

We've reduced the number of claim line types that now may be submitted. Please reference the claim types in the claim versioning presentation.

16. To clarify, should denied claims be flagged as void?

Note: *This refers to claim LINES, if the entire claim was denied due to (perhaps) the individual was not eligible, then it should not be reported and several CARC codes covering these situations are not required.*

Medical:

(a) *It was not paid (example, the procedure happened but was not covered) – then it would be reported as O (original) with Denied Claim Line Indicator = Y, and CARC giving the reason.*

(b) *It was previously paid – then it would be reported as B (backout) with Denied Claim Line Indicator = Y, and CARC giving the reason.*

(c) *It was voided (as if the procedure never happened) – then it would be reported as V (void) with Denied Claim Line Indicator = Y and CARC giving the reason.*

Pharmacy:

(a) *It was not paid – then it would be reported a O (original) with RECORD STATUS CODE = 2 (for Rejected) along with appropriate REJECT CODE (CDLPC067).*

(b) *It was previously paid – then it would be reported as B (backout) with appropriate REJECT CODE (CDLPC067).*

(c) *It was voided – then it would be reported as V (void) with appropriate REJECT CODE (CDLPC067).*

Dental:

**CDLDCXXX would be used as the equivalent of DENIED CLAIM LINE INDICATOR:*

1 = Denied, 2 = Not denied

(a) *It was not paid - then it would be reported as O (original) with CDLDCXXX set to 1*

(b) *It was previously paid - then it would be reported as B (backout) with CDLDCXXX set to 1*

(c) *It was voided - then it would be reported as V (void) with CDLDCXXX set to 1*

ACTION ITEMS
• Follow-up survey.